FQHC Billing Guide: Annual Wellness Visits & Chronic Care Management

There are few better ways for federally qualified health centers to improve patient and financial health than through the provision of Medicare annual wellness visits (AWV) and chronic care management (CCM) services. In this billing guide, you will learn how FQHCs should code and bill for AWV and CCM services. You'll also learn some quick tips to help with coding and billing.

First, let's define the core concepts that will be covered in the guide.

Definition of AWV, CCM, and Related Concepts

Annual wellness visit (AWV): A yearly visit with a primary care provider or specialist to create or update the patient's personalized prevention care plan. The AWV, which is covered by Medicare, focuses on the patient's current health status and risk factors to create a prevention plan that will slow the progressions on chronic disease.

Initial Preventive Physical Exam (IPPE): Commonly known as the "welcome to Medicare preventive visit," IPPE is a service for newly enrolled Medicare beneficiaries that places emphasis on health promotion and disease prevention and detection.

Chronic care management (CCM): A care coordination service model that reimburses practitioners for non-face-to-face care coordination activities for those patients with two or more chronic conditions.

Complex chronic care management (CCCM): A variation of chronic care management, CCCM is for patients with two or more qualifying chronic conditions that require moderate or high complexity medical decision making.

Principal care management (PCM): A service that provides additional care to patients with one or more chronic conditions by focusing care solely on one such condition.

Coding and Billing the IPPE and AWV

Coding for the IPPE and AWV is easy since the services share the same HCPCS code: G0468.

FQHCs should use G0468 for the following provider codes and services:

- **G0402** — IPPE; face-to-face visit during first 12 months of Medicare Part B enrollment.
- **G0438** — AWV billable after the first 12 months of Medicare Part B enrollment.
- **G0439** — AWV, subsequent visit, billable once every 12 months after the Initial AWV.

In terms of billing the IPPE and AWV, here's what FQHCs need to know:

- IPPE is billable once per patient per lifetime — not per provider — and must be rendered within the 12 months of the initial Medicare Part B enrollment date.
- Initial AWV is billable after the first 12 months of Medicare Part B enrollment have passed, after the IPPE.
- Subsequent AWV is billable once every 12 months after the initial AWV.

For 2022, FQHCs get paid $241.70 for G0468.*

IPPE and AWV Quick Tips

- ☑ The IPPE and AWV do not need to be performed by an MD or DO. Non-physician practitioners can perform the service. These include nurse practitioners (NP), physician assistants (PA), certified nurse midwives (CNM), and clinical nurse specialists (CNS).
- ☑ AWVs can also be performed by clinical staff with direct supervision by physicians or NPs.
- ☑ When performing the IPPE and AWV, the treating provider should identify preventive services that would benefit the patient, such as obesity, alcohol misuse, and smoking cessation counseling. These preventive services can help patients improve their health and represent additional billing opportunities for FQHCs.

Coding and Billing for CCM, CCCM, and PCM

Coding for CCM, CCCM, and PCM is also easy since the services share the same HCPCS code: G0511. G0511 is defined as 20 minutes or more of clinical staff time for CCM services under the general supervision of an FQHC practitioner — physician, NP, PA, or CNM — per calendar month.

Differences Between Care Management Services

Before we move forward with a discussion about coding, it's helpful to gain a better understanding CCM services and how CCM varies from CCCM and PCM. CCM services include formulating a comprehensive care plan, interactive remote communication and management (usually over the phone), medication management, and coordination of care between providers.

CCCM is essentially CCM but for patients requiring greater clinical support. This translates to more staff service time provided, greater involvement of the billing practitioner, and more extensive care planning.

PCM is essentially CCM but for patients with a single, serious chronic condition. PCM also differs from CCM in how a patient's care plan is developed. The focus must be on the specific disease or chronic condition whereas the care plan for CCM is much broader in scope. PCM is provided far less frequently than CCM.

FQHC Care Management: Billing HCPCs G0511As noted previously, all CCM, CCCM, and PCM codes fall under G0511 for FQHCs. Whether you provide CCM, CCCM, or PCM the amount of time you spend providing those services essentially does not matter. As long as you provide 20 minutes or more of clinical staff time for CCM/CCCM/PCM services, with those services directed by an FQHC practitioner, you can bill G0511.

The lowest threshold FQHCs must meet to bill G0511 are the requirements of the base, non-complex CCM CPT code: 99490. This requires at least 20 minutes of clinical staff time allocated to chronic care management services and directed by a physician or qualified health professional (QHP). In other words, once clinical staff provide at least 20 minutes of CCM, the FQHC can bill G0511.

Here's a breakdown of the provider codes, many with more complex requirements, that qualify for billing under G0511:

CCM:

- **Non-complex CCM (CPT 99490)** — First 20 minutes of CCM clinical staff time directed by a physician or qualified health professional (QHP).
- **Non-complex CCM additional time (CPT +99439**) — Each additional 20 minutes of clinical staff time directed by physician or QHP; added to 99490 (clinical staff time)
- **Provider-only CCM (CPT 99491)** — 30 minutes or more of CCM services in a month provided personally by a physician or QHP.
- **Provider-only CCM (CPT +99437)** — Each additional 30 minutes of CCM services provided personally by a physician or QHP; added to 99491.

CCCM:

- **Complex CCM (CPT 99487)** — First 60 minutes of CCCM clinical staff time directed by a physician or QHP.
- **Complex CCM additional time (CPT +99489)** — Each additional 30 minutes of clinical staff time directed by physician or QHP; added to 99487.

PCM:

- **CPT 99424** — Comprehensive care management services for a single high-risk disease; first 30 minutes of PCM personally provided by a physician or QHP.
- **CPT 99425** — Each additional 30 minutes of PCM services provided personally by a physician or QHP; added to 99424.
- **CPT 99426** — First 30 minutes of PCM clinical staff time directed by a physician or QHP.
- **CPT 99427** — Each additional 30 minutes of PCM clinical staff time directed by physician or QHP; added to 99426.

In terms of billing for CCM, CCCM, and PCM, here's what FQHCs need to know:

- ☑ G0511 can be billed just once per calendar month per patient.
- ☑ The minimum time of care management services must be delivered and totaled within each calendar month, not during a 30-day period that overlaps with the start and end of consecutive months.
- ☑ Contact with the patient is not necessary for FQHCs to bill for care management services. Those care management activities that fall under the scope of service elements (e.g., coordination with home- and community-based providers) may be billed in a calendar month even if no direct-to-patient care management services are provided.

For 2022, FQHCs get paid $81.26 for G0511.*

Chronic Care Management Quick Tips

1. CCM, CCCM, and PCM do not need to be performed by an MD or DO. Non-physician practitioners can perform the service. These include NPs, PAs, and CNMs.
2. CCM, CCCM, and PCM can also be performed by clinical staff under general supervision of the billing practitioner.
3. As of 2022, FQHCs can bill for transitional care management (TCM) and care management services (e.g., CCM, CCCM, PCM) furnished for the same beneficiary during the same service period, provided all requirements for each medically necessary service are separately met. TCM helps patients transition from inpatient care to the community setting. TCM services may be provided once within a 30-day period post-discharge.

**The contents of this guide is intended to convey general information only and not to provide legal advice or opinions. All medical insurance claims should be reviewed by a qualified medical coding and billing professional prior to submission.*