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Medicare Chronic Care Management & Transitional Management

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Care Management Services

- Transitional Care Management (TCM)
- Chronic Care Management (CCM)
- General Behavioral Health Integration (BHI)
- Psychiatric Collaborative Care Model (CoCM)

Transitional Care Management

- Transitional care refers to the coordination & continuity of health care during a movement from one healthcare setting to either another or to home, called care transition, between health care practitioners & settings as their condition & care needs change during the course of a chronic or acute illness.

Transitional Care Management

From
• Inpatient Acute Care Hospital • Inpatient Psychiatric Hospital • Long Term Care Hospital • Skilled Nursing Facility • Inpatient Rehabilitation Facility • Hospital outpatient observation or partial hospitalization • Partial hospitalization at a Community Mental Health Center

To
• His or her home • His or her domiciliary • A rest home • Assisted living

Transitional Care Management

- Furnished during the first 30 days:
- An interactive contact
- Certain non-face-to-face services
- A face-to-face visit
  - 7 or 14 days of discharge

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf

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Chronic Care Management

- Effective January 1, 2016
- Chronic Care Management (CCM) services by a physician or non-physician practitioner (Physician Assistant [PA], Nurse Practitioner [NP], Certified Nurse-Midwife [CNM]) and their clinical staff, per calendar month, for patients with multiple (two or more) chronic conditions expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. Only 1 practitioner can bill CCM per service period (month)

Chronic Care Management

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 functional decline

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf

Chronic Care Management

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 FQHC visit.	Same	Same
Beneficiary Consent	Obtained during or after initiating visit and before provision of care coordination services by 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 permission to consult with relevant specialists.	Same	Same

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf

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Chronic Care Management

Requirements	CCM
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 on the chronic conditions being managed; • Care plan information made available electronically (including fax) in a timely manner within and outside the FQHC as appropriate and a copy of the plan of care given to the patient and/or caregiver;

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf

Chronic Care Management

Requirement Service Elements	• 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, but also through the use of secure messaging, Internet, or other asynchronous non-face-to-face consultation methods.

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf

Chronic Care Management

Requirements	CCM
Billing Requirements	At least 20 minutes of care coordination services per calendar month that is: • Furnished under the direction of the FQHC primary care physician, NP, PA, or CNM; and • Furnished by an FQHC practitioner, or by clinical personnel under general supervision.
Billing Code	• G0511
2019 Payment Rate	• $67.03

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf

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Behavioral Health Integration

- BHI is a team-based, collaborative approach to care that focuses on integrative treatment of patients with primary care and mental or behavioral health conditions

Behavioral Health Integration

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

Behavioral Health Integration

Requirements	General BHI
Requirement Service Elements	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.

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf

Behavioral Health Integration

Requirements	General BHI
Billing Requirements	At least 20 minutes of care coordination services per calendar month that is: • Furnished under the direction of the FQHC primary care physician, NP, PA, or CNM; and • Furnished by an FQHC practitioner, or by clinical personnel under general supervision.
Billing Code	• G0511
2019 Payment	• $67.03

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf

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Psychiatric Collaborative Care Model

- CoCM is a specific model of care provided by a primary care team consisting of a primary care provider & a health care manager who works in collaboration with a psychiatric consultant.

Psychiatric Collaborative Care Model

Patient Eligibility	Any behavioral health or psychiatric condition being treated by the FQHC primary care practitioner, including substance use disorders, that, in the clinical judgment of the FQHC practitioner, warrants CoCM services

Psychiatric Collaborative Care Model

Requirements	Psychiatric CoCM
Requirement Service Elements	Includes: FQHC primary care practitioner: • 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 Behavioral Health Care Manager: • 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 FQHC practitioner; maintenance of the registry; acting in consultation with the psychiatric consultant; • Be available to provide services face-to-face with the beneficiary; having a continuous relationship with the patient and a collaborative, integrated relationship with the rest of the care team; and Psychiatric Consultant: • Participate in regular reviews of the clinical status of patients receiving CoCM services; • Advise the 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 psychiatric care when clinically indicated

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf

Psychiatric Collaborative Care Model

Requirements	Psychiatric CoCM
Requirement Service Elements	<u>Psychiatric Consultant:</u> • Participate in regular reviews of the clinical status of patients receiving CoCM services; • Advise the 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 psychiatric care when clinically indicated

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf

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Psychiatric Collaborative Care Model

Requirements	Psychiatric CoCM
Billing Requirements	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 FQHC primary care practitioner; and • Furnished by an FQHC practitioner or behavioral health care manager under general supervision.
Billing Code	• G0512
2019 Payment	• $145.96

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf

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Questions?

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Thank You!