RHC Committee Webinar Series

Care Management Services and Proposed Virtual Communication Services in RHCs and FQHCs

National Organization of **State Offices of Rural Health**

RHC Committee Webinar

- Welcome & Introductions

Presenter:

- Captain Corinne Axelrod

Logistics

- Phone lines are not muted. Please mute your own phone line unless you are speaking. When you speak, please state your name and state.

- If you have questions during the session, please feel free to use the chat box in the bottom right corner of the screen.

Logistics

- There will also be opportunity for questions following the presentation.
- Please make sure to complete the survey that will appear as you exit the webinar.
- The recording of this webinar will be posted to on the NOSORH website.

Today's Presenter

Captain Corinne Axelrod

Learning Objectives

Participants will gain an understanding of:

- Understand the Medicare requirements and payment for care management services (including chronic care management and behavioral health integration) in RHCs and FQHCs.
- Understand the proposed new requirements and payment for Communication Technology-Based Services and Remote Evaluations in RHCs and FQHCs.

Care Management Services and Proposed Virtual Communication Services in RHCs and FQHCs

NATIONAL ORGANIZATION OF STATE OFFICES OF RURAL HEALTH

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Objectives

- 1. Understand Medicare requirements and payment for Care Management services (including chronic care management and behavioral health integration) in RHCs and FQHCs, and

- 2. Understand the proposed new requirements and payment for Virtual Communication services (including communication technology-based and remote evaluation services) in RHCs and FQHCs.

Background – RHCs

- Eligible to participate in the Medicare program since March 1978
- Must be in a non-urbanized and designated shortage area for certification
- Practitioners are physicians, NPs, PAs, CNMs, CPs, and CSWs
- Typically furnish evaluation and management (E/M) and certain preventive services
- Billable visits must be medically-necessary, face-to-face visits with an RHC practitioner for a service that requires the skill level of the RHC practitioner
- Payment includes all services furnished by or incident to the visit
- Paid an all-inclusive rate (AIR), subject to a payment limit ($83.45 in CY 2018)
- Some provider-based RHCs have an exception to the payment limit

Background – FQHCs

- Eligible to participate in the Medicare program since October 1991
- Must be in or serve a medically underserved area or population
- Practitioners are physicians, NPs, PAs, CNMs, CPs, and CSWs
- Typically furnish evaluation and management E/M and certain preventive services
- Billable visits must be medically-necessary, face-to-face visits with an FQHC practitioner for a service that requires the skill level of the FQHC practitioner
- Payment includes all services furnished by or incident to the visit
- Since 2014, paid the lesser of their charges or the FQHC PPS ($166.60 in CY 2018)

Care Management Services in RHCs and FQHCs

Care Management Services in RHCs and FQHCs

- **General Care Management**
  - Chronic Care Management (CCM) - CPT 99490
  - Complex CCM Services - CPT 99487
  - General Behavioral Health Integration (BHI) - CPT 99484
  - Billed using HCPCS Code G0511

- **Psychiatric Collaborative Care Model (CoCM)**
  - (not covered in today's presentation)

Care Management - Patient Eligibility

CCM:

- Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, and
- Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline

General BHI:

- Any behavioral health or psychiatric condition being treated by the RHC or FQHC primary care practitioner, including substance use disorders, that, in the clinical practitioner, warrants BHI services

Care Management - Initiating Visit

- Must have an Evaluation/Management (E/M) Visit, Annual Wellness Visit (AWV), or Initial Preventive Physical Exam (IPPE) visit occurring no more than one-year prior to commencing care management services, furnished by a primary care physician, NP, PA, or CNM

Care Management - Beneficiary Consent

- Obtained during or after initiating visit and before provision of care management services
- Written or verbal, documented in the medical record
- Includes information:
  - On the availability of care coordination services
  - That the patient has given permission to consult with relevant specialists as needed
  - Been informed that there cost-sharing (e.g. deductible and coinsurance in RHCs, and coinsurance in FQHCs) applies for both in-person and non-face-to-face services
  - That only one practitioner can furnish and be paid for care management services during a calendar month
  - That the patient has right to stop care management services at any time (effective at the end of the calendar month)

Care Management - Billing Requirements

At least 20 minutes of care management time directed by an RHC or FQHC practitioner, 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

CCM Specific Service 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

CCM Specific Service Requirements

- 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 of care given to the patient and/or caregiver

CCM Specific Service Requirements

- 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.

General BHI Specific Service Requirements

- An initial assessment and ongoing monitoring using validated clinical 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.

Payment for Care Management Services in RHCs and FQHCs

- Are RHC and FQHC services (cannot be billed to the PFS)
- Do not qualify as RHC or FQHC billable visits
- Not paid under the RHC AIR or FQHC PPS payment methodologies
- Billed using HCPCS code G0511

Payment for Care Management Services in RHCs and FQHCs

- Payment authorized for RHCs and FQHCs when at least 20 minutes of eligible CCM or General BHI services are furnished and HCPCS code G0511 is on an RHC or FQHC claim
- HCPCS code G0511:
  - Effective for services furnished on or after January 1, 2018
  - Used for CCM or General BHI services
  - For use By RHCs and FQHCs only

HCPCS Code G0511- Billing

Can:

- Be billed once per month per beneficiary when the 20-minute threshold is met for either CCM or general BHI
- Be billed alone or in addition to other services furnished during the RHC or FQHC visit

Cannot:

- Be billed if other care management services (such as TCM, home health care supervision, or G0512) are billed for the same time period
- Count time spent by administrative or clerical staff towards the time required to bill these services

HCPCS Code G0511

Payment amount is set at the average of the national non-facility PFS payment rates for

- CCM code 99490,
- Complex CCM code 99487, and
- General BHI code CPT code 99484

2018 Payment Rate - $62.28

Proposed Change for 2019

- CMS has proposed to add CPT code 99491 (30 minutes or more of CCM furnished by a physician or other qualified health care professional) to G0511, which would result in a payment of approximately $65
- Regulation will be finalized in November, effective January 1, 2019

Proposed New Virtual Communications Services in RHCs and FQHCs

Virtual Communications Services in RHCs and FQHCs

- Proposed in the CY 2019 Physician Fee Schedule Proposed Rule
- Includes communication technology-based services and remote evaluation services
- Effective January 1, 2019, if finalized

Virtual Communications Services Requirements

- At least 5 minutes of communications-based technology or remote evaluation services are furnished by an RHC or FQHC practitioner to a patient that has had an RHC or FQHC billable visit within the previous year
- For a condition not related to an RHC or FQHC service provided within the previous 7 days
- Does not lead to an RHC or FQHC visit within the next 24 hours or at the soonest available appointment.

Virtual Communications Services Proposed Payment

- Billed using HCPCS code G0071
- Payment for G0071 would be set at the average of the national non-facility PFS payment rates for HCPCS code GVCI1 (communication technology-based services) and HCPCS code GRAS1 (remote evaluation services)
- Payment approximately $14

Additional Information for RHCs and FQHCs

- **RHCs**
- https://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html

- **FQHCs**
- https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html

Questions???

Power of Rural Campaign

Founded to bring attention to:

- Rural America is a great place to live and work and be a healthcare provider
- Quality and innovation are abundant in rural communities
- Disparities do exist and can be addressed through joint national, state and local efforts
- Growing beyond the day into a movement!

Visit PowerofRural.org

National Rural Health Day™

Celebrating the Power of Rural!

Power of Rural Campaign

Share information about the RHC impact in your state

- Nominate a community star from a RHC
- Plan an educational event for RHC
- Make an award for RHC
- Invite legislators to visit RHC

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Questions?

Please complete the ***survey*** following this session.

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Thanks so much!
We appreciate your participation!

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