The Doctor's & Healthcare Administrator's

2021 Guide to Medicare CPT Codes, Qualifications and Support Methodology


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Hello! We are Vital Health Links, a doctor-led provider of dedicated coordinated care.

We partner with practices across the country, but credit out midwestern diligence and care to our home-base, among the shores of 10,000 lakes, in Minnesota. In other words, we are friendly and would love to connect with you.

To say 'hello'

CARE @VITALHEALTHLINKS.COM | 1-888-515-VHL-0 (8450)

Dear colleagues,

Integrated Chronic Care Management works. It helps mitigate the systemic drain caused by chronic illness treatment, which is 3.5 times more expensive to treat than other conditions and accounts for 90% of U.S. healthcare costs, according to the American Heart Association. Moreover, it works so well that reimbursements for non-face-to-face CCM have steadily increased and broadened since the introduction of CPT 99490 in 2015.

As you know, in 2020, the need for virtual health exploded. Results included the massive patient and physician adoption of platforms like Remote Patient Monitoring and telehealth—even among some of the slowest populations to change. Despite initial protests, virtual health platforms proved so efficient and safe they became an accepted, if not necessary, tool to provide quality care.

For the first time, the platforms that support CCM and RPM are considered business-as-usual. Moreover, the paths of least resistance favor providing quality care to more patients and increasing reimbursements without compromising.

In this guide, you will find the critical elements to provide more profitable, personalized care that complements and enhances your existing model and standards of healthcare.

Welcome to your practice without boundaries.

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Important reading for those who....

- Are ready to move forward with CCM/RPM but don't know the next steps
- See the value of CCM/RPM for their patients and practice, but worry about time and resources needed to meet requirements
- Recognize the benefits of a partner who can scale their program effectively and improve value
- Want to understand better the connection between CCM, RPM and other CMS initiatives
- Recognize that 10,000 baby boomers will turn 65 every day for the next 8 years, which is a growing patient base that is prone to devel-oping multiple chronic conditions
- Are participating in RHC or FQHC and can now con tract with third parties to deliver CCM

Addressing early challenges.

Medicare's CCM program began in 2015 with CPT 99490, which, at that time, reimbursed physicians approximately $41 per patient per month for providing at least 20 minutes of non-face-to-face care coordination activities to eligible Medicare beneficiaries with two or more chronic conditions.

The code offered an opportunity for physicians to build a new revenue stream by supporting the proactive, between-visit care of their Medicare patients.
It also provided reimbursement for the extra time and effort they were already investing in caring for chronic patients outside of traditional office visits

Early Adopters

At first, the adoption of the CCM program was slower than expected. While there was significant interest in CPT 99490 and its reimbursements, there were substantial challenges for implementing it. Practices that tried to do it independently often found they could not adequately meet Medicare's requirements in time or scope.

Additionally, some early adopters struggled with physician engagement, patient education, staffing, workflows, and technology challenges.

To implement CCM without third-party support and scale effectively, a physician's practice would need to hire one full-time employee for every 200 to 250 Medicare patients enrolled, according to estimations. Plus, the program required providing non-visit-based care, 24/7 access to clinical staff, creating a comprehensive care plan for each patient, ongoing care management for all chronic conditions, and more. With physicians and their staffs already feeling stretched thin, how could they possibly add to their workload?

But as daunting as implementing CCM seemed, doing nothing wasn't an option. With every passing month, practices were missing out on CCM's potential revenue stream, and patients missed important, between-visit care.

There was also another business perspective to consider. It was becoming clear that implementing CCM was a necessary stepping stone toward something more significant: a precursor to the type of care physicians would need to demonstrate to achieve success with programs like MACRA (the Medicare Access and CHIP Reauthorization Act in 2015). As a result, there was a genuine possibility that practices without CCM could be at a disadvantage as the industry continued its shift away from fee-for-service toward value-based care.

The Third Party Solution

From the onset of the code, CMS (Center for Medicare and Medicaid Services) had recognized how demanding the program's protocols could be, so it set the requirement as "indirect supervision" (except, at that time, for RHCs and FQHCs). This allowed physician practices to bring in a third party to provide CCM services to patients on the practice's behalf. The intent was to provide a viable option for practices to meet the protocols. At the same time, ensuring patients were not denied the benefit of CCM because a practice didn't have the infrastructure to provide it.

As physicians partnered with third parties, the implementation of CCM grew: once there had been primarily single-physician practices actively seeking CCM support, but larger practices started to recognize the potential of partnering with care coordination companies.

Some had tried to implement CCM on their own and found they couldn't sustain or scale it. Others had experienced some success with CCM but now wanted to take it to the next level and maximize their reimbursements.

2016 Data Spurs Excitement, Implementation

In 2015 CCM was brand new to physicians. But by 2016, there was data about CCM circulating, included data that proved assumptions about the program's value. There were also testimonials verifying generated revenue, improved health outcomes, cost savings, and even examples of CCM helping save lives. This increased physician engagement and subsequent adoption.

A review of several studies[1] showed results from care coordination::

↓25%

Hospitalizations
Health Quality Partners, a participant in the Medicare Coordinated Care Demonstration)

↓36%

Readmissions
University of Pennsylvania

↓26%

ER visits
Health Quality Partners

↓26%

Skilled nursing facility days
Johns Hopkins University

↓29%

Home health episodes
Johns Hopkins University

> **Practices that haven't implemented CCM could be at a disadvantage as the industry continues its shift away from fee-for-service toward value-based care.**

2016 Data Spurs Excitement, Implementation

Additionally, research from a care coordination solutions company showed recipients of CCM services benefited in the following ways

64%
Avoided one or more duplicate tests in a year

84%
Said it helped them remember important follow-up items they had forgotten after an appointment

65%
Said they felt more engaged in their healthcare experience

49%
Reported finding a medical error and 33% of those errors were significant enough to potentially cause an adverse effect

9%
Avoided serious drug interactions

Social media sources, articles from organizations like AARP, and patient resources in doctor's offices also fostered patient education regarding CCM and care coordination, helping to make enrollment easier.

> **10,000 baby boomers will turn 65 everyday for the next 8 years, a growing patient base that is prone to developing multiple chronic conditions.**

Early RHC AND FQHCs Changes

In 2015, RHCs and FQHCs were unable to participate in CCM. In 2016, they could participate in CCM, but any non-face-to-face care coordination services had to be furnished by clinical staff under direction supervision. This meant they had to provide these services while present in the same office as the supervising practitioner who had to be immediately available to provide assistance.

"RHCs and FQHCs can bill for CCM via HCPCS code G0511. Medicare reimburses $62.28 per patient per month."

For most RHCs and FQHCs, this presented a considerable challenge. Clinical staffs were overwhelmed by CCM during regular office hours, practitioners were burdened by supervising after-hours, and for some practices, CCM requirements felt unrealistic given budget, resources, and time constraints.

However, recognizing the need to remove obstacles to broader CCM implementation and ensure RHCs and FQHCs requirements were "not more burdensome than those for practitioners billing under the PFS," The CMS made changes to CCM requirements as they apply to RHCs and FQHCs.

RHCs and FQHCs can realize potential annual revenue of $747,360 per 1000 patient enrolled.

The first change gives RHCs and FQHCs the abilit to have general supervision of clinical staff, which allows them to now contract with third parties to deliv-er effective CCM programs and services on their behalf under HCPCS code G0511.

The second change amended the requirement that CCM patients have 24/7 direct access to RHC and FQHC practitioners. Instead, they must have 24/7 access to auxiliary personnel who have the means to contact those practitioners.

The third change is the most significant. CMS combined all care management services, including Transitional Care Management, Chronic Care Management, and Behavioral Health Integration, into one HCPCS code G0511. This code can be billed one time per month.

With these changes in place, RHCs and FQHCs are now much better positioned to improve the overall health of their patients and generate new revenue for their practice through HCPCS Code G0511 (RHCs and FQHCs are not able to participate in the new complex CCM codes or add-on code).

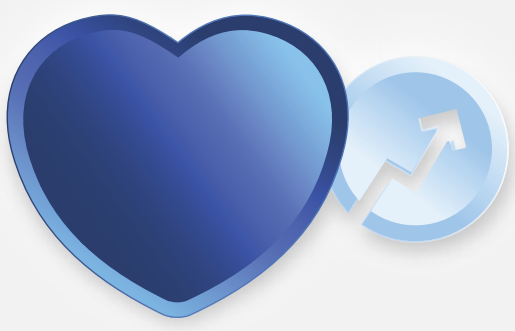
MACRA Forced Physicians to Look Outward

A big boost for CCM adoption was the official implementation of The Medicare Access and CHIP Reauthorization Act of 2015, known as MACRA.

January 1, 2017, was the first performance year under MACRA, a complete game-changer for the healthcare industry.

MACRA had a dramatic impact on the way Medicare pays physicians moving forward by repealing the Sustainable Growth Rate (SGR) Formula that had determined Medicare Part B reimbursement. Yet, a survey by Deloitte revealed that as late as June 2016, nearly half of U.S. physicians were unfamiliar with MACRA, at a time when the program was only six months away from its implementation. Additionally, many hadn't adopted CCM yet, which would have helped prepare them for what was to come.

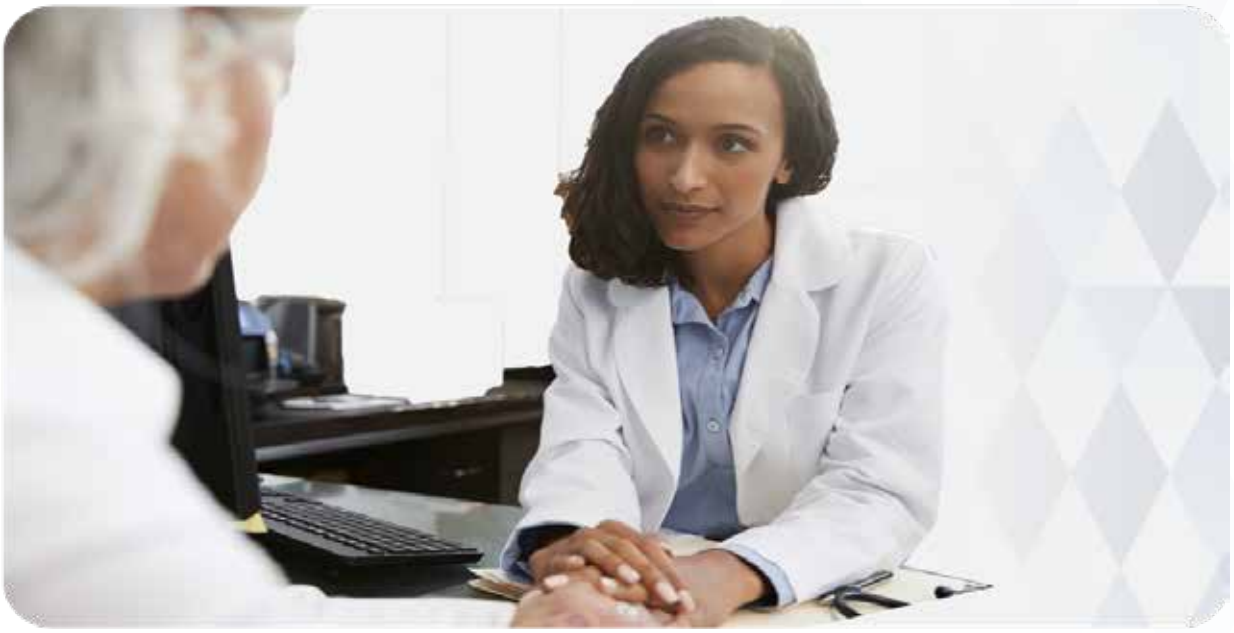
As government deadlines drew closer and the threat of negative payment adjustments from Medicare loomed, physicians are increasingly turning to third parties to help them implement CCM. As more physicians acknowledge the connection between CCM services and major initiatives such as MACRA, there is a growing understanding that implementing CCM creates a foundation for success with MACRA and an extraordinary ability to demonstrate quality and performance-based measures.



CCM creates a foundation for success with MACRA and an extraordinary ability to demonstrate quality and performance-based measures.

Comp. Primary Care +

Like MACRA, even as implementation grew closer, physicians remained unfamiliar with implementing Comprehensive Primary Care Plus (CPC+), a national advanced primary care medical home model. The care coordination services behind CCM are also behind programs like CPC+. As Round 1 of this new care delivery and payment model for primary care began on January 1, 2017, it became increasingly clear to participants how much familiarity with and implementation of CCM would go a long way toward setting practices up for success. Providing CCM to patients can serve as a precursor to attribution in CPC+, and specific fees in the program are intended to pay for CCM-covered services.



A doctors' touch, extended.

Vital Health Links care coordinator provides a clinical approach to CCM and RPM support that fulfills the needs of doctors and patients.

Comprehensive Care Plan

At the core of the CCM program, physicians must maintain a regularly updated, person-centered, electronic care plan. It must:

"At the core of the CCM program, physicians must maintain a regularly updated, personcentered, electronic care plan."

- Be created, revised, and/or monitored
- Be based on a physical, mental, cognitive, psychosocial, functional, and environmental assessment of the patient
- Include all health issues, with particular focus on the chronic conditions being managed
- Include an inventory of resources and supports (for example, care planning tools and resources publicly available from a number of organizations, such as diabetes information from the American Diabetes Association)

The CCM provider must at least electronically capture care plan information and ensure the care plan can be shared electronically (as of 2017, this can include fax), in a timely manner, with individuals involved in the patient's care. A copy of the care plan must be given to the patient and/or caregiver.

CCM/RPM Billing & Qualifications

With the expansion of the CCM program and Remote Patient Monitoring, CMS now offers more opportunities to help patients achieve optimum health while putting physicians and practices in the best possible position to receive reimbursement for their care coordination efforts. The following describes CCM program fees and details.

CPT Code	Description	Requirements	Reimbursements
99453	Initial setup: remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate	Patient education on use of equipment	$19 *One-time reimbursement
99091	Collection and interpretation of physiologic data (eg, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified healthca e professional, qualified by education, training, licensu e/ regulation (when applicable)	Requiured minimum of 30 minutes of time, each 30 days	$57
99454	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with dailyb recording(s) or programmed alert(s) transmission	Every 30 days	$63
99457	Remote physiologic monitoring treatment management services by clinical staff/physician/other qualified healthca e professional	20 minutes or more time in a calendar month Interactive communication with the patient or a caregiver during the month	$51
99458	Remote physiologic monitoring treatment management services by a clinical staff/physician/other qualified health care professional.	Additional 20 minutes interactive communication with the patient/caregiver during the month;	$41

CPT Code	Description	Requirements	Reimbursements
99490	Chronic care management services, directed by a physician or other qualified healthca e professional	• 20 minutes or more time in a calendar month, multiple (two or more) • Chronic conditions expected to last at least 12 months, or until the death of the patient; • Chronic conditions place the patient at significant risk of death acute exacerbation/ decompensation, or functional decline; • Comprehensive care plan established, implemented, revised, or monitored.	$42
99457	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial device(s) supply with daily recording(s) or programmed alert(s) transmission	Every 30 days	$63
99458	Remote physiologic monitoring treatment management services by a clinical staff/physician/other qualified health care professional.	Each additional 20 minutes of clinical staff time directed by a physician or other qualified healthca e professional, per calendar month	$63

NOTE: INFORMATION IN THIS PUBLICATION APPLIES ONLY TO THE MEDICARE FEE FOR-SERVICE PROGRAM/ MEDICARE

RHC & FQHC FAQs: answered.

Care Management Services for Rural Health Clinics and Federally Qualified Health Centers Frequently Asked Questions. Source CMS.org

Q1. What are care management services?

A1. Care management services in RHCs and FQHCs include the following 4 services:

- Transitional Care Management
- Chronic Care Management
- General Behavioral Health Integration (BHI)
- Psychiatric Collaborative Care Model (CoCM)

Q2. Are care management services considered RHC and FQHC services?

A2. Yes, care management services are RHC and FQHC services.

Q3. Are RHCs and FQHCs required to provide TCM, CCM, general BHI, or psychiatric CoCM services?

A3. No. These structured care management services are in addition to any routine care coordination services already furnished as part of an RHC or FQHC visit.

Q4. Where can I find information on the requirements for each of the care management services?

A4. Please see Addendum I of this FAQ document for information on RHC and FQHC requirements and payment for CCM, General BHI, and Psychiatric CoCM. Information is also available on the RHCs and FQHCs webpages:
https://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html
https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHCCente .html

Q5. How do RHCs and FQHCs bill for care management services and how are they paid?

A5. Care Management services are billed and paid as follows:

TCM: For TCM services furnished on or after January 1, 2013, TCM services can be billed by adding CPT code 99495 or CPT code 99496 to an RHC or FQHC claim, either alone or with other payable services. If it is the only medical service provided on that day with an RHC or FQHC practitioner it is paid as a stand-alone billable visit. If it is furnished on the same day as another visit, only one visit is paid.

CCM: For CCM services furnished between January 1, 2016 and December 31, 2017, CCM services can be billed by adding CPT code 99490 to an RHC or FQHC claim, either alone or with other payable services. Payment is based on the Physician Fee Schedule (PFS) national average non-facility payment rate for CPT code 99490.

For CCM services furnished on or after January 1, 2018, CCM services can be billed by adding the general care management G code, G0511, to an RHC or FQHC claim, either alone or with other payable services. Payment is set annually at the average of the national non-facility PFS payment rate for CPT codes 99490 (20 minutes or more of CCM services), 99487 (60 minutes or more of complex CCM services), and 99484 (20 minutes or more of general behavioral health integration services).

For CCM services furnished on or after January 1, 2019, CCM services can be billed by adding the general care management G code, G0511, to an RHC or FQHC claim, either alone or with other payable services. Payment is set annually at the average of the national non-facility PFS payment rate for CPT codes 99490 (20 minutes or more of CCM services), 99487 (60 minutes or more of complex CCM services), CPT code 99491 (30 minutes or more of CCM services furnished by an RHC or FQHC practitioner) and 99484 (20 minutes or more of general behavioral health integration services).

General BHI: For general BHI services furnished on or after January 1, 2018, general BHI services can be billed by adding the general care management G code, G0511, to an RHC or FQHC claim, either alone or with other payable services. Payment is set annually at the average of the national non-facility PFS payment rate for CPT codes 99490 (20 minutes or more of CCM services), 99487 (60 minutes or more of complex CCM services), and 99484 (20 minutes or more of general behavioral health integration services).

Psychiatric CoCM: For psychiatric CoCM services furnished on or after January 1, 2018, psychiatric CoCM services can be billed by adding the psychiatric CoCM G code, G0512, to an RHC or FQHC claim, either alone or with other payable services.
Payment is set annually at the average of the national non-facility PFS payment rate for CPT codes 99492 (70 minutes or more of initial psychiatric CoCM services) and CPT code 99493 (60 minutes or more of subsequent psychiatric CoCM services).

Q6. What are the 2019 payment rates for care management services in RHCs and FQHCs?

A6. The 2019 care management payment rates are:
TCM (CPT code 99495 or 99496) – Same as payment for an RHC or FQHC visit
CCM or General BHI (HCPCS code G0511) – The 2019 rate is $67.03.
Psychiatric CoCM (HCPCS code G0512) - The 2019 rate is $145.96.

Q6a. What are the 2020 payment rates for care management services in RHCs and FQHCs?

A6a. The 2020 care management payment rates are:
TCM (CPT code 99495 or 99496) – Same as payment for an RHC or FQHC visit
CCM or General BHI (HCPCS code G0511) – The 2020 rate is $66.77.
Psychiatric CoCM (HCPCS code G0512) - The 2020 rate is $141.83.

Q7. Will the payment rate change?

A7. All payment rates are adjusted annually. The RHC TCM rate is the same as the RHC All-Inclusive Rate (AIR), which is adjusted annually based on the Medicare Economic Index. The FQHC TCM rate is the lesser of the FQHC's charges or the FQHC PPS rate, which is adjusted annually based on the FQHC Market Basket. The payment rates for general care management and psychiatric CoCM services are updated annually based on updates to the CCM, general BHI, and psychiatric CoCM codes in the PFS.

> **"CCM is a critical component of primary care that contributes to better health and care for individuals."**
>
> *-American Medical Association*

Q8. Will the payment methodology for care management services change?

A8. (CMS) will be reviewing available data over the next several years as more RHCs and FQHCs furnish these services. If the data indicates that a weighted average may be more appropriate in determining the payment rates, (CMS) would consider proposing a revision to the methodology. Any changes to the payment methodology would be undertaken through future notice and rule making.

Q9. Could new care management services be added in the future?

A9. If new care management services become available, (CMS) will evaluate them to determine their applicability to RHCs and FQHCs. The addition of any new codes or services would be undertaken through future notice and rule making.

Q10. Will claims submitted with CPT 99490 be paid?

A10. Claims with CPT code 99490 for CCM services furnished on or before December 31, 2017, will be processed and paid. Service lines reported with CPT code 99490 will be denied for dates of service on or after January 1, 2018.

Q11. Will claims with CPT codes 99487, 99484, or 99493 be paid?

A11. No. RHCs and FQHCs are required to bill for care management services using G0511 or G0512

Q12. Do coinsurance and deductibles apply to care management services?

A12. Coinsurance and deductibles apply to all care management services in RHCs, and coinsurance applies to all care management services in FQHCs.

Q13. If a patient cannot affo d the copayment but would benefit from this service, can the copayment be waived?

A13. The coinsurance for care management services cannot be waived, however, many RHCs and FQHCs offer financial assistance for patients who qualif .

Q14. How is coinsurance determined for care management services?

A14. Coinsurance is the lesser of the submitted charges or the payment rate.

Q15. What are the care management CPT codes and rates for practitioners billing under the PFS?

A15. The CPT codes for practitioners billing under the PFS are:
TCM - CPT code 99490 (Moderate Complexity), CPT code 99496 (High Complexity)
CCM - CPT code 99490 (>20 minutes), CPT code 99487 (>60 minutes complex), CPT 99491 (>30 minutes practitioner furnished)
General BHI - -CPT code 99484 (>20 minutes)
Psychiatric CoCM - CPT code 99492 (Init. >70 min.), CPT code 99493 (Subseq. >60min.)
The care management rates paid under the PFS can be found at https://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/PFSLookup/index.html?redirect=/pfslookup/02_pfssearch.asp

Q16. Are care management services required to be billed on a claim with an RHC or FQHC visit?

A16. No. Care management services can be billed either alone or on a claim with an RHC or FQHC billable visit.

Q17. Will care management services be paid in addition to an RHC or FQHC visit?

A17. Yes. If care management services are billed on the same claim as an RHC or FQHC visit, both will be paid.

Q18. If an RHC submits a claim for a billable visit and a care management service, is the total payment subject to the RHC payment limit?

A18. Except for TCM, which is paid as an RHC visit, payments for G0511 and G0512 are not factored in to the RHC AIR. The RHC would be paid 80% of their rate for the billable visit, subject to the RHC payment limit, plus 80% of the charges for care management.

Q18. If an RHC submits a claim for a billable visit and a care management service, is the total payment subject to the RHC payment limit?

A18. Except for TCM, which is paid as an RHC visit, payments for G0511 and G0512 are not factored in to the RHC AIR. The RHC would be paid 80% of their rate for the billable visit, subject to the RHC payment limit, plus 80% of the charges for care management.

Q19. If an FQHC submits a claim for a billable visit and a care management service, would these be added together to determine the payment?

A19. No. The FQHC would be paid 80% of the lesser of its charges or the fully adjusted PPS rate for the billable visit,plus 80% of the charges for care management.

Q20. What revenue code should be used for care management services?

A20. Care management services should be reported with revenue code 052x.

Q21. What date of service should be used on the claim?

A21. The service period for care management services is a calendar month. The date of service can be the date that the requirements to bill for the service have been met for that month, or any date after that but on or before the last day of the month.

Q22. When should the claim be submitted?

A22. The claim can be submitted when the requirements to bill for the services have been met, or any time after that within the timely filing requirement period, which is one year from the date of service (Pub 100-04, chapter 1, section 70).

Q23.What diagnosis code should be used when billing for care management services? Are there specific conditions that qualify?

A23. All claims must include a diagnosis code and practitioners should use the most appropriate diagnosis code for the patient.

Q24. Can care management costs such as software or management oversight be included on the cost report?

A24. Yes. Any cost incurred as a result of the provision of RHC and FQHC services, including care management, is a reportable cost and must be included in the Medicare cost report. Direct costs for care management services are reported in the “Other than RHC/FQHC Services” section of the cost report and are not used in determining the RHC AIR or the FQHC PPS rate.

Q25. Can RHCs and FQHCs bill for more than one care management service in the same month for an individual?
For example, could an RHC or FQHC furnish 20 minutes of CCM services at the beginning of the month, and 70 minutes of psychiatric services later in the month, and bill for both?

A25. No. RHCs and FQHCs can only bill one care management service for an individual per month.

Q26. Can an RHC or FQHC bill HCPCS codes G0511 or G0512 twice in the same month if more than twice the required amount of time is used?

A26. No. The specified amounts of time a e minimum requirements and there is no additional payment if more time is spent.

Q27. Can RHCs and FQHCs bill for care management during the same month as another facility that bills for care management?

A27. RHCs and FQHCs can bill for care management services if all the requirements for billing are met and there is no overlap of dates of services with another entity billing for care management services.

Q28. Can RHCs and FQHCs bill for care management services furnished to a patient in a skilled nursing facility (SNF)?

A28. RHCs and FQHCs cannot bill for care management 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 RHC or FQHC could bill for care management services furnished to the patient while the patient is not in the Part A SNF if the care management requirements are met.

Q29. Can RHCs and FQHCs bill for care management services provided to beneficiaries in nursing facilities or assisted living facilities?

A29. If the nursing facility or assisted living facility is not furnishing care management services and the RHC or FQHC has met the billing requirements, then the RHC or FQHC can bill for care management services furnished to beneficiaries in nursing or assisted living facilities

Q30. Are there other restrictions on when care management services can be billed?

A30. RHCs and FQHCs cannot bill for care management 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, or any other services that would result in duplicative payment for care management services.

Q31. Can RHCs and FQHCs bill HCPCS code G0511 if 10 minutes of general care management (CCM or general BHI services) are furnished at the end of one month and another 10 minutes are furnished at the beginning of the next month?

A 31. No. A minimum of 20 minutes of CCM or general BHI services are required to be furnished within the calendar month, not during a 30 day period.

Q33. Can RHCs and FQHCs bill HCPCS code G0512 if 30 minutes of psychiatric CoCM services are furnished at the end of one month and another 30 minutes are furnished at the beginning of the next month?

A33. No. A minimum of 60 minutes of psychiatric CoCM services are required to be furnished within the calendar month, not during a 30 day period.

Q34. If 2 or more RHC or FQHC practitioners or auxiliary staff discuss a patient's care, would time for each of them be counted towards the minimum requirements?

A34. No. If 2 or more RHC or FQHC practitioners or auxiliary staff people are discussing the patient's care coordination, only one person's time would be counted. For example, if 2 people are discussing care for 5 minutes, then 5 minutes would be counted, not 10 minutes.

Q35. Can care management services be conducted by auxiliary personnel in a location other than the RHC or FQHC?

A35. The direct supervision requirements for auxiliary personnel have been waived for TCM, CCM, general BHI, and psychiatric CoCM services furnished by RHCs and FQHCs.
These services can be furnished by auxiliary personnel under general supervision of the RHC or FQHC practitioner. General supervision does not require the RHC or FQHC practitioner to be in the same building or immediately available, but it does require the services to be furnished under the RHC or FQHC practitioner's overall supervision and control.

Q36. Is contact with the patient every month necessary to bill for care management services if the billing requirements are met?

A36. No, although we expect that RHCs and 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.

Q37. Can the time spent performing secure messaging or other asynchronous non face-to face consultation methods such as email count toward the minutes required to bill for care management services?

A37. Activities that are within the scope of service elements may be counted toward the time required for billing if they are measurable and can be documented.

Q38. Can smartphone medication adherence reporting from an individual patient or caregiver back to their care manager count towards the minutes required to bill for care management services?

38. No. Patient or caregiver time is not counted towards the time required to bill for care management services.

Q39. Are psychiatric consultant services for psychiatric CoCM separately billable?

A39. No. All services furnished as part of psychiatric CoCM are included in the psychiatric CoCM payment (HCPCS code G0512) and cannot be separately billed to Medicare wither by the RHC or FQHC or by the psychiatric consultant.

Q40. Can RHCs and FQHCs bill care management services for Medicare Advantage patients?

A40. RHCs and FQHCs should consult the MA plan for billing information.

a. Initiating Visit

Q41. Is an initiating visit required for all patients before care management services can begin?

A41. Yes. An initiating visit with an RHC or FQHC practitioner (primary care physician, NP, PA, or CNM) is required before CCM, general BHI, or psychiatric CoCM services can be furnished.
The initiating visit must be an evaluation and management (E/M) visit, annual wellness visit (AWV), or an initial preventive physical exam (IPPE), and must occur no more than one-year prior to commencing care coordination services.

Q42. Does care management need to be discussed during the initiating visit before care management services can begin?

A42. Care management services do not need to have been discussed during the E/M, AWV, or IPPE visit in order to begin care management services. However, prior to the commencement of care management services, consent must be obtained. Consent may be verbal (written consent is not required) but must be documented in the medical record.

Q43. Who can determine if a patient is eligible for care management services?

A43. The RHC or FQHC practitioner (primary care physician, NP, PA, or CNM) determines if the patient meets the criteria for care management services and if they are likely to benefit f om
care management services.

Q44. Can a clinical social worker, clinical psychologist, or psychiatrist determine that a patient meets the criteria for general BHI or psychiatric CoCM services and furnish the initiating visit?

A44. General BHI and psychiatric CoCM are both defined models of care that focus on integrative treatment of patients with primary care and mental or behavioral health conditions. A social worker, clinical psychologist, or psychiatrist can recommend to the primary care practitioner that a patient would benefit from general BHI or psychiatric CoCM services, but only a member of the primary care team can make the eligibility determination and furnish the initiating visit.

Q45. Does the patient need to have a mental health encounter before general BHI or psychiatric CoCM services can be furnished?

A45. No. Only an initiating visit (E/M, AWV, or IPPE) with the primary care team (primary care physician, NP, PA, or CNM) within 1 year prior to commencement of care management services is required. The primary care practitioner determines if the patient is eligible for general BHI or psychiatric CoCM. An initial assessment by the behavioral health manager is part of the care management payment and is not separately billable.

Q46. Can the initiating visit be furnished via telehealth?

A46. No. RHCs and FQHCs are not authorized to serve as distant sites for telehealth services.

Q47. Does the time spent during the E/M, AWV, or IPPE discussing care management services count taowards the time required to bill for these services?

A47. No. The E/M, AWV, or IPPE is separately paid and the time cannot be counted towards the required time for billing HCPCS codes G0511 or G0512

b. Consent and Opting Out

Q48. When is patient consent for care management services required?

A48. Patient consent is required before time is counted toward care management services.

Q49. How often is consent required for care management services?

A49. If a patient continues to receive care management services from the same RHC or FQHC, consent is only required when the care management service is initiated.

Q50. Does the patient have to sign a consent form for care management services?

A50. Consent can be verbal (written consent is not required), but must be documented in the medical record.

Q51. If a patient has consented to receive CCM services and later is switched to general BHI or psychiatric CoCM services, does the patient have to provide additional consent?

A51. Yes. A patient that has consented to receive CCM services would need to separately consent.

Q52. How does a patient opt out of care management services?

A52. A patient can opt out of care management services by notifying the RHC or FQHC that he/she does not want to continue this service. The date of revocation must be recorded in the patient's medical record.

Q53. If a patient opts out of care management services and later wants to resume receiving care management services, is consent required?

A53. Yes.

Q54. Once a patient has consented to receive care management services, do the services have to be provided every month?

A54. Care management services should only be furnished on an as-needed basis. The consent for receiving care management services remains in effect until revoked, even if no CCM services are furnished.

c. Care Plan

Q55. How often does the care plan need to be reviewed and updated?

A55. There are no specific requirements for updating the care plan. It should be reviewed and updated as appropriate for the patient's care.

Q56. Should the general BHI and psychiatric CoCM care plans also include physical health issues?

A56. Although physical health care planning is not a required element of the general BHI or psychiatric CoCM care plan, physical health and extended care team members should be included as appropriate to assure that all aspects of care are coordinated.

Q57. Is certified EHR technology required for billing HCPCS code G0511 when BHI services are furnished?

A57. Certified EHR technology is a requirement for CCM, but it is not a requirement for general BHI or psychiatric CoCM services. To bill the new HCPCS code G0511, an RHC or FQHC must meet the requirements for either CCM (CPT code 99490 or CPT code 99487) or general BHI (CPT code 99484). If the requirements for CPT code 99484 are met, the code can be billed and certified EHR technology is not required.

a. Behavioral Health Care Manager

Q58. What credentials are required for the CoCM behavioral health care manager?

A58. The behavioral health care manager must have formal education or specialized training in behavioral health such as social work, nursing, or psychology, and must have a minimum of a bachelor's degree in a behavioral health field (such as in clinical social work or psychology), or be a clinician with behavioral health training, including RNs and LPNs.

Q59. Can a certified addiction counselor serve as the behavioral health care manager?

A59. A certified addiction counselor can serve as the behavioral health care manager if they meet the behavioral health care manager requirements listed in the previous response.

Q60. Can the RHC or FQHC contract with another company for the services of the behavioral health care manager?

A60. The behavioral health care manager furnishes both face-to-face and non-face-to-face services. This person works under the general supervision of the RHC or FQHC practitioner and may be employed by or working under contract to the RHC or FQHC, not to another company.

CARE MANAGEMENT SERVICES (CARE TEAM)

Q61. Can someone other than the health care manager administer screenings and enter data for the registry?

A61. RHCs and FQHCs can delegate duties as appropriate. It is the responsibility of the RHC or FQHC to assure that personnel meet any requirements and to manage any delegation of duties and supervision as appropriate.

b. Psychiatric Consultant

Q62. What credentials are required for the psychiatric CoCM psychiatric consultant?

A62. The psychiatric consultant must be a medical professional trained in psychiatry and qualified to p escribe the full range of medications.

Q63. Does the psychiatric consultant have any face-to-face contact with the patient receiving psychiatric CoCM services?

A63. No. The psychiatric consultant is a consultant to the RHC or FQHC. They are not required to be on site or have direct contact with the patient, and they do not prescribe medications or furnish treatment to the beneficiary di ectly.

Q64. Can a psychiatric mental health nurse practitioner (PMH-NP) serve as the psychiatric consultant to RHCs and FQHCs that are furnishing psychiatric CoCM?

A64. Any medical professional, including a PMH-NP, who is trained in psychiatry and qualified to prescribe the full range of medications serves would meet the requirements to serve as a psychiatric CoCM psychiatric consultant.

REQUIREMENTS AND PAYMENT FOR RHCS AND FQHCS

CCM, GENERAL BHI, PSYCHIATRIC COCM

Requirements	CCM	General BHI	Psychiatric CoCM
Initiating Visit	An E/M, AWV, or IPPE visit occurring no more than one-year priorto commencing care coordination services.	Same	Same
	Furnished by a primary care physician, NP, PA, or CNM.	Same	Same
	Separately billable RHC/FQHC visit.	Same	Same
Beneficiar Consent	Obtained during or after initiating visit and before provision of care coordination services by RHC or FQHC practitioner or clinical staff.	Same	Same
	Written or verbal, documented in the medical record. Includes information:	Same	Same
	• On the availability of care coordination services and applicable cost-sharing;	Same	Same
	• 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		
	• That the patient has given permission to consult with relevant specialists.		
Billing Requirements	At least 20 minutes of care coordination services per calendar month that is: • Furnished under the direction of the RHC or FQHC primary care physician, NP, PA, or CNM; and • Furnished by an RHC or FQHC practitioner, or by clinical personnel under general supervision.	Same	At least 70 minutes in the first calendar month, and at least 60 minutes in subsequent calendar months of psychiatric CoCM services that is: • Furnished under the direction of the RHC or FQHC primary care practitioner. • Furnished by an RHC or FQHC practitioner or behavioral health care manager under general supervision.

Requirements	CCM	General BHI	Psychiatric CoCM
Patient Eligibility	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.	Any behavioral health or psychiatric condition being treated by the RHC or FQHC primary care practitioner, including substance use disorders, that, in the clinical judgment of the RHC or FQHC practitioner, warrants BHI services	Same As General BHI
Requirement Service Elements	Includes: • Structured recording of patient health information using Certified EH Technology and includes demographics, problems, medications, and medication allergies that inform the careplan, care coordination, and ongoing clinical care; 2 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 withinand outside the RHC or FQHC as appropriate and a copy of the plan resources and supports; a comprehensive care plan for all health issues with particular focus on the chronic conditions being managed;	Includes: • Initial assessment or follow-up monitoring, including the use of applicable validated rating scales... (continued on p. 28)	Includes: • Initial assessment or follow-up monitoring, including the use of applicable validated rating scales... (continued on p. 28)

Requirements	CCM	General BHI	Psychiatric CoCM
Requirement Service Elements (Cont'd)	• 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 th 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.		...relationship with the rest of the care team; and Psychiatric Consultant: • Participate in regular reviews of the clinical status of patients receiving CoCM services; • Advise the RHC or FQHC practitioner regarding diagnosis, options for resolving issues with beneficiar adherence and tolerance of behavioral health treatment; making adjustments to behavioral health treatment for beneficiaries who a e 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

The time is now.

CCM, RPM, and other extended patient care services help practices generate revenue beyond what CPT codes provide. When done correctly, remote patient care provides contextual engagement with patients, collects important between-visit data, and can help spot potential concerns early.

"It is critical to the success of achieving the "Triple Aim" of providing better care, lower costs, and improved health."

This relationship-based, proactive approach to care helps encourage preventive care making your patients' next visit more encouraging than the last.

Additionally, with the industry's latest reimbursement models, there is tremendous value in how CCM & RPM can improve patient satisfaction and health, leading to better quality and performance scores.

CCM and RPM are two significant pieces of coordinated care. However, there are still others, including Annual Wellness Visits and Transitional Care Management.

Additionally, having success with MACRA (MIPS or Advanced APM path) and CPC+ are part of a larger goal—which is proactively managing chronic conditions before they become a more significant threat to patient and population health, which has an extremely high impact on the U.S. economy.

Medicare has been specifically advancing a complete care coordination strategy that year after year because it is critical to providing better care, lower costs, and improved health.

10,000 baby boomers will turn 65 every day for the next 8 years, a growing patient base that is prone to developing multiple chronic conditions.

Know your CCM/RPM options before you have to. Speak with one of our physicians:
1-888-515-8450 | care@vitalhealthlinks.com

6 RPM solutions to persistent challenges.

To help offset the costs of rising hospitalizations, healthcare spending and patient disengagement Remote Patient Monitoring is a practical tool

Common Healthcare Challenges

81% of physicians feel overextended or at full capacity

People with chronic diseases account for **81%** o f hospital admissions

6% of U.S. health-care spending goes to the treatment of chronic diseases

Up to **50%** of patients don't comply to medical treatment

60% of health systems rank improv-ing patient outcomes as a critical priority

Disengaged patients are **3x** as likely to have unmet medical and **2x** as likely to delay medical care

Smart Solutions

Remote Patient Monitoring provides physicians with cellularly-transmitted, physiological patient-data between clinical visits. Combined with coordinated care, RPM is a valuable compliment to your care plan.

Devices include...

- Weight Scales
- Blood Pressure Cuffs
- Pulse Oximetre
- Blood Glucose Monitor

RPM gathers real-time data and provides 20 minutes of coaching with registered nurses every month to help patients reach their wellness goals.

Patient Adoption, Clinical Results

50% of Americans supplemented care with telehealth visits in 2020+

29% Reduction in heart failure-related hospitalizations (NCBI)++

24% of practices have RPM technology *(American College of Physicians)*

23M Americans used RPM in 2020; up from 7M in 2016+

43% of patients listed "greater convenience" as top benefit (MSI, June '21)

Ask our physicians about clinical, turn-key RPM and its uses.

+https://www.mobihealthnews.com/content/remote-patient-monitoring-market-grew-44-percent-2016-report-says
++https://pubmed.ncbi.nlm.nih.gov/26517969/

It takes these 4 steps to launch RPM.

Vital Health Links Care Coordinators add financial, operational, and personal value to data monitoring for doctors, patients, and practices, to optimize RPM benefits.

01

Consent, order, education and setup

Doctor and CCM patients agree to the health benefits of inc eased connection and accessibility that RPM provides.

02

Cellular transmission, collection of physiological data

Essential patient physiologic data is collected and analyzed by care coordinators.

03

Evaluation, management and engagement

Vital Health Links RPM Care Coordinators facilitate personal care-plan engagement based on physician and national guidelines.

04

Billing and reimbursement

RPM has proven so beneficial that Medicare programs compensate clinics ≈ $155 per qualified chronic illness patient per month to achieve benchmarks through RPM

RPM Guidance from the American Heart Association.

Position—Remote patient monitoring (RPM) can empower patients to better manage their health and participate in their health care.[2] When used by clinicians, RPM can provide a more holistic view of a patient's health over time, increase visibility into a patient's adherence to a treatment, and enable timely intervention before a costly care episode. Clinicians can strengthen their relationships with, and improve the experience of, their patients by using the data sent to them via RPM to develop a personalized care plan and to engage in joint decision-making to foster better outcomes.[3] The American Heart Association supports initiatives that increase access to and incentivize the appropriate design and use of evidence-based Remote Patient Monitoring technologies.

"The American Heart Association supports initiatives that increase access to... and use of evidence based remote patient monitoring technologies."

The cost of healthcare has soared to untenable heights. In the United States, federal healthcare spending is rapidly approaching 20% of GDP. Furthermore, chronic disease is highly prevalent, accounting for nearly 90% of all healthcare spending in the United States.

Additionally, it costs 3.5 times more to treat chronic diseases than it does other conditions, and they account for 80% of all hospital admissions.

Access to care is also variable based on socioeconomic issues and environ-mental factors. In recent years, rapid advancements in healthcare delivery models and low-cost wireless communication have spurred optimism in finding cost effective, value-enhancing solutions to these issues.

Notably, the integration of mobile communications with wearable sensors has facilitated the shift of healthcare services from clinic-centric to patient-centric delivery models such as remote patient monitoring.

GUIDELINES FOR THE APPROPRIATE DESIGN AND USE OF RPM

SOURCE: AMERICAN HEART ASSOCIATION

Guiding Principle: Remote Patient Monitoring technologies should reflect evidence-based, user-centered design principles, human factors science, and best practices.

Guiding Principle: Remote Patient Monitoring technologies should be rigorously evaluated in clinical trials to ensure patient efficac .

Guiding Principle: Remote Patient Monitoring technologies should address the needs of all patients without disenfranchising financially disadvantaged populations or thos with low literacy or low technologic literacy.

Guiding Principle: Remote Patient Monitoring technologies should not create an unnecessary burden on end users.

Guiding Principle: Remote Patient Monitoring technologies should be customizable to users' specific needs

Guiding Principle: Training and support must be available for all users of Remote Patient Monitoring technologies with a duration of support dependent upon user capabilities

RPM -> PATIENT-GENERATED HEALTH DATA

Most RPM technologies allow for patients to generate their own data. Patient-generated health data (PGHD) are data created, recorded, or gathered by or from patients (or family members or other caregivers) to support their health. This data may include variables related to health history, biometric data, symptoms, and lifestyle information.

The recent proliferation of RPM has increased the frequency, amount, and types of PGHD available. These advances in RPM have the potential to allow patients and their caregivers to independently and seamlessly capture and share their health data electronically with clinicians from any location.

Hello! We are Vital Health Links, a doctor-led provider of dedicated coordinated care. We partner with practices across the country, but credit out midwestern diligence and care to our home-base, among the shores of 10,000 lakes, in Minnesota. In other words, we are friendly and would love to connect with you.

To say 'hello'

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