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

Frequently Asked Questions

February 2018

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I. General Information

Q1. What are care management services?

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

- Transitional care management (TCM)
- Chronic care management (CCM)
- 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? Is there a penalty if these services are not provided?

A3. No, RHCs and FQHCs are not required to furnish care management services and there is no penalty if they are not provided. 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. Do RHCs and FQHCs have to enroll and be approved in order to furnish and bill for care management services?

A4. No, there is no enrollment or approval process for furnishing care management services. Any RHC or FQHC can bill for care management services if all requirements are met.

Q5. Where can I find information on the requirements for each of the care management services?

A5. 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 in Chapter 13, section 230, of the CMS Benefit Policy Manual, and 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-FQHC-Center.html

II. Billing, Claims Processing, and Payment

Q6. How do RHCs and FQHCs bill for care management services and how are they paid?

A6. Care Management services are billed and paid as follows:

TCM: For TCM services furnished on or after January 1, 2013, TCM services are billed by adding CPT code 99495 (14 day discharge, moderate complexity) or CPT code 99496 (7 day discharge, high complexity) 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.

2018 payment (CPT code 99495 or 99496) - Same as payment for an RHC or FQHC visit

CCM: For CCM services furnished between January 1, 2016 and December 31, 2017, CCM services are billed by adding CPT code 99490 (20 minutes or more of CCM services) 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. RHC or FQHC claims submitted using CPT code 99490 for services on or after January 1, 2018 will be denied.

For CCM services furnished on or after January 1, 2018, CCM services are billed by

adding the general care management HCPCS 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).

2018 payment (HCPCS code G0511) – $62.28

General BHI: For general BHI services furnished on or after January 1, 2018, general BHI services are billed by adding the general care management HCPCS 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).

2018 payment (HCPCS code G0511) – $62.28

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).

2018 payment (HCPCS code G0512) – $145.08

Q7. Are the rates geographically adjusted?

A7. G0511 and G0512 are national rates with no geographic adjustment.

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

A8. 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.

Q9. Will the payment methodologies for care management services change?

A9. We 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, we would consider proposing a revision to the methodology. Any changes to the payment methodology would be undertaken through future notice and rulemaking.

Q10. Will new care management services be added in the future?

A10. If new care management services become available, we 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 rulemaking.

Q11. Will claims submitted with CPT 99490 be paid?

A11. 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.

Q12. Will claims submitted with CPT codes 99487, 99484, or 99493 be paid?

A12. No. RHCs and FQHCs are required to bill for care management services using G0511 or G0512.

Q13. Do coinsurance and deductibles apply to care management services?

A13. Coinsurance and deductibles apply to all care management services in RHCs, and coinsurance applies to all care management services in FQHCs.

Q14. If a patient cannot afford the copayment but would benefit from this service, can the copayment be waived?

A14. The coinsurance for care management services cannot be waived, however, many RHCs and FQHCs offer financial assistance for patients who qualify.

Q15. How is coinsurance determined for care management services?

A15. Coinsurance is 20% of submitted charges.

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

A16. Care management services can be billed either alone or on a claim with an RHC or FQHC billable visit.

Q17. Are care management services paid in addition to payment for an RHC or FQHC visit?

A17. Except for TCM which is not separately payable if furnished on the same day as another billable visit, care management services are paid in addition to the RHC or FQHC billable visit.

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 rate 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 rate for G0511 or G0512 ($62.28 and $145.08 respectively).

Q20. Can an FQHC look-alike bill for care management services?

A20. Yes, billing and payment is the same for FQHC look-alikes.

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 revenue code should be used for care management services?

A23. Care management services should be reported with revenue code 052x.

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. These costs are reported in the non-reimbursable 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 are minimum requirements and payment is based on an average, so there is no additional payment if more time is used.

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

A27. In some limited situations, 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?

A31. 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.

Q32. 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?

A32. 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.

Q33. Why is the same code, G0512, used for both 70 minutes in the first month of psychiatric CoCM and 60 minutes in subsequent months of psychiatric CoCM?

A33. HCPCS code G0512 is used by RHCs and FQHCs to bill for psychiatric CoCM services that have met the requirements for either initial psychiatric CoCM or subsequent psychiatric CoCM. Once the minimum time required is met, the payment does not change.

Q34. If 2 or more RHC or FQHC practitioners or auxiliary personnel 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 personnel 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. Once consent has been obtained, care management services can be furnished by auxiliary personnel under general supervision of the RHC or FQHC primary care 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 services, especially since this is a service that the patient is paying for but is not typically visible to them.

Q37. Would 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 furnished by the RHC or FQHC practitioner, auxiliary personnel, or the behavioral health care manager 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. This would not include administrative time setting up messaging or communication systems.

Q38. Would the time spent transcribing or translating the care plan count towards the minimum required time?

A38. No. Only services furnished by an RHC or FQHC practitioner or auxiliary personnel that are within the scope of service elements can be counted and would not include administrative activities.

Q39. Can smartphone medication adherence reporting from individual patient or caregiver back to their care manager count towards the minutes required to bill for care management services?

A39. No. Patient or caregiver time is not counted towards the time required to bill for care management services.

Q40. Are psychiatric consultant services for psychiatric CoCM separately billable?

A40. 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 by either the RHC or FQHC or the psychiatric consultant.

Q41. How is the psychiatric consultant paid for psychiatric CoCM services?

A41. The psychiatric consultant is paid by the RHC or FQHC for psychiatric CoCM services in accordance with their payment agreement as determined by the RHC or FQHC.

Q42. Can RHCs and FQHCs bill care management services for Medicare Advantage patients?

A42. RHCs and FQHCs should consult the MA plan for billing information.

Q43. Will secondary payors recognize HCPCS codes G0511 and G0512?

A43. HCPCS codes are recognized by all secondary payors. In some cases, there may be a delay if the secondary payor has not yet updated their systems to accept new codes.

III. Program Requirements for CCM, General BHI, and Psychiatric CoCM

Eligibility and Initiating Visit

Q44. What conditions qualify a patient for care management services and what diagnosis code should be used?

A44. Care management services are not limited to specific conditions as long as the specific requirements for the type of care management service are met. All claims must include a diagnosis code and practitioners should use the most appropriate diagnosis code for the patient.

Q45. Is an initiating visit required for all patients before care management services can begin?

A45. 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.

Q46. Does care management need to be discussed during the initiating visit before care management services can begin?

A46. 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. Care management services can begin if the patient has had an initiating visit within one year and consent for care management services has been obtained.

Q47. Who can determine if a patient is eligible for care management services?

A47. The RHC or FQHC 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 from care management services.

Q48. 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?

A48. No. 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.

Q49. Does the patient need to have a mental health encounter before general BHI or psychiatric CoCM services can be furnished?

A49. 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.

Q50. Can the initiating visit be furnished via telehealth?

A50. No. RHCs and FQHCs are not authorized to serve as distant sites for telehealth services.

Q51. Does the time spent during the E/M, AWV, or IPPE discussing care management services count towards the time required to bill for these services?

A51. 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.

Consent and Opting Out

Q52. When is patient consent for care management services required?

A52. Patient consent is required before time is counted toward care management services.

Q53. How often is consent required for care management services?

A53. 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.

Q54. Does the patient have to sign a consent form for care management services?

A54. Consent can be verbal or written but must be documented in the medical record.

Q55. What information should be included in the consent process?

A55. The consent process should discuss the services that will be provided, the cost to the patient (copayment and/or deductible), that only one practitioner can furnish and be paid for care management services during a calendar month, that the patient may stop care management services at any time (effective at the end of the calendar month), and that the patient has given permission to consult with relevant specialists.

Q56. Does CMS have a template or an example of the consent form?

A56. No, we do not provide consent form templates or examples.

Q57. 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?

A57. Yes. A patient that has consented to receive CCM services would need to separately consent to receiving general BHI or psychiatric CoCM services to ensure that they are aware of the change in services and any differences in copayment amounts.

Q58. Who can obtain patient consent from the patient for care management services?

A59. Consent for care management services must be obtained by the RHC or FQHC practitioner or auxiliary personnel working under direct supervision of the RHC or FQHC practitioner.

Q60. How does a patient opt out of care management services?

A60. 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, and is effective at the end of the calendar month.

Q61. If a patient opts out of care management services and later wants to resume receiving care management services, is consent required?

A61. Yes.

Q62. Once a patient has consented to receive care management services, do the services have to be provided every month?

A62. 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.

Q63. If some months go by without furnishing any care management services and then they start up again, is consent required?

A63. No, the consent is not needed when services are resumed unless the patient has opted out of care management services.

Care Plan

Q64. How often does the care plan need to be reviewed and updated?

A64. There are no specific requirements for updating the care plan. It should be reviewed and updated as appropriate for the patient's care.

Q65. Does CMS have a template or form for the care plan?

A65. No, we do not provide templates or forms for the care plan.

Q66. Should the general BHI and psychiatric CoCM care plans also include non-behavioral health issues?

A66. Although not a required element of the general BHI or psychiatric CoCM care plan, non-behavioral health issues and extended care team members should be included as appropriate to assure that all aspects of care are coordinated.

Q67. Is certified EHR technology required for billing HCPCS code G0511 when BHI services are furnished?

A67. 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.

IV. Care Team

Auxiliary Personnel

Q68. Who is included under "auxiliary personnel"?

A68. Auxiliary personnel includes clinicians such as nurses, medical assistants, and others who furnish services incident to and under the supervision of an RHC or FQHC practitioner.

Q69. Can a pharmacist furnish CCM services?

A69. Yes. Pharmacists are considered auxiliary personnel and can provide CCM services under general supervision once the service is initiated by an RHC or FQHC practitioner.

Q70. Are auxiliary personnel required to be licensed and/or certified to furnish care management services?

A70. Auxiliary personnel must meet any applicable State law, licensure, and scope of practice requirements to furnish services.

Q71. Do auxiliary personnel have to be in the same building as the RHC or FQHC practitioner when furnishing care management services?

A71. No. Auxiliary personnel may be in another location when furnishing care management services because the direct supervision requirements have been waived for care management services.

Behavioral Health Care Manager

Q72. What credentials are required for the CoCM behavioral health care manager?

A72. 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.

Q73. Can a certified addiction counselor or licensed professional counselor serve as the behavioral health care manager?

A73. A certified addiction counselor, licensed professional counselor, or any other type of behavioral health provider can serve as the behavioral health care manager if he/she meets the behavioral health care manager requirements listed in the previous response.

Q74. Can the RHC or FQHC contract with another company for the services of the behavioral health care manager?

A74. 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.

Q75. Can someone other than the behavioral health care manager administer screenings and enter data for the registry?

A75. 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. However, only the time of the behavioral health care manager is counted towards the minimum time requirements for billing.

Psychiatric Consultant

Q76. What credentials are required for the psychiatric CoCM psychiatric consultant?

A76. The psychiatric consultant must be a medical professional trained in psychiatry and qualified to prescribe the full range of medications.

Q77. Does the psychiatric consultant have any face-to-face contact with the patient receiving psychiatric CoCM services?

A77. 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 directly.

Q78. Can a psychiatric mental health nurse practitioner (PMH-NP) serve as the psychiatric consultant to RHCs and FQHCs that are furnishing psychiatric CoCM?

A78. 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.

Addendum I
CCM, General BHI, and Psychiatric CoCM Requirements and Payment for RHCs and FQHCs

Requirements	CCM	General BHI	Psychiatric CoCM
Initiating Visit	An E/M, AWV, or IPPE visit occurring no more than one-year prior to 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
Beneficiary 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.	Same	Same
	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; ● That the patient has right to stop care coordination services at any time (effective at the end of the calendar month); and ● That the patient has given	Same	Same
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; and ● Furnished by an RHC or FQHC practitioner or behavioral health care
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	Any behavioral health or psychiatric condition being treated by the RHC or FQHC primary care practitioner, including substance use disorders, that, in the clinical	Same As General BHI

Requirements	CCM	General BHI	Psychiatric CoCM
		practitioner, warrants BHI services	
Requirement Service Elements	Includes: ● Structured recording of patient health information using Certified EHR Technology and includes demographics, problems, medications, and medication allergies that inform the care plan, care coordination, and ongoing clinical care; ● 24/7 access to physicians or other qualified health care professionals or clinical staff including providing patients/caregivers with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of week, and continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments; ● Comprehensive care management including systematic assessment of the patient's medical, functional, and psychosocial needs; system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions; and oversight of patient self-management of medications; ● Comprehensive care plan including the creation, revision, and/or monitoring of an electronic care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment and an inventory of resources and supports; a comprehensive care plan for all health issues with particular focus	Includes: ● 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.	Includes: <u>RHC or FQHC primary care practitioner:</u> ● Direct the behavioral health care manager or clinical staff; ● Oversee the beneficiary's care, including prescribing medications, providing treatments for medical conditions, and making referrals to specialty care when needed; and ● Remain involved through ongoing oversight, management, collaboration and reassessment <u>Behavioral Health Care Manager:</u> ● Provide 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; ● Be available to

Requirements	CCM	General BHI	Psychiatric CoCM
	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.		relationship with the rest of the care team; and <u>Psychiatric Consultant:</u> ● 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 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
Billing Code	G0511	G0511	G0512
Payment	$62.28 (Average of CPT codes 99490, 99487 and 99484)	$62.28 (Average of CPT codes 99490, 99487 and	$145.08 (Average of CPT codes 99492 and 99493)