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General Care Management Services

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Participants will:

- Review the physician fee schedule changes for 2024
- Discuss the requirements for each care management code
- Develop policies to cover the additional services at the RHC

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2024 Physician Fee Schedule

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Resources:

- **MLN Matters006398**
  - **Updated 2/24**
  - **https://www.cms.gov/files/document/mln006398-information-rural-health-clinics.pdf**
- **RHIhub Webinar:**
  - **February 27, 2024**
  - **https://www.ruralhealthinfo.org/webinars/physician-fee-schedule**

What was added? (pg. 3 MLN006398)

- Marriage and family therapists and mental health counselors as practitioners (page 4)
- Remote physiologic monitoring (RPM), remote therapeutic monitoring (RTM), community health integration (CHI) and principal illness navigation (PIN) (page 5)
- Intensive outpatient program services (pages 5 and 7)
- All-Inclusive Rate (AIR) per visit for CY 2024 (page 7)
- Social determinants of health (page 8)
- Table of general care management services HCPCS/CPT codes (pages 9-10)
- Rural health reports and publications as a resource (page 14)

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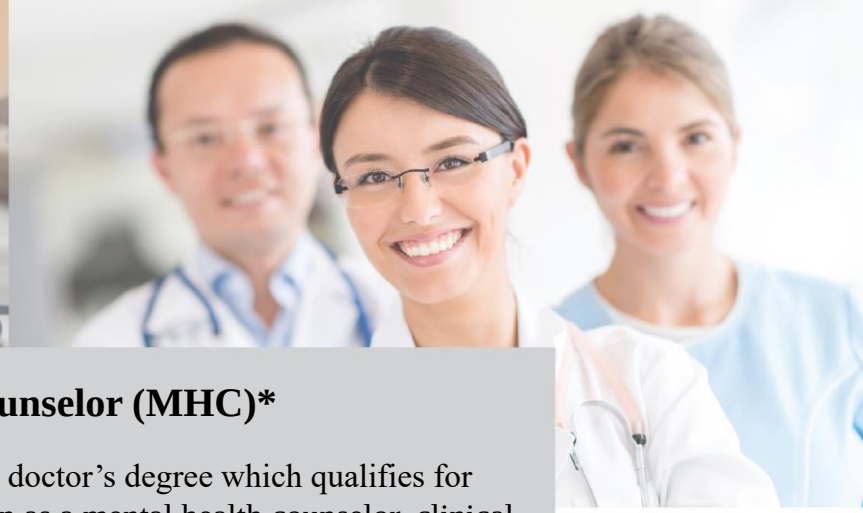

Marriage and Family Therapist (MFT)

Possesses a master's or doctor's degree which qualifies for licensure or certification as a MFT pursuant to State law of the State in which such individual furnishes marriage and family therapist services;

Is licensed or certified as a MFT by the State in which such individual furnishes such services;

After obtaining such degree has performed at least 2 years (or 3,000 hours) of clinical supervised experience in marriage and family therapy; and

Meets such other requirements as specified by the Secretary.

Mental Health Counselor (MHC)*

Possesses a master's or doctor's degree which qualifies for licensure or certification as a mental health counselor, clinical professional counselor, or professional counselor under State law of the State in which such individual furnishes MHC services;

Is licensed or certified as a mental health counselor, clinical professional counselor, or professional counselor by the State in which the services are furnished;

After obtaining such degree has performed at least 2 years (or 3,000 hours) of clinical supervised experience in mental health counseling; and

Meets such other requirements as specified by the Secretary.

***Addiction counselors who meet all applicable requirements can also enroll as Medicare providers under MHC category.**

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Effective 1/1/2024: New Medicare Billable Providers in RHCs

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Code Requirements

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General Care Management Services	HCPCS/CPT Codes
CCM	99487, 99490, 99491
PCM	99424, 99426
CPM	G3002
General BHI	99484
RPM	99453, 99454, 99457, 99091
RTM	98975, 98976, 98977, 98980
CHI	G0019
PIN	G0023
PIN-PS	G0140

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G0511: Chronic Care Management, CHI, PIN Services

CPT Code	Chronic Care Management, Principal Care Management, Chronic Pain Management
99484	General Behavioral Health Integration (BHI) (20 minutes)
99487	Complex Chronic Care Management (over 60 minutes of care management per month)
99490	Basic Chronic Care Management (20 minutes of care management)
99491	Chronic Care Management furnished by a physician or other qualified health professional (30 minutes or more)
99424	Principal Care Management furnished by physicians or non-physician practitioners (30 minutes or more)
99426	Principal Care Management services furnished by clinical staff under the supervision of a physician or non-physician practitioner (30 minutes or more)
G3002	Chronic pain management first 30 minutes

CPT Code	Community Health Integration and Principal Illness Navigation Services
G0019	Community health integration services performed by certified or trained auxiliary personnel, including a **community health worker**, under the direction of a physician or other practitioner; 60 minutes per calendar month, in the following activities to address social determinants of health (SDOH) need(s) that are significantly limiting ability to diagnose or treat problem(s) addressed in an initiating E/M visit
G0023	Principal Illness Navigation services by **certified or trained auxiliary personnel** under the direction of a physician or other practitioner, including a **patient navigator or certified peer specialist**; 60 minutes per calendar month
G0140	Principal Illness Navigation peer support

An RHC may bill HCPCS code G0511 multiple times in a calendar month as long as all requirements are met and there is no double counting.

2024 Reimbursement rate is $72.98.

Copay and Deductible do apply to each instance it is billed.

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G0511: Remote Monitoring (RPM and RTM are mutually exclusive)

CPT Code	Remote Physiologic Monitoring
99453	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), **initial; set-up** and patient education on use of equipment
99454	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,** each 30 days
99457	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring **interactive** communication with the patient/caregiver during the month; **first 20 minutes**
99091	Collection and interpretation of physiologic **data** (e.g. Blood pressure, glucose monitoring) digitally **stored** and/or **transmitted** by the patient and/or caregiver to the physician or other qualified health professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days

CPT Code	Remote Therapeutic Monitoring
98975	Remote therapeutic monitoring (eg, therapy adherence, therapy response); **initial set-up** and patient education on use of equipment
98976	Remote therapeutic monitoring (eg, therapy adherence, therapy response); **device(s) supply** with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor **respiratory system**, each 30 days
98977	Remote therapeutic monitoring (eg, therapy adherence, therapy response); **device(s) supply** with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor **musculoskeletal system,** each 30 days
98980	Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; **first 20 minutes**

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Psychiatric Chronic Care Management (G0512)

Psychiatric CoCM is a specific model of care provided by a primary care team consisting of:

1. Primary care provider
2. Health care manager
3. Psychiatric consultant

The 3 different provider groups work in collaboration to integrate primary health care services with care management support for patients receiving behavioral health treatment. 60 minutes or more of clinical staff time for psychiatric CoCM services directed by an RHC or FQHC practitioner.

Eligibility requirements: Patients with mental health, behavioral health, or psychiatric conditions, including substance use disorders, who are being treated by an RHC practitioner.

Initiating visit: Psychiatric CoCM services do not need to have been discussed during the initiating visit, and the same initiating visit can be used for psychiatric CoCM as for CCM and BHI services, as long as it occurs with an RHC primary care practitioner within one year of commencement of psychiatric CoCM services.

Behavioral health care manager: A designated individual with formal education or specialized training in behavioral health, including social work, nursing, or psychology, and has a minimum of a bachelor's degree in a behavioral health field (such as in clinical social work or psychology), or is a clinician with behavioral health training, including RNs and LPNs.

Psychiatric consultant: A medical professional trained in psychiatry and qualified to prescribe the full range of medications. The psychiatric consultant is not required to be on site or to have direct contact with the patient and does not prescribe medications or furnish treatment to the beneficiary directly.

Paid at the average of the 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) - $144.07 - 2024 payment rate.

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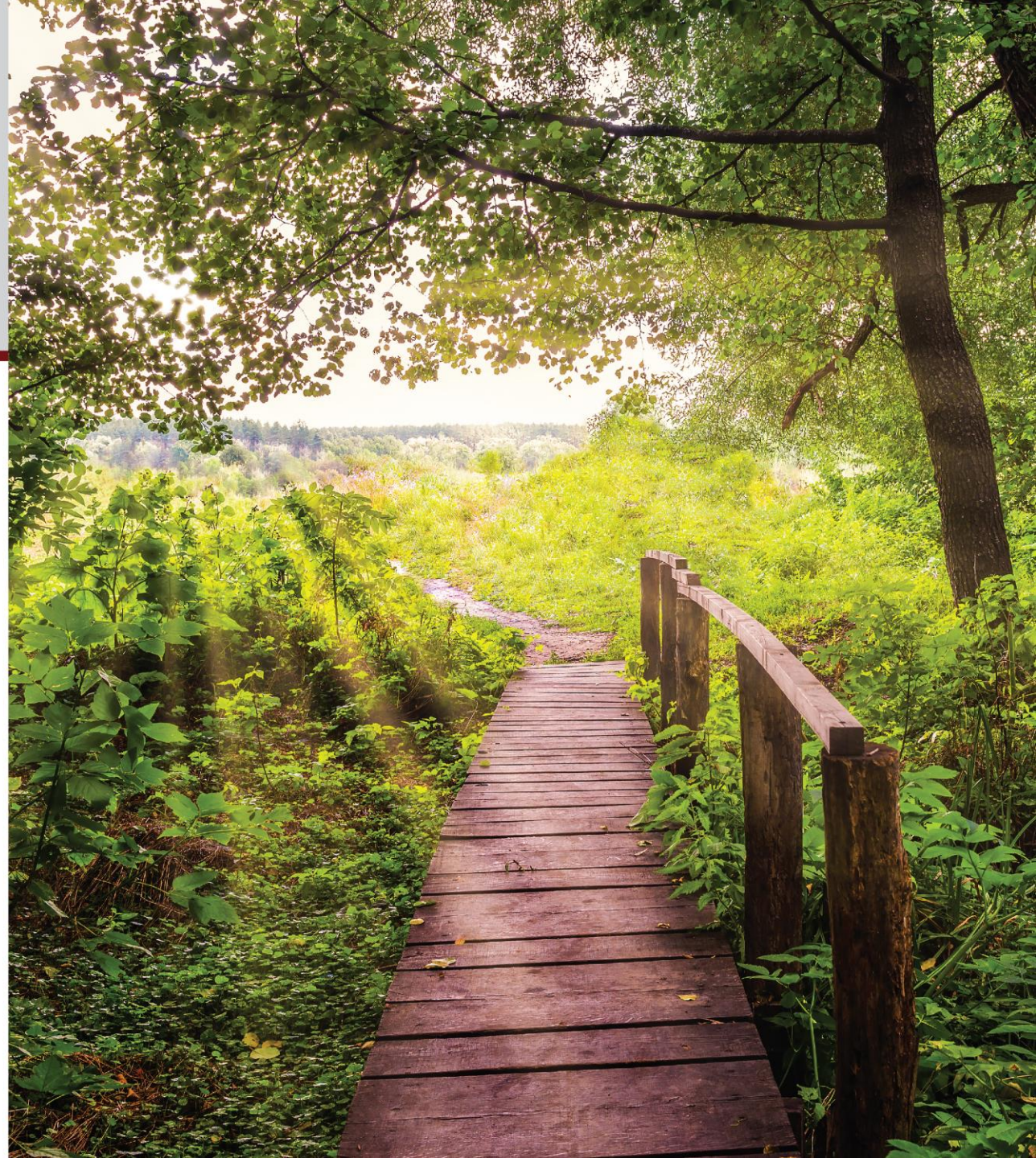
Considerations

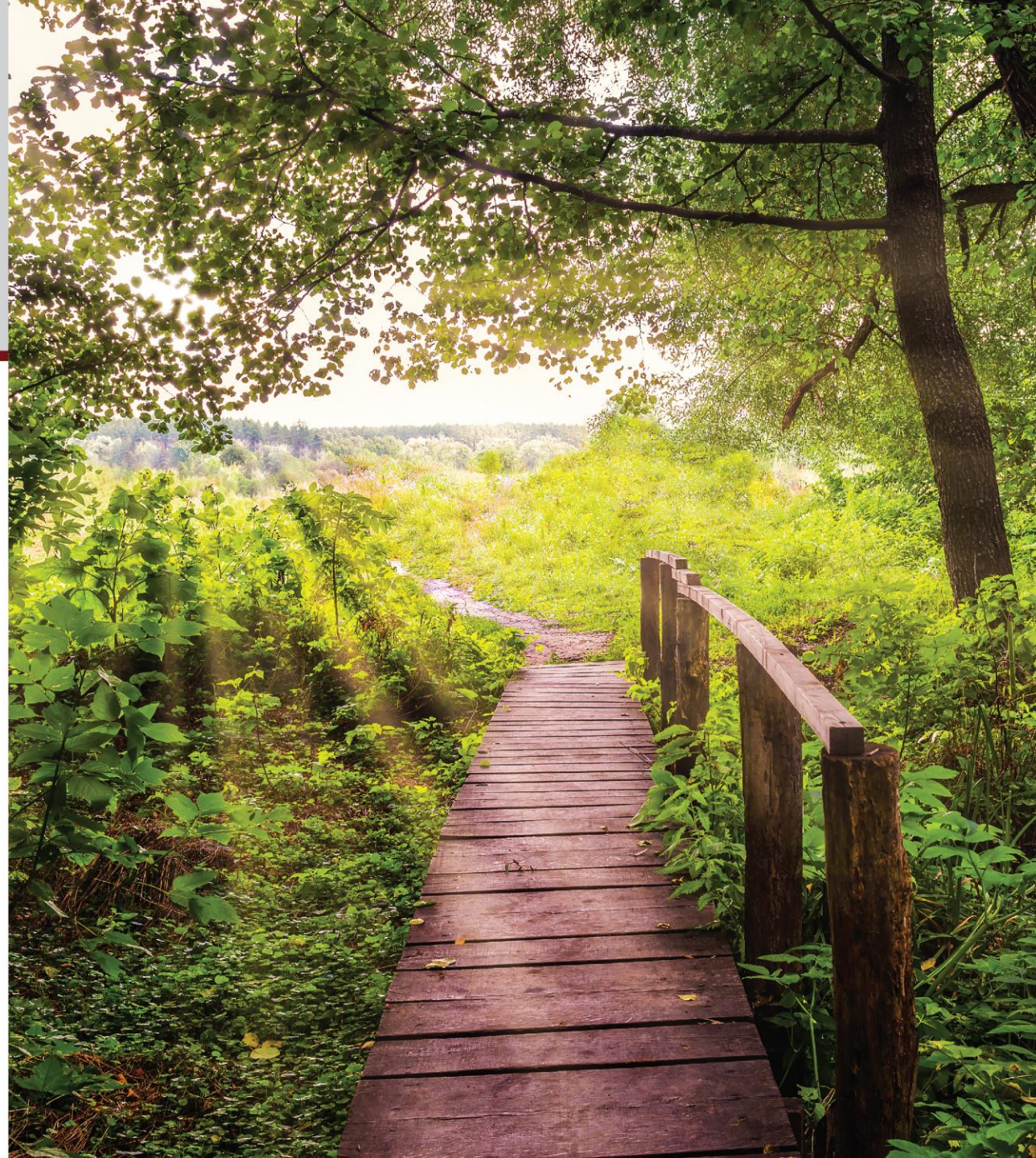
New Services:

- When a clinic adds a new service to the RHC, a policy should be developed to define the workflow/process the clinic will follow.
  - Unless it is covered by Medical Management policy.



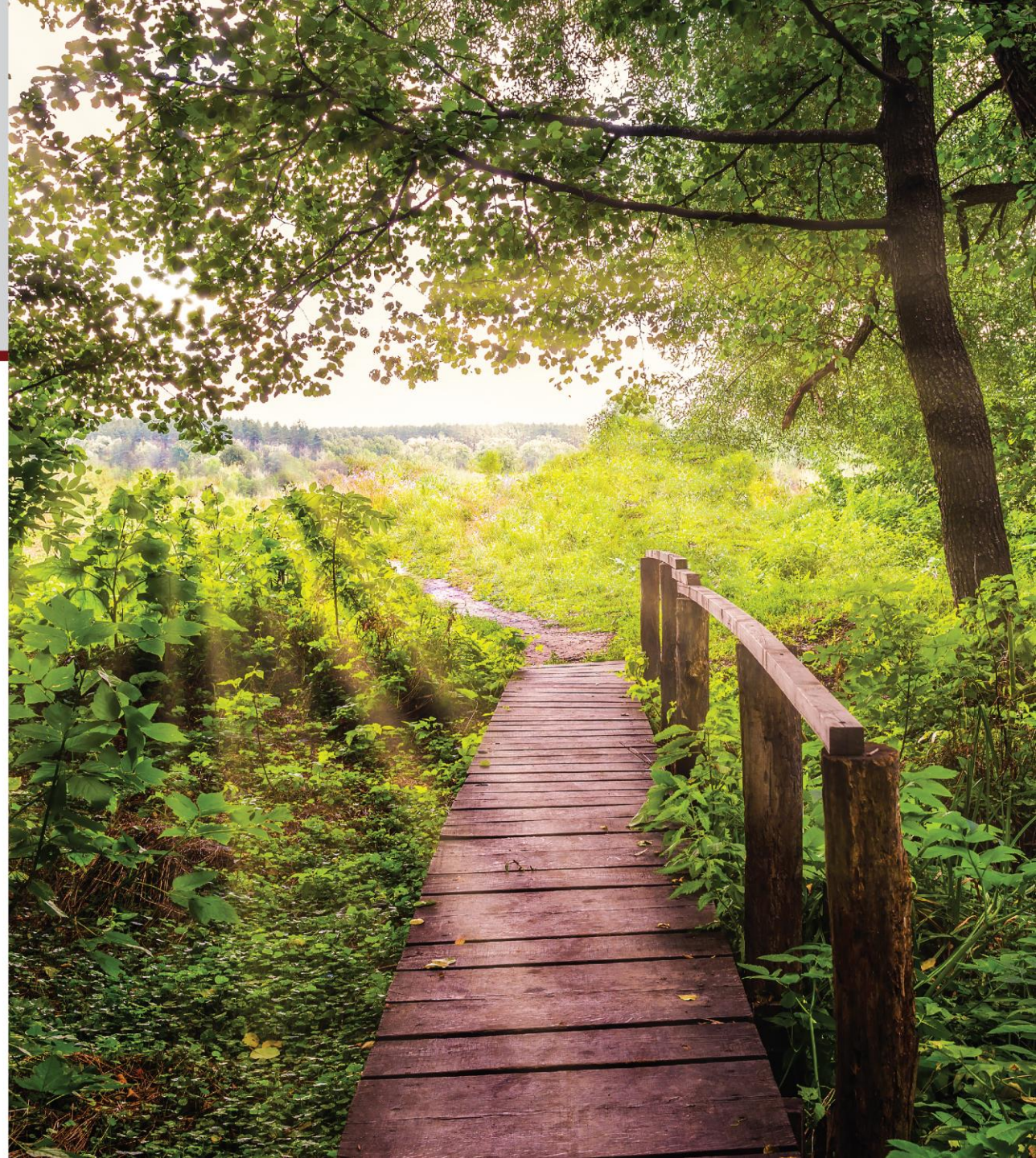
Policy Outline:

- Purpose
- Definitions
- Procedures
  - Provider/Staff will…
    - Breakdown initial/subsequent visits
  - Consent
  - Medical record requirements
  - Care plan requirements
  - Access to care



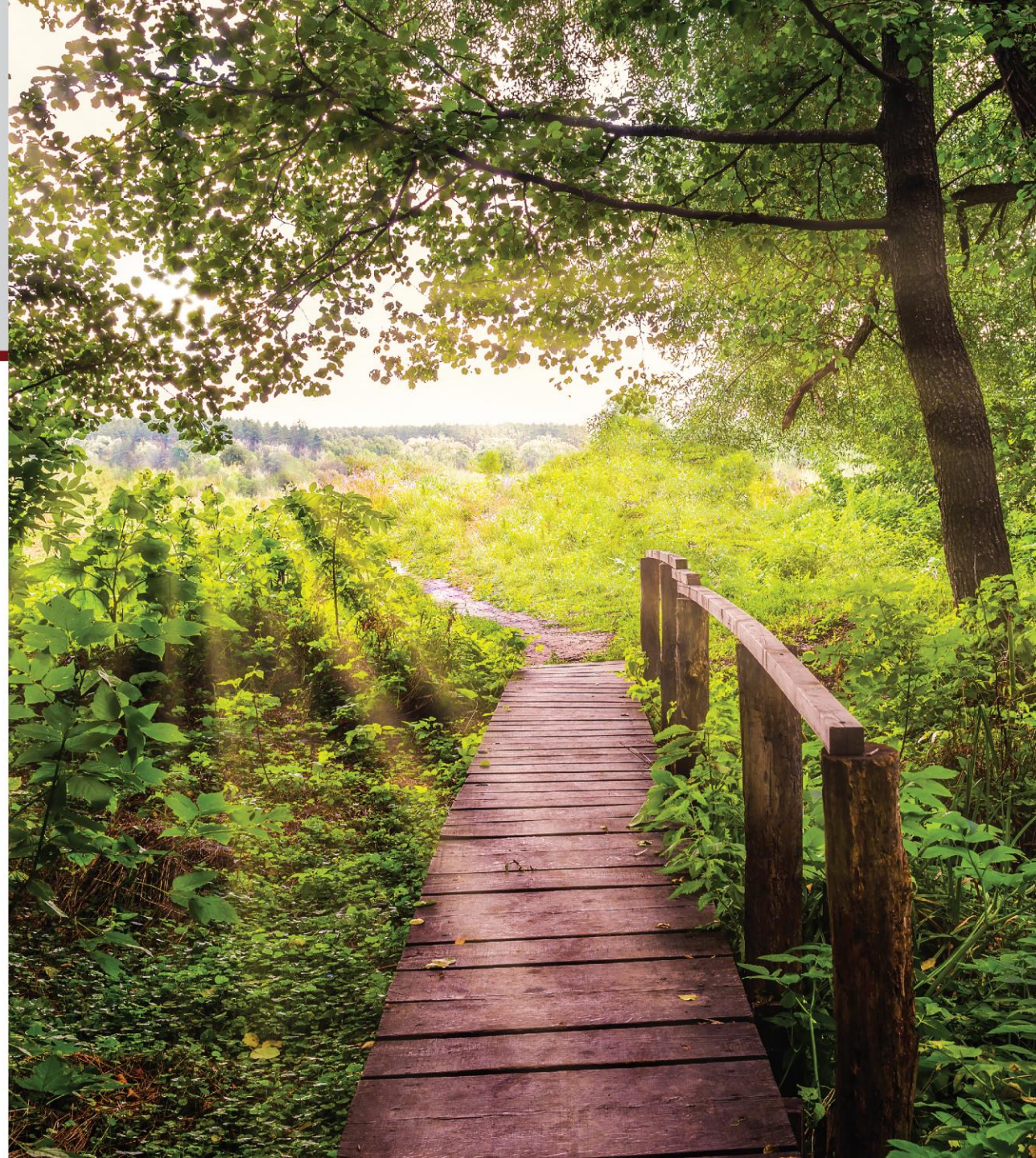
Considerations:

- **Patient Benefits**
  - Improves quality of care
  - Prevents over utilization of services
  - Reduces hospitalizations
  - Patient engagement
- **Staffing**
  - Can you meet the requirements?
  - In-house vs. Outsourcing
  - Volume of services



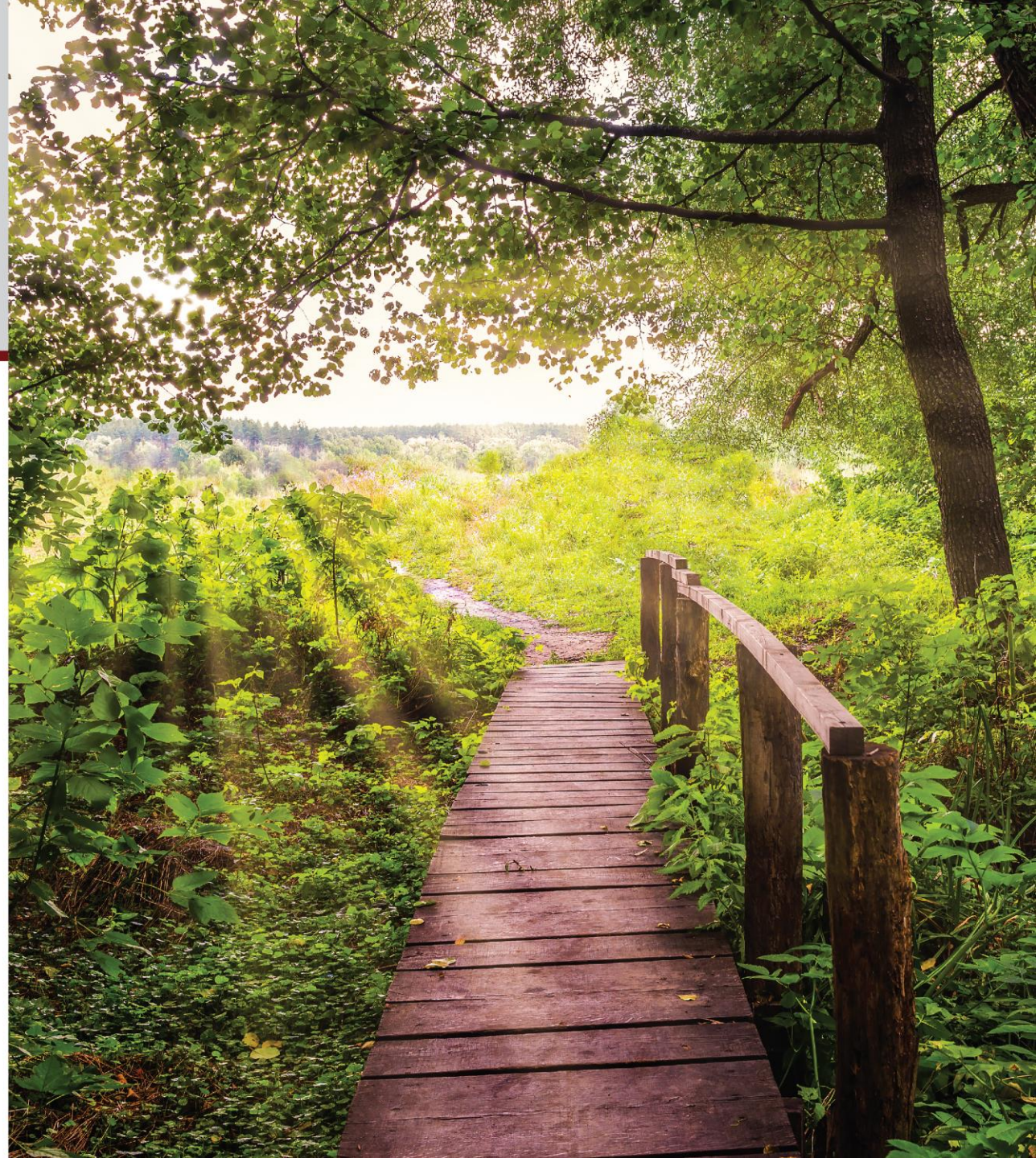
Considerations:

- **Patient Education**
  - Define the service
  - Access to services/care
  - Sharing of information
  - Costs (copays/deductibles apply)
  - How to enroll/revoke the service
- **Medical Records**
  - Work with vendors (templates)
  - Confirm complete/accurate records that document all requirements



Considerations:

- Costs
  - Care management services are considered “Non-RHC” as they are paid outside the rate
  - Need to capture overhead if completed “in-house” OR remove all together if outsourced
    - In-house services
      - Reclassify staff cost (time studies)
      - Direct costs to Non-RHC cost center
- FAQ



Implementing Care Management Services at the RHC FAQ

What are the benefits of starting a care management service at the clinic?

- The clinic is able to capture a better picture of the whole patient.
- The patients seem more open to sharing their health struggles with their dedicated care staff when speaking to them "on their home turf"
- Better quality care (follow-up and continuity of care)
- Keeping information current in a patient's record (updating demographics, information, pharmacy, other changes within the record on a more consistent basis)
- Additional revenue

What are some educational items you have found helpful?

- Staff need to be educated on how to identify if a patient is eligible
    - Front desk for scheduling, clinical support staff AND providers
- Records need to be kept current. Staff need to be reminded to keep all demographics current at EVERY visit because the care team pulls directly from the patient record
- Costs of the service need to be transparent and discuss with the patient how their specific insurance handles the services
- Education with patients on how to use equipment if the clinic is incorporating RPM (Remote Patient Monitoring) as well.

What questions do you commonly receive from your patients?

- Who's this person calling me?
- Why are they calling me from an (800) number?
- Why am I getting this bill?

Why did you outsource the service?

- Staffing levels

What were some struggles?

- Communication threads between the care management team (internal or not) AND the clinical team
    - Who does the care team contact at the clinic if they need to make space for an appointment, who does the clinic contact if they need information for a patient that has an upcoming appointment, etc.
- Knowing the care team well enough that the clinic can handle patient calls
- Handling the "delivery" of supplies for RPM services to the patient relating to their care plan (ie. blood pressure machine, etc. for the patient to use at home)
- CCM team not knowing community resources available to the patient

What recommendations would you have for other clinic's that are looking to start this service?

- The pros far outweigh the cons.
- Dedicate a team member to be the liaison between the clinic and the care management team.
- During a patients visit at the clinic, conduct "controls" on their at home equipment to confirm accurate information is being captured
- Discussions with the care team on how the clinic likes to schedule patients to avoid double booking or to ensure there is enough time to handle the patient's needs
- Working with the care team to ensure they understand the workflow of the clinic, as well as, turn around time (ie. Prescription refills)
- CCM team understand the area or demographic of the area they are servicing.
- Provide a list of community resources to the CCM team (ie. Local food pantries)

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