CMS Reimbursement Methods including : Telehealth, Virtual Telecommunication and Chronic Care Management,

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Create Opportunities

Telehealth

Virtual

Telecommunications

Chronic Care Management

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Telehealth

Billing requirements for billing an Originating Facility Site Fee for Telehealth Services:
The Patient must be located at an Originating Site at the time the telecommunication services are furnished. .
The originating site must be within a FQHC. The FQHC must be Located within qualifying areas such as a:

HPSA-Health Professional Shortage Area.
outside a MSA-Metropolitan Statistical Area
Patient must be a eligible Medicare Patient at the time of service.

Patient	**Provider**
Originating Site	Distant Site
Location of Patient –RURAL LOCATION	Location of Provider

The cost of a visit may not be billed or included on the cost report.

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DISTANT SITE PRACTITIONERS Distant site practitioners who can furnish and get payment for covered telehealth services (subject to State law) are:

- Physicians
- Nurse practitioners (NPs)
- Physician assistants (PAs)
- Nurse-midwives
- Clinical nurse specialists (CNSs)
- Certified registered nurse anesthetists
- Clinical psychologists (CPs) and clinical social workers (CSWs)

  CPs and CSWs cannot bill Medicare for psychiatric diagnostic interview examinations with medical services or medical evaluation and management services.

  They cannot bill or get paid for Current Procedural Terminology (CPT) codes 90792, 90833, 90836, and 90838.
- Registered dietitians or nutrition professional

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Acceptable Equipment

Common Skype is not acceptable for telehealth purposes; however, professional Skype-like products are available.

Health Insurance Portability and Accountability Act (HIPAA) guidelines require that any software transmitting protected personal health information meet a 128-bit level of encryption, at a minimum, need auditing, archival and backup capabilities. State laws must also be followed.

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TELEHEALTH ORIGINATING SITES BILLING AND PAYMENT

TELEHEALTH ORIGINATING FACILITY SITE FEE

HCPCS Code Q3014

Medicare Reimbursement of $17.00 per session

(covers technology and supervision on the client side)

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Virtual Telecommunication

- **New Virtual Communication Services Code:** Effective 01/01/2019

- Payment for Virtual Communication services when at least 5 minutes of:
- **Communication Technology-Based** or
- **Remote Evaluation Services**
- are furnished to a patient who has had an billable visit within the previous year, and both of the following requirements are met:
  - The medical discussion or remote evaluation is for a condition not related to an RHC service provided within the previous 7 days, and
  - The medical discussion or remote evaluation does not lead to an RHC visit within the next 24 hours or at the soonest available appointment.

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Virtual Telecommunication- Effective 01/01/2019

- **New Virtual Communication Services Codes:**
- **G2012** Virtual Communication Services
- **G2010** Remote Evaluation Services

For RHC/FQHC

- **G0071** for either Virtual Communication or Remote Evaluation Services

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Virtual Telecommunication Services: G2012/G0071

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- **New Virtual Communication Services** Effective 01/01/2019

HCPCS RHC/FQHC Code G0071

Payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between an rural health clinic (rhc) or federally qualified health center (fqhc) practitioner and rhc or fqhc patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an rhc or fqhc practitioner, occurring in lieu of an office visit; rhc or fqhc only

Virtual Telecommunication Services: G2012/G0071

- **New Virtual Communication Services** Effective 01/01/20119,
- To receive payment for Virtual Communication services
- PFQHCs and RHCs must submit an claim with HCPCS code G0071 (Virtual Communication Services) either alone or with other payable services.
- Payment for G0071 is set at the average of the national non-facility PFS payment rates for HCPCS code G2012 (RHC and FQHC bill using G0071)
- (communication technology-based services) is updated annually based on the PFS national non-facility payment rate for these codes.
- RHC/FQHC face-to-face requirements are waived when these services are furnished to an RHC/FQHC patient, and coinsurance and deductibles apply.

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Virtual Telecommunication: Remote Evaluation Services G2010/G0071

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Remote Evaluation Services G2010.

RHC and FQHC will ALSO bill this service with G0071.

- HCPCS code G2010/G0071 (for RHC and FQHC) (remote evaluation services) and is updated annually based on the PFS national non-facility payment rate for these codes. When at least 5 minutes of communication technology-based remote evaluation services are furnished by an RHC or FQHC practitioner to a patient who has had an RHC or FQHC billable visit within the previous year, and both of the following requirements are met:
- The remote evaluation is for a condition not related to an RHC or FQHC service provided within the previous 7 days, and
- The medical discussion or remote evaluation does not lead to an RHC or FQHC visit within the next 24 hours or at the soonest available appointment.

G0071 is a valid 2019 HCPCS cod.

For *Payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between an rural health clinic (rhc) or federally qualified health center (fqhc) practitioner and rhc or fqhc patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an rhc or fqhc practitioner, occurring in lieu of an office visit; rhc or fqhc only* or just "***Communication services by rhc/fqhc 5 min***" for short, used in *Medical care*.
G0071 has been in effect since 01/01/2019

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The Virtual Check-in

$14.78

- Brief communication technology-based service, e.g. **virtual check-in**, by a physician or other qualified health care professional **who can report evaluation and management services**, provided to an established patient; **5-10 minutes of medical discussion**

Video/Image Evaluation

$12.61

- **Remote evaluation of recorded video and/or images** submitted by an established patient (e.g., store and forward),

Reimbursement Source: National Average, MPFS, 2019

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Technology Mediums

Audio only, real time interactions (i.e. telephone)

Synchronous, two-way audio enhanced with video (i.e. iPad, tablet, smart phone)

Verbal follow-up options for video/image evaluation (G2010): phone call, audio/video communication, secure text messaging, email, or patient portal communication

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The Details

- Requires verbal interaction with the FCHQ billing provider
- Patient consent must be documented
  - Since this service is patient initiated, it can be implied
- Can be part of an opioid or SUD treatment regimen
  - i.e. Medication assisted therapy
- No frequency limitations – can bill multiple times per patient
  - Paid once per day
- Patient cost sharing applies
- Established patient must have been seen (billable visit) in last calendar year. Not billable if visit furnished within the previous 7 days or within the next 24 hrs.

Federally Qualified Health Centers are paid for both services under the PFS in addition to the encounter rate using code G0071.

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Implementing Communication Technology

Opportunities

- Expands access
- New revenue source
- Chronic care management enhancer
- Patient satisfier

Considerations

- Workflows/staffing
- Integrating with the medical record
- Education/communication to a heterogeneous population
- Securing the information

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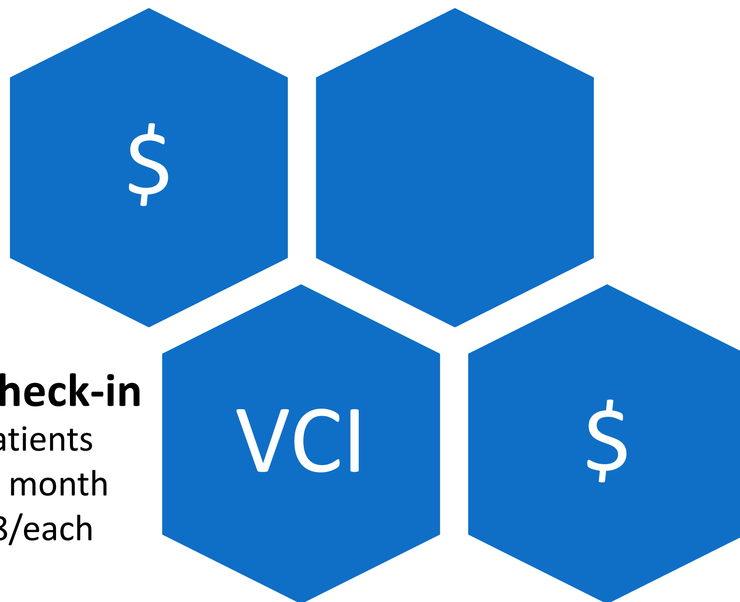
Virtual Visit ROI ~ 250 Patients



Virtual Check-in
125 patients
VCI per month
$14.78/each

125 Patients
(RHC/FQHC)

Monthly: $1,847.50

Annually: $22,170 VCI

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Cost Report Connection

- Virtual communication services must be included on the cost report ,but direct costs for these 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.

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Chronic Care Management-CCM

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Critical Component of Primary Care

At least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements:

- 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

Assumes 15 minutes of work by the billing practitioner per month

Who may provide services in an FQHC?

The following people may provide FQHC services:

- Physicians
- Dentists
- Physician assistants (PAs)
- Nurse practitioners (NPs)
- Nurse midwives or other specialized nurse practitioners
- Certified nurse midwives
- Registered nurses (RNs) or licensed practical nurses (LPNs)
- Mental health professionals – for a list of qualified professionals eligible to provide mental health services
- Naturopathic physicians,

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https://www.azahcccs.gov/PlansProviders/Downloads/FFSProviderManual/FFS_Chap_10AddendumFQHC.pdf

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Care Management Services Effective January 1, 2018,
FQHCs can receive payment for:

● Chronic Care Management (CCM)
General Behavioral Health Integration (BHI) services when 20 minutes or more of CCM or general BHI services are furnished and FQHCs bill HCPCS code G0511 either alone or with other payable services.

● Psychiatric Collaborative Care Model (CoCM) services when 70 minutes or more of initial psychiatric CoCM services or 60 minutes or more of subsequent psychiatric CoCM services are furnished and FQHCs bill HCPCS code G0512 either alone or with other payable services on an FQHC claim.

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CARE MANAGEMENT STEPS:

- Identify or hire a Care Manager
- Identify high-risk patients
- Define care manager – care team interface
- Define the care management model
- Enroll in care management

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Action item: Identify or Hire a Care Manager.

The RN Care Manager works one-on-one with a panel of high-risk patients to develop and manage the individual care plan and is accountable for coordination of care in partnership with the care team and across the care continuum.

Define the roles and responsibilities of the Care Manager. Health centers can leverage job descriptions previously developed by other care management programs

Care manager training is critical to the success of a program.[1] Training should include didactic experience as well as mentoring or shadowing.[8] Also, given that much of the work of care managers requires the building of trusting relationships with patients and caregivers, skill building in motivational interviewing is effective for activating and engaging patients

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Action item: Identify high-risk patients.

Patient should be identified through risk stratification high risk action guide.

Triage and identify a pool of patients
Factors affecting caseload size and complexity include health center environment, experience of the care manager, the clinical and social complexity of patients, available social supports, and target care management outcomes.[13]
Caseload size and manageability should be evaluated on an ongoing basis.
Estimated case load per Care manager: 50-150 patients

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Action item: Define Care Manager - Care Team Interface.

In addition to the Care Manager, each patient is assigned a Care Team – including a designated provider - that works to carry out the patient’s individualized care plan.

Care management programs are most successful when integrated with the patient’s primary care team.[1]

It is essential to determine how, and in what ways, the care manager and care team will work together. This should include how often they meet together, what mechanisms they will use to communicate in between face-to-face meetings, documentation expectations, and follow-up.

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Action item: Define the Care Management Model.

A care management program for high-risk patients should ensure comprehensive care plans that support chronic disease and prevention needs, as well as mental, social, and environmental factors.
Only a provider who can furnish a comprehensive evaluation (E/M) visit, Annual Wellness Visit (AWV), or Initial Preventive Physical Exam (IPPE) to determine whether or not a patient is eligible for CMS reimbursable comprehensive care management (CCM) services. CCM payments are for the management of chronic illnesses. It does not include time spent on acute care services. CCM supports activities that are not typically furnished face-to-face such as telephone communication, review of medical records and test results, and coordination and exchange of health information with other providers. CCM also includes activities such as patient education or motivational counseling.

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Components of a care management model for high-risk patients that must be met if your health center intends to bill CMS for CCM services include:[7]

• Patients have access to care management services 24/7.
• Patients receive continuity of care so that they are able to get successive routine appointments with a designated provider or care team member.
• Care management is provided for chronic conditions that include:
• Assessment of a patient's medical, functional and psychosocial needs through either an initial preventive physical exam or a comprehensive evaluation and management visit.
• Timely receipt of all recommended preventive care.
• Patient's medication is reconciled.
• There is oversight of patient self-management of medication.
• Development of a patient-centered care plan that includes the patient's choices. The care plan is based on a physical, mental, cognitive, psychosocial, functional and environmental assessment. A copy of the care plan is provided to patients.
• Care transitions between providers and care settings is managed.
• Services provided by home- and community-based clinical service providers is coordinated.
• Patients and caregivers can communicate with the provider by phone or using other electronic methods for non-face-to-face consultation.
• The care plan is electronic and is available 24/7 to all providers furnishing care to the patient.

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Action item: Enroll in Care Management.

A warm handoff and introduction of a patient to the care manager by the provider is a best practice.[14] In the absence of a warm handoff, a care manager may reach out to a patient via phone or letter to a patient indicating their provider has recommended the patient for care management. The Care Manager then coordinates a comprehensive clinical and non-clinical assessment of the patient, and a visit with provider – culminating in an individualized care plan. Care plans should include steps for patient engagement in self-care.

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Patient Consent Required:

1. Discussion with patient during a visit

As long at the provider discusses CCM services with the patient during a visit, other clinical staff (e.g., nurse, medical assistant, and others under direct supervision of the provider) can complete the consent process.

Direct supervision means that a provider is immediately available to guide the process; the provider does not need to be in the room when a service is furnished.

Patient consent to CCM is required for initiation. Once a provider initiates the discussion of CCM with the patient and the patient has consented, any provider (e.g., MD, PA, NP, PharmD., RPh, CSW or qualified support staff with direct supervision) can provide CCM services.

After the initial CCM visit, there is not a face-to-face visit requirement.

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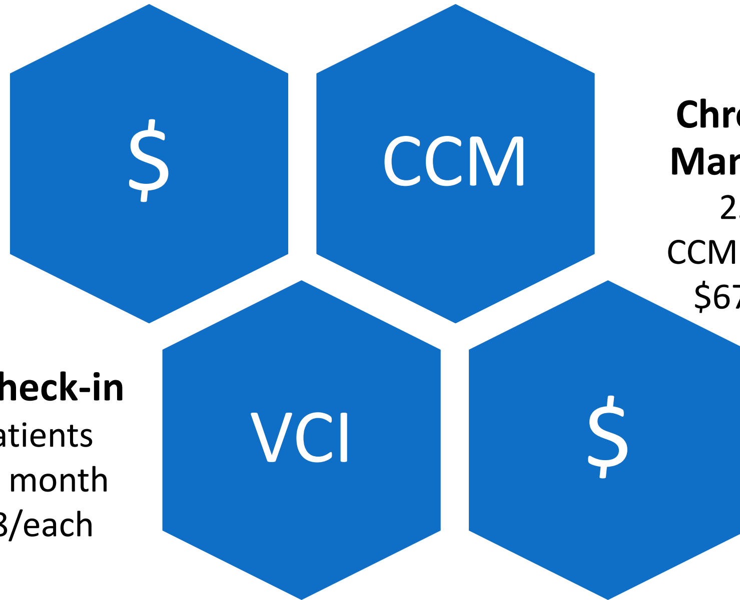
Virtual Visit ROI ~
An Annual, 250 Patient Chronic Care Example



Chronic Care Management
250 patients
CCM for 12 months
$67.03 pp/mos.

Virtual Check-in
125 patients
VCI per month
$14.78/each

250 Patients Annually (FQHC)

$201,090 CCM
$22,170 VCI
$223,260

or
$18,605/mo.

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Action item: Enhance and Expand Partnerships. Care in a value-based environment requires care across a continuum of providers rather than the traditional 'silo' model. Care Managers should develop a list of community resources and partners who the patient and care team will interface with in carrying out a plan of care. Some high performing health care organizations coordinate with providers who follow-up high-risk patients in their home, or support patient's use of telehealth, or other self-care activities.

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Action item: Graduate patients from care management, as appropriate. While the frequency of interaction between a care manager and patient will vary depending on the medical and social needs of each patient, and individual care plan goals, contact is typically more frequent initially then tapers as the patient reaches goals. Every two to three weeks until goals were reached, followed by telephone follow-up every four weeks,.

The effectiveness of care management programs increases with face-to-face time, with telephone-only interventions having little success.[4] The duration of care management will vary, depending on the needs of the patient, although there is some indication that longer programs (e.g., six months or more) are more effective.[4]

Cases are typically closed at a point when all goals have been reached and patient and care manager agree continued engaged is not needed (e.g., 60–90 days after reaching goals). Document each patient's graduation, transfer, or termination from the CCM program.

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Action item: Document and bill for care management.

Utilize the existing EHR care plan template, or create a structure within current EHR capabilities, to document each patient's individual care plan.

Establish a system to track time spent on care management services including phone calls, emails, coordination with others, prescription management and medication reconciliation.

Document time spent on care management for each patient monthly. Time spent performing secure messaging or email consultation is counted toward time that can be billed to CMS if measurable and documented.

The development of the care plan can be counted towards the minimum 20 minutes required for billing.

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While the most common revenue code to bill CCM services is 052X, CMS does not have a revenue code restriction for CCM services. All claims must include a diagnosis code and providers should use the most appropriate diagnosis code for that patient. The billing codes and Medicare physician fee schedule payments for CCM services are:

CCM Initial Visit + New patient or those not seen within a year prior to starting CCM 223.51 x GPSI

CCM G0511

20 minutes or more of clinical staff time spent on non-complex CCM per calendar month that requires establishment, implementation, revision or monitoring of a care plan. $62.28.

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The usual cost-share rules apply to these services so patients are responsible for the usual Medicare Part B cost sharing (deductible and copayment/coinsurance) if they do not have supplemental (‘wrap-around’) insurance.

Please note that the majority of dual eligible beneficiaries (Medicare and Medicaid) are exempt from cost sharing. Patients are also subject to health center guidelines around receipt of service regardless of the ability to pay.

Action item: Measure Outcomes.

Care management effectiveness can be measured by the degree to which patients achieve care plan goals. Performance should also be measured against key clinical and quality indicators, including performance on relevant Uniform Data Systems (UDS) measures and patient experience.

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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)
99484 (20 minutes or more of general behavioral health integration services).

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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),
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).

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What are the 2019 payment rates for care management services inn 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.

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FAQ:

- Will claims with CPT codes 99487, 99484, or 99493 be paid?
- No. RHCs and FQHCs are required to bill for care management services using G0511 or G0512.
- Are care management services required to be billed on a claim with an RHC or FQHC visit?
- No. Care management services can be billed either alone or on a claim with an RHC or FQHC billable visit.
- Will care management services be paid in addition to an RHC or FQHC visit?
- Yes. If care management services are billed on the same claim as an RHC or FQHC visit, both will be paid.

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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?
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.

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

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- What date of service should be used on the claim? Can care management costs such as software or management oversight be included on the cost report?
- Yes. Any cost incurred as a result of the provision of RHC and FQHC services, 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.
- 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.
- 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?
- No. RHCs and FQHCs can only bill one care management service for an individual per month.

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Hurdles with Virtual Programs

- Technology
  - Provider
  - Patient
  - Technology Costs
- Buy-In
  - Provider
  - Patient
  - Staff

- Service Awareness
- Documentation
- Billing
- Track-Ability
- Lack of integration
- Resources
- Profitability

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Jo Potts, CPC
Director-Healthcare
CliftonLarsonAllen LLP
Jo.potts@CLAConnect.com
1-425-250-6026

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