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Medicare Care Management Billing Strategies

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Medicare Care Management Billing Strategies

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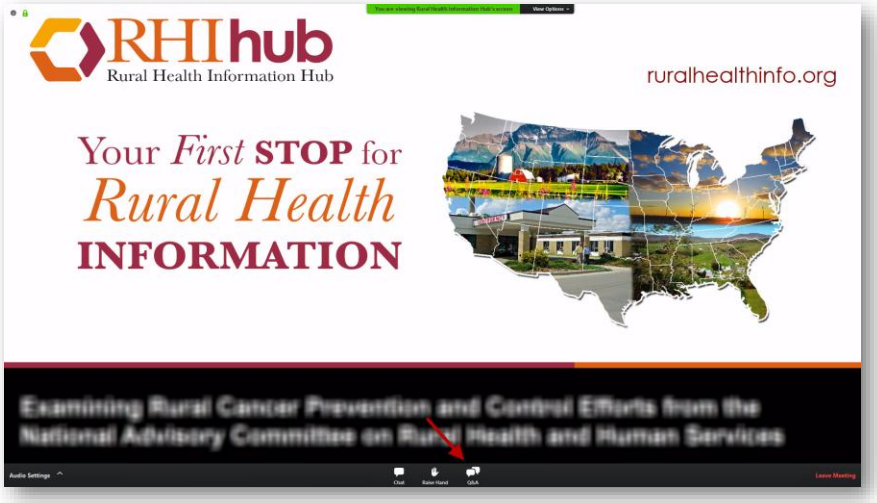
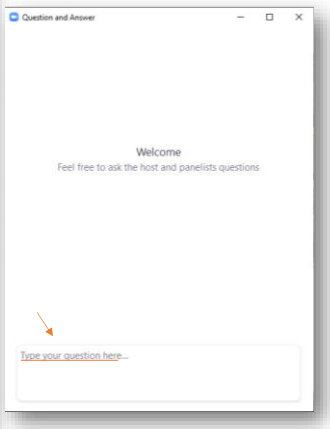
Housekeeping

- Slides are available at www.ruralhealthinfo.org/webinars/care-management-billing-strategies
- Technical difficulties please visit the Zoom Help Center at support.zoom.us

If you have questions…





Featured Speakers

Craig Holden, PhD, MPH, MBA, Senior Research Scientist with the NORC Walsh Center for Rural Health Analysis

Susan Rohde, RHIT, CCS-P, CPC, Director, Eide Bailly

Joy Krush, RHIT, CCS, CCS-P, CDIP, CRHCP, Senior Manager, Eide Bailly

Background

NORC Walsh Center FOR RURAL HEALTH ANALYSIS

Medicare care management services can facilitate the transition to value-based care (e.g., accountable care organizations [ACOs]).

Value-based care incentivizes health care providers and payers to focus on providing high quality, patient-centered care.

CMS set a goal of having all Medicare fee-for-service (FFS) beneficiaries in a care relationship with accountability for quality and total cost of care by 2030.

Care management services can facilitate the transition to value-based care by allowing providers to bill for services that improve quality of care, including increasing preventive service use and reducing potentially avoidable utilization.

Medicare Care Management Services

Annual Wellness Visit (AWVs) and Initial Preventive Physical Exams (IPPE)	Chronic Care Management (CCM) and Principal Care Management (PCM)	Transitional Care Management (TCM)	Behavioral Health Integration Services	Remote Patient Monitoring & Remote Therapeutic Monitoring
Social Determinants of Health Risk Assessment*	Community Health Integration Services*	Principal Illness Navigation Services*	Caregiver Training Services*	Advanced Primary Care Management**

**New in CY 2024*
***New in CY 2025*

In the Calendar Year (CY) 2024 and CY 2025 Medicare Physician Fee Schedule Final Rules, CMS added new billing codes to support care coordination and health related social needs.

The new codes in CY 2024 include:

- Social Determinants of Health Risk Assessment
- Caregiver Training Services
- Community Health Integration Services
- Principal Illness Navigation Services

In CY 2025, changes include:

- Advanced Primary Care Management (APCM) billing codes
- Reporting individual CPT and HCPCS codes for RHCs and FQHCs to replace G0511

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Care Management Medicare Reimbursement Strategies for Rural Providers

In recent years, Medicare has added more billing codes to keep Traditional Medicare patients healthy and better coordinate services to support patients at home. These services can also support rural hospitals, Rural Health Clinics, Federally Qualified Health Centers, and practitioners participating in value-based care programs and alternative payment models by helping improve quality of care and health outcomes. RHIhub, in coordination with the Federal Office of Rural Health Policy (FORHP) and the NORC Walsh Center for Rural Health Analysis, have created this resource to help rural providers become more aware of these new billing codes and how to use them to better serve their patients and assist them in billing appropriately for these services.

Each of the guides below provides a brief overview and links to key documents to help rural healthcare professionals, practices, and hospitals understand the billing code, consider the benefit to their patients and organization, and begin billing Traditional Medicare for the code. RHIhub will be updating this resource with additional billing information as new codes are created and other payment changes are finalized. The current guides include:

www.ruralhealthinfo.org/care-management

current guides include:

- Annual Wellness Visits: Yearly visit to review a patient's medical and social history and provide counseling about preventive services.
- Initial Preventive Physical Exam: The "Welcome to Medicare" visit for patients who are new to Medicare.
- Chronic Care Management: Monthly non-face-to-face support for patients with two or more chronic conditions.
- Principal Care Management: Monthly non-face-to-face support for patients with a single high-risk disease.
- Behavioral Health Integration Services: Care management provided primarily in a primary care setting for patients with behavioral health needs. Also includes information about the Psychiatric Collaborative Care Model (CoCM).
- Transitional Care Management: Certain non-face-to-face services and face-to-face visit for patients in the 30 days after discharge from an acute care setting.
- Social Determinants of Health Risk Assessment: Assessment of a patient's unmet social needs using a standardized, evidence-based tool.
- Community Health Integration Services: Services to address unmet social needs affecting diagnosis and treatment of medical conditions.
- Principal Illness Navigation Services: Services to support patients with high-risk conditions access resources for health and social needs.
- Caregiver Training Services: Education provided to a patient's caregiver related to support for the patient's physical and/or mental health.
- Marriage and Family Therapists and Mental Health Counselors Billing: New rule allowing MFTs and MHCs to bill Medicare independently for their services furnished for the diagnosis and treatment of mental illnesses.
- Advanced Primary Care Management Services: Bundle of care management and technology-based services.

More information on care management can also be found on the Care Management section of the CMS website.

Agenda

- Understanding Care Management
- Action Plan for Implementation
- Core Components of Specific Care Management Services
- Best Practice for Implementing Care Management

Understanding Care Management

Understand Care Management Program

- Before implementation, develop a deep understanding of CMS-approved care management services applicable to RHCs, CAHs, and FQHCs. The key programs include:
- **Chronic Care Management (CCM):** For patients with **2+ chronic conditions** expected to last at least 12 months or until death, where the conditions place the patient at significant risk of death or functional decline.
- **Principal Care Management (PCM):** For patients with **one complex chronic condition** that requires frequent monitoring and adjustment.
- **Transitional Care Management (TCM):** Set of services provided to patients as they transition from one healthcare setting to another—such as from a hospital to their home or to a skilled nursing facility. The goal of TCM is to ensure continuity of care, reduce the risk of readmissions, and support patient recovery during this vulnerable period.
- **Behavioral Health Integration (BHI):** Targets patients with diagnosed **behavioral or mental health conditions** and supports integration with primary care.
- **Collaborative Care Model (CoCM):** Integrated behavioral healthcare model that combines primary care and behavioral health services within same setting.
- **Advanced Primary Care Management (APCM): Program designed to support primary care providers in delivering ongoing, patient centered care.**

Understanding Care Management Program

- **IPPE** – Initial Preventative Physical Exam: **"Welcome to Medicare" visit**, is a one-time preventive service covered by Medicare Part B. It must be completed within the first 12 months of a patient's enrollment in Medicare.
- **AWV** – Annual Wellness Visit: Yearly preventive service covered by Medicare that focuses on creating or updating a personalized prevention plan to help prevent disease and disability. It is available to beneficiaries who have been enrolled in Medicare Part B for more than 12 months. Initial and Subsequent.
- **RPM/RTM**-Remote Monitoring: Medicare-covered services that use digital technologies to collect and monitor patients' health data or therapy adherence outside of traditional clinical settings, supporting ongoing management of chronic or acute conditions.
- **CHI**-Community Health Integration Services: Medicare-covered supports provided by clinical staff to address health-related social needs, such as housing, nutrition, or transportation, that impact a patient's overall health and care outcomes.
- **PIN and PIN-PS**-Principal Illness Navigation Services and Peer Support (PS): Medicare-covered services that help patients with serious, high-risk chronic conditions by providing care navigation and support, including through trained peer support specialists, to improve care coordination and outcomes.

Understanding Care Management Program (2)

- Why Care Management

CMS recognizes that Care Management is just one component of primary care that is critical to improving beneficiary outcomes while providing higher patient satisfaction.

Takes provider time and effort to provide the between appoint help to stay on track with plans.

Provides separate payment billing codes to allow for additional time and resources.

One in eight Medicare beneficiaries are dually enrolled with Medicare/Medicaid.

Tool to help reduce geographic, racial or ethnic healthcare disparities.

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Opportunities

Despite important steps to pay separately for care management services promoted by CMS, there has been limited uptake of care management services and Medicare still overwhelmingly pays for primary care through traditional office/outpatient (O/O) Evaluation and Management (E/M) visit codes, which describe a broad range of physicians' services but do not fully distinguish and account for the resources associated with primary care and other longitudinal care.

Increasing the provision of care management services can influence other reimbursable services to be performed.

There are multiple indirect benefits of care management which improve patients' overall health and wellness.

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Opportunities-Usage per AMA

CPT/ HCPCS	DESCRIPTION	CMS Previous Utilization	CMS NPRM Utilization	Ratio	NPRM Work RVU	CMS Est. Change in Physician Work Payment	CMS Est. Change in Total Allowed Charges
99439	Chrnc care mgmt staf ea addl	1,812,427	1,585,874	0.875	0.70	$ (5,110,732)	$ (11,418,612)
99452	Ntrprof ph1/ntrnet/ehr rfrl	20,803	18,639	0.896	0.70	$ (48,766)	$ (52,269)
99487	Cplx chrnc care 1st 60 min	411,603	368,796	0.896	1.81	$ (2,494,892)	$ (4,884,242)
99489	Cplx chrnc care ea addl 30	784,850	658,489	0.839	1.00	$ (4,075,841)	$ (8,548,501)
99490	Chrnc care mgmt staff 1st 20	5,007,519	4,486,737	0.896	1.00	$ (16,769,404)	$ (32,747,187)
99491	Chrnc care mgmt phys 1st 30	193,760	173,609	0.896	1.50	$ (973,308)	$ (1,633,206)

ACTION PLAN FOR IMPLEMENTATION

Identify Eligible Patients

- Use your EHR to identify patients eligible for care management services and who would benefit from care management services:
  - Chronic conditions (for PCM, APCM and CCM)
  - Recent hospitalizations/discharges (for TCM)
  - High ED/Hospital utilization (PCM/TCM/CCM/APCM)
  - Behavioral health conditions (for BHI and/or CoCM)

Assign Care Management Staff

Designate specific staff to lead care management efforts, which may include:

- **RN or LPN care managers**: Ideal for clinical coordination and medication management.
- **Social workers**: Especially helpful for behavioral health integration and addressing SDOH.
- **Medical assistants or health coaches**: Can provide non-clinical follow-up, lifestyle education, and reminders.
- **Community Health Worker:** Can link patients to community resources to assist with healthy lifestyle, etc.
- **Paramedic/EMT:** In downtime, can assist with patient management

Assign Care Management Title

- Case Manager
- Care Coordinator
- Patient Navigator
- Outreach
- Community Resource Specialist
- Community Health Representative
- Advocate
- Educator
- Translation/Interpretation Specialist

Assign Care Management Roles

- Policies and procedures should be in place to outline services and duties provided by clinical and auxiliary staff
- Provide education on expectations of auxiliary services providing
- Provide ongoing education as guidance and requirements change for services involved in providing
- Dependent on what individuals are assigned to will dictate supervision requirements
- For billable services, work under the supervision of the physician
- Examples of services staff will provide are non-face to face phone calls and digital contact

Assign Care Management Roles (2)

- Billing time for clinical or auxiliary staff:
  - For services we are presenting on, there is a component of the service which can be performed by clinical or auxiliary staff.
  - Furnished under the direction of the billing practitioner (incident to) as an integral part of services provided.
  - Clinical staff includes employees or contracted services for facility.
- For example, CCM services are subject to general supervision rules under the Medicare Physician Fee Schedule (MPFS).
  - Under their overall direction and control as outlined in Comprehensive Care Plan.
  - Billing practitioner need not be physically present while services are furnished.
- When we discuss specifically Care Management type services there is an exception to the Direct Supervision rules for billing these services.
- For example, CCM services are subject to general supervision rules under the Medicare Physician Fee Schedule (MPFS).
  - Under their overall direction and control as outlined in Comprehensive Care Plan.
  - Billing practitioner need not be physically present while services are furnished.

Develop Policies and Workflows

Create **structured policies and workflows** to guide your care management program. This ensures standardization and compliance. Key workflow components should include:

- Patient identification and enrollment
  - Eligibility
- Consent documentation (verbal or written per CMS requirements)
- Care plan development and documentation standards
- Time tracking for billable activities
- Monthly task checklists for care managers

Example of Checklist for Chronic Care Management

Checklist Criteria	Yes	No	N/A	Comments
Staffing				
Clinic has determined the staffing model for CCM. Provider understands his/her role in the service offering.	☐	☐	☐	
CCM services are conducted under general supervision of an eligible Medicare Provider (physician or non-physician provider). The supervising provider has a process to review the CCM plan and the subsequent monthly CCM intervention documentation.	☐	☐	☐	
Projected number of patients eligible for CCM is expected to align with staffing model.	☐	☐	☐	
Implementation Considerations				
CCM documentation will be incorporated into the medical record and a process to exchange CCM documentation with all providers and associated hospital.	☐	☐	☐	
CCM patients eligible for CCM are identified in collaboration with the provider, with consideration given to those at high risk.	☐	☐	☐	
CCM consent process defined of who will obtain consent, verbal or written, and if verbal how consent is documented. Scripting to inform patient of what CCM entails along with patient information regarding applicable cost-sharing responsibilities.	☐	☐	☐	

Example of Checklist for Chronic Care Management (2)

Checklist Criteria	Yes	No	N/A	Comments
Patient Care Plan developed				
A care plan should be based on a thorough assessment of overall health and individual care needs.	☐	☐	☐	
Care plan should include factors that include medical, psychological, and psychosocial factors that impact health outcomes.	☐	☐	☐	
Care plan should list community-based resources which include evidence-based programs, evidence-informed interventions, and support for disease self-management in addition to prescribed medical interventions.	☐	☐	☐	
Establish a process to document the monthly CCM intervention				
CCM services are provided on a calendar month basis.	☐	☐	☐	
Documentation tool supports development of a care plan.	☐	☐	☐	
Interventions provided and documented are tied to a goal in the care plan.	☐	☐	☐	

Example of Checklist for Chronic Care Management (3)

Checklist Criteria	Yes	No	N/A	Comments
Establish a process to document the monthly CCM intervention (continued)	☐	☐	☐	
CCM is billed based on time and complexity. There must be a process to track and capture the time that is spent on behalf of each patient	☐	☐	☐	
Identified CCM clinical staff including but not limited to, community health workers, nurses, dietitians, pharmacists and social workers have access to care plan in EMR and able to document within CCM encounter.	☐	☐	☐	
CCM clinical staff understand what is expected for documentation for each intervention and how to capture the time and intervention provided.	☐	☐	☐	
The CCM documentation must be incorporated into the electronic health record.	☐	☐	☐	
There is a process to aggregate all the time spent in care management of each patient over the course of each calendar month.	☐	☐	☐	
CCM services will be reviewed by the billing provider.	☐	☐	☐	
Process for filing claims based on service and time. Determine if this will be at end of month or other determined date.	☐	☐	☐	

CORE COMPONENTS OF SPECIFIC CARE MANAGEMENT SERVICES

Policies/Workflows – CCM & Complex CCM

- Documentation Standards-Chronic Care Management (CCM) and Complex Chronic Care Management
  - Generally, non face to face services provided to Medicare beneficiaries who have multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient. Chronic conditions could put patient at risk for exacerbation, decompensation, functional decline and death.
- Primary Care Practitioners under which services can be provided:
  - MD/DO – Physician
  - Certified Nurse Midwives
  - Clinical Nurse Specialists
  - Nurse Practitioners
  - Physician Assistants
- Complex Chronic Care Management (CCCM)
  - Similar definition to CCM with difference in amount of time spent with patient.

Policies/Workflows - CCM

- **CPT 99490 – at least 20 minutes**
- **CPT 99439 – each additional 20 minutes (up to 2 units per the MUE - Medicare Medically Unlikely Edit)**
- Chronic care management services for medical and/or psychosocial needs of a patient, at least 20 minutes of clinical staff time directed by a physician or NPP, per calendar month with following required elements:
  - Multiple (two or more) chronic conditions expected to last 12 months or until patient's death
  - Chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;
  - Comprehensive care plan established, implemented, revised, or monitored

Policies/Workflows - Complex CCM

- **CPT 99487 – at least 60 minutes**
- **CPT 99489 – each additional 30 minutes (up to 4 units per the MUE - Medicare Medically Unlikely Edit for Part A, up to 10 units per the MUE for Part B)**
- Complex CCM services performed by clinical staff under general supervision of physician or NPP, first 60 minutes per calendar month:
  - Multiple (two or more) chronic conditions expected to last 12 months or until patient's death
  - Chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;
  - Comprehensive care plan established, implemented, revised, or monitored
  - **In addition to same requirements as CCM above, patient's condition must require moderate or high medical complexity medical decision making as defined in the E/M guidelines.**

Policies/Workflows - PCM

- Documentation Standards-Principal Care Management (PCM)

- Covers disease-specific services to help manage care for a single, high risk chronic condition that puts a patient at risk of hospitalization, acute exacerbation/decompensation, physical or cognitive decline, or death. Patients who have one chronic high-risk condition that is expected to last at least 3 months (like cancer).

Policies/Workflows - PCM continued

- **CPT 99424 – first 30 minutes**
- **CPT 99425 – each additional 30 minutes (up to 2 units per the MUE - Medicare Medically Unlikely Edit)**
- Care management services personally provided by physician or NPP, first 30 minutes per calendar month, for a single high-risk disease with following required elements:
  - One Complex chronic condition expected to last at least 3 months that places patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death
  - Requires development, monitoring, or revision of disease-specific care plan
  - Frequent adjustments in the medication regimen; and/or management that is unusually complex due to comorbidities
  - Requires ongoing communication and care coordination between relevant practitioners furnishing care

Policies/Workflows - TCM

- Documentation Standards-Transitional Care Management (TCM)
- Definition of TCM services in CPT book:
  - TCM services “are for a new or established patient whose medical and/or psychosocial problems require moderate or high level of medical decision-making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility to the patient’s community setting (home, domiciliary, rest home, or assisted living).”
- Purpose of TCM is to reduce the number of subsequent readmissions to an acute care facility by giving patients and caregivers the knowledge and skills to address healthcare needs as they arise
- Care coordination with goal of streamlining care and addressing needs of the patient at any given time
- Multidisciplinary approach, with an emphasis on teamwork between community resources, ancillary staff and patient's provider

Policies/Workflows - TCM continued

- **CPT 99495 – Transitional Care Management services, Moderate Complexity, within 14 calendar days of discharge**
- **CPT 99496 – Transitional Care Management services, High complexity, within 7 calendar days of discharge**
- **Transitional Care management services with following required elements:**
  - Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
  - CPT 99495 – Moderate Level of Medical Decision Making
  - CPT 99496 – High Level of Medical Decision Making
  - CPT 99495 – Face-to-face visit within 14 calendar days of discharge
  - CPT 99496 – Face-to-face visit within 7 calendar days of discharge

Transitional Care Management	**99496 – within 7 days of discharge** • **High complexity decision making** **99495 – within 14 days of discharge** • **Moderate complexity decision making**

Face-to-face visit

- **Date of service on the claim will be the date of the face-to-face encounter.**
- **Work RVU for a TCM visit is typically higher.**

Policies/Workflows - BHI

- Documentation Standards- Behavioral Health Integration (BHI)
- Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month.
- Codes are specific for clinical staff and may be reported when services are provided by clinical staff under the direction of a physician or other qualified healthcare professional.

Policies/Workflows - BHI (2)

- Code 99484 may be reported in any setting except inpatient or observation, provided the reporting physician/QHP has an established relationship with the patient and clinical staff, and the clinical staff is available for face-to-face services.
- Clinical-staff time spent coordinating care with emergency department may not be reported for time spent while the patient is inpatient or in observation status.
- For new patients or patients not seen within a year prior to the commencement of BHI services, BHI must be initiated by the billing practitioner during a “comprehensive” Evaluation & Management (E/M) visit, annual wellness visit (AWV) or initial preventive physical exam (IPPE). The billing practitioner must discuss BHI with the patient at this visit.

Policies/Workflows - BHI (3)

- Required elements of BHI:
- 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
- Continuity of care with a designated member of the care team.

Policies/Workflows - CoCM

- Documentation Standards- Collaborative Care Model (CoCM)
- Behavioral health integration enhances usual primary care by adding 2 key services to the primary care team, particularly for patients whose conditions aren't improving:
  - Care management support for patients receiving behavioral health treatment
  - Regular psychiatric inter-specialty consultation
  - A team of 3 delivers CoCM:
    - Behavioral Health Care Manager – designated provider w/formal education or training in behavioral health, including social work, nursing or psychology, working under oversight of billing practitioner.
    - Psychiatric Consultant – medical provider trained in psychiatry and qualified to prescribe full range of medications.
    - Treating (Billing) Practitioner- physician or non physician practitioner who typically works in primary but may be specialized in other areas.

Policies/Workflows - CoCM (2)

- Documentation Standards- Collaborative Care Model (CoCM)
- CoCM Service Components
  - **Initial assessment**: The primary care team assesses patients and administers validated rating scales.
  - **Joint care planning**: The primary care team works with the patient to revise the care plan if the condition isn't improving adequately. Treatment may include pharmacotherapy, psychotherapy, or other recommended treatments.
  - **Ongoing follow-up**: The behavioral health care manager follows up proactively and systematically using validated rating scales and a registry.
    - Assesses treatment adherence, tolerability, and clinical response using validated rating scales.
    - Delivers brief, evidence-based psychosocial interventions such as behavioral activation or motivational interviewing.
    - Provides 70 minutes of behavioral health care manager time in the first month, 60 minutes in following months, and an add-on code adds 30 more minutes in any month.

Policies/Workflows - CoCM (3)

- Documentation Standards- Collaborative Care Model (CoCM)
- CoCM Service Components (continued)
  - **Systematic case review**: The behavioral health care manager and psychiatric consultant conduct regular caseload reviews:
    - The behavioral health care manager and psychiatric consultant review the patient's treatment plan and status weekly, and if the patient isn't improving, discuss potential revisions.
    - The primary care team continues or adjusts treatment, including referral to behavioral health specialty care, as needed.

Policies/Workflows - CoCM (4)

- Documentation Standards- Collaborative Care Model (CoCM)
- Advance Consent
  - Before starting BHI services, the patient must give the billing practitioner permission to consult with relevant specialists, which includes talking with a psychiatric consultant.
  - Consent can be verbal from the patient and must be documented in the medical record.
  - Billing practitioner must inform that cost sharing applies for services.

Policies/Workflows - CoCM (5)

CPT codes:

- 99492 – Initial Psychiatric Collaborative Care Management – first 70nminutes in the first calendar month
- 99493 – Subsequent Psychiatric Collaborative Care Management – first 60 minutes in a subsequent month
- 99494 – Initial or Subsequent Psychiatric Collaborative Care Management – each additional 30 minutes in a calendar month

Policies/Workflows - CoCM (6)

CPT codes:

- G2214 – Added in the CY 2021 MPFS Final Rule
  - Initial or subsequent psychiatric collaborative care management
  - First 30 minutes of behavioral health are manager activities in a month
  - Services in consultation with a psychiatric consultant and directed by the treating physician or other qualified health care professional.
  - An example of when to use this code is when you see a patient for services, then hospitalize them or refer them for specialized care, and you don't meet the number of minutes needed to bill using the current coding.

Policies/Workflows - CoCM (7)

CPT codes:

- G0323 – Added in CY 2023 – Care management services for Behavioral Health Conditions
  - Introduced in CY 2023 to describe general BHI that a clinical psychologist (CP) or clinical social worker (CSW) performs
  - Accounts for monthly care integration, with the CP or CSW serving as the focal point for mental health services
  - Requires at least 20 minutes of CP or CSW time per calendar month
  - A Psychiatric diagnostic evaluation, CPT code 90791, serves as the initiating visit for G0323.

Policies/Workflows - APCM

- APCM – Advanced Primary Care Management
  - HCPCS G0556 – APCM for patients with one or no chronic conditions
  - HCPCS G0557 – APCM for patients with multiple chronic conditions
  - HCPCS G0558 – APCM for patients with multiple chronic conditions who are Qualified Medicare Beneficiaries
- No monthly minimum time requirements.
- Services provided by clinical staff and directed by a physician or other qualified healthcare professional who is responsible for all primary care and serves as the continuing focal point for all needed healthcare services.

Policies/Workflows - APCM continued

- Documentation Standards- Advanced Primary Care Management (APCM)
  - Similar to CCM, services may be furnished by clinical staff under the general supervision of the billing practitioner.
  - Not all services must be provided each month, and a minimum number of minutes of service is not required.
- Requirements are substantially similar to CCM and PCM:
  - Provide 24/7 access and continuity of care
  - Provide comprehensive care management
  - Implement, revise, and maintain an electronic comprehensive care plan

Policies/Workflows

- Documentation Standards- Advanced Primary Care Management (APCM) (continued)
  - Coordinate Care Transitions
  - Coordinate Practitioner, home, and community-based care
  - Provide enhanced communication opportunities
- What must a provider satisfy in addition to other care management to bill APCM:
  - Conduct patient population level management
  - Measure and report performance, including assessment of primary care quality, total cost of care, meaningful use. This can be done via MIPS or participate in a Shared Savings program, ACO, or other models.

BEST PRATICE FOR IMPLEMENTING CARE MANAGEMENT

Train Staff

- Comprehensive training is essential to success. Topics should include:
- **CMS requirements** for billing codes
- **Care management best practices** (developing a care plan)
- **Documentation expectations** (time tracking, clinical relevance)
- Use of **EHR templates and alerts**
- **Patient engagement techniques**, particularly for underserved populations
- Create **job aids and checklists** for daily use.

Implement Documentation Tools

- Use your **EHR** to:
  - Track time per patient per month
  - Record care plan activities
  - Set reminders for monthly follow-ups
- Determine if your facility has access to **population health management tools**, care/data registries, or **chronic care dashboards**.

Develop a Pilot Program

- Begin with a small group of patients (e.g., 10–20) to test your process.
- Track:
  - Time management
  - Patient response
  - Billing success
  - Patient Outcomes

Monitor Performance and Adjust

- Collect data on:
  - Patient satisfaction
  - Avoided hospitalizations or ER visits
  - Success in meeting patient goals
  - Improvement to medication adherence
- Adjust staffing or workflows as needed:
  - Contact patients at right time of day
  - Understand patients' communication preferences (i.e. text, call, email)
  - Any duplication of processes

Ensure Coding/Billing Compliance

- **Documentation Must Include:**
  - Consent
  - Chronic conditions
  - Monthly activities performed
  - Total time spent (i.e.≥ 20 minutes)

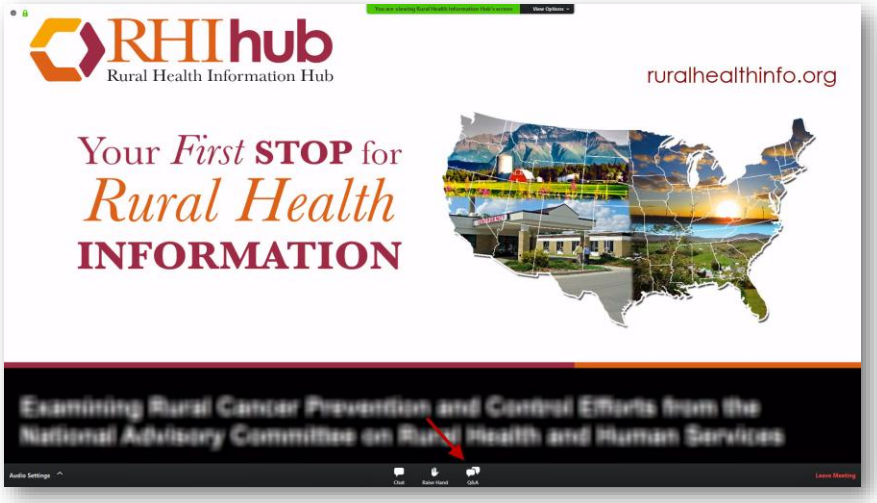
Consider Expansion

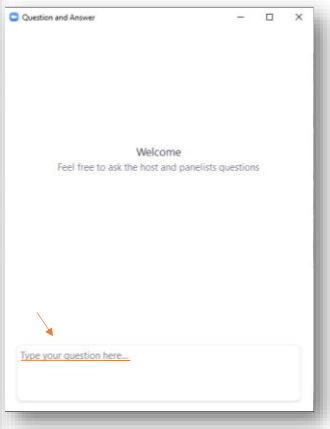
- Expand to more patients once the workflow is running smoothly.
- Consider integrating:
  - Social drivers of health (SDOH)
  - Various communication techniques (i.e. telehealth)
  - Connecting patients to community resources

Social Drivers of Health Risk Assessment

- **HCPCS Code G0136 – Social Driver of Health Risk Assessment**
- SDoH Risk Assessment management services with following required elements:
  - Administration of standardized, evidence based SDoH risk assessment tool (i.e., PRAPARE tool or AHC tool)
  - Tool must address domains of food insecurity, housing insecurity, transportation needs, and utility difficulties
  - SDoH needs identified through completion of risk assessment must be documented in medical record
  - Reimbursement once every six months
  - Consent not required
  - CMS did not add SDOH risk assessments to the list of general care management services for which RHCs and FQHCs may be reimbursed. Thus, RHCs and FQHCs do not receive any additional reimbursement from Medicare for performing SDOH risk assessments.

Questions?





Thank you!

- Contact us at ruralhealthinfo.org with any questions
- Please complete webinar survey
- Recording and transcript will be available on RHIhub website