NATIONAL ASSOCIATION OF Community Health Centers®

The Building Blocks of Care Coordination: Basics, Billing, and Looking Beyond to PACE

Part II: Medicare Billing Logistics

December 8, 2025

Welcome!

Community health centers are caring for a rapidly growing population of older adults, many of whom have complex medical and social needs. This three-part webinar series equips CHCs with foundational and practical knowledge to strengthen care coordination for Medicare patients. The series draws on real-world CHC experiences and subject-matter experts to support both new and experienced billing teams.

Objective: Participants will understand the billing requirements, documentation standards, and operational workflows necessary for CHCs to successfully and compliantly bill Medicare care coordination services.

Housekeeping

Please support **NACHC's commitment to creating a respectful and professional environment** for all webinar participants, including attendees, speakers, and moderators.

To promote a positive experience for everyone, we expect all participants to use the chat and Q&A functions in a respectful and professional manner. Harassment, discrimination, and disruptive or inappropriate behavior of any kind will not be tolerated. Failure to follow these guidelines may result in removal from the webinar at our discretion. **Thank you for your cooperation.**

Today’s Speakers

Mellissa Kenney

Billing Manager, *Eastport Health Care*

Nicole Mascatelli, CHFP

Director, *Forvis Mazars*

Elizabeth Linderbaum, MPP

Director of Regulatory Affairs, *NACHC*

Why Medicare?

FQHCs can strategically leverage Medicare reimbursement and care models to:

- ✓ Increase the size of their current patient population served, and retain their current population
- ✓ Strengthen their mission by serving vulnerable older adults and individuals with disabilities
- ✓ Improve financial stability
- ✓ Enhance community health outcomes through team-based care and opportunities for reimbursement led by care team members other than the provider

Why is Care Coordination Important?

Care management programs in Community Health Centers (CHCs) support patients with chronic conditions, social risk factors, and complex care needs through structured, ongoing services.

These programs aim to improve patient outcomes, enhance coordination across providers, and optimize care transitions.

Care Coordination Connection to PACE

Joint Medicare-Medicaid program that covers all medical and social needs for participants
Goal of allowing participants to live in their homes safely for as long as possible

Patient Eligibility

At least 55 years old

Must live in a service area of a PACE organization

Certified to need nursing home level care but cleared to live in a community safely (with support)

Services Provided

- Adult day care
- Recreational therapy
- Home care and nursing home care
- Transportation to appts and the PACE center
- Hospital care and emergency services
- Prescription drugs
- Medical, dental, vision & hearing care

Care Coordination

Personalized care plan development

Doctors, nurses, social workers, therapists, social worker, dieticians etc all working together

Care Coordination: Practical Considerations and Real Life Experiences

National Association of Community Health Centers

Nicole Moscatelli, CHFP, Director

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AGENDA

- Care Coordination Services
  - Coding & Billing Readiness
  - Billing Software – selection process considerations
  - Medicare Advantage Plan – contracting elements

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Medicare

Care Coordination Services

- Transitional Care Management (TCM)
- Chronic Care Management (CCM)
- General Behavioral Health Integration (BHI)
- Psychiatric Collaborative Care Model (CoCM)
- Principle Care Management
- Chronic Pain Management
- Remote Physiologic Monitoring
- Remote Therapeutic Monitoring
- Community Health Integration
- Principal Illness Navigation

MLN909188 – Chronic Care Management Services

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Medicare

Care Coordination Services

- Bill G0511 through September 30, 2025
  - Payment $72.90
- Effective October 1, 2025 bill individual CPT codes
  - Payment = Physician Fee Schedule
- Report CPT/HCPC code on UB-04/837I claim form
- Revenue Code 0521
- Can be reported on the same claim as a qualifying visit or in the absence of a qualifying visit
- Coinsurance applies

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Medicare

Care Coordination Services

- Concurrent Billing
  - **Can't** report non-complex CCM and complex CCM for the same patient in a calendar month (don't report 99491 and 99437 in the same calendar month as 99487, 99489, 99490, or 99439).
  - **Can't** bill CCM during the same service period as HCPCS code G0181 (home health care supervision), HCPCS code G0182 (hospice care supervision), or CPT codes 90951–90970 (certain ESRD services).
  - **Can** report CCM codes 99487, 99489, 99490, and 99491 for services provided during the 30-day transitional care management (TCM) service period (CPT codes 99495 and 99496).
  - **Can't** report complex CCM and prolonged E/M services in the same calendar month.
  - **Can't** count time toward the CCM service code for any other billed code.
  - RHCs and FQHCs **can** bill CCM and TCM services for the same patient during the same period.
  - **Can** bill either remote physiologic monitoring (RPM) or remote therapeutic monitoring (RTM), but not both, concurrently with any CCM or TCM service.
  - Consult CPT instructions for other codes you can't bill concurrently with CCM. Other provider billing restrictions may apply if you're taking part in a CMS-sponsored model or demonstration program.

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Medicare

Care Coordination Services Payment Rates CY 2026

HCPCS	Short Descriptor	NonFac Payment CY 2026
98016	Brief communication tech-bsd	17.37
98975	Rem ther mntr 1st setup&edu	21.71
98976	Rem ther mntr dev sply resp	47.43
98977	Rem ther mntr dv sply mscskl	40.08
98980	Rem ther mntr 1st 20 min	54.11
98981	Rem ther mntr ea addl 20 min	41.42
99091	Collj & interpj data ea 30 d	55.45
99424	Prin care mgmt phys 1st 30	87.51
99425	Prin care mgmt phys ea addl 30	61.46
99426	Prin care mgmt staff 1st 30	67.80
99427	Prin care mgmt staff ea addl 30	54.11
99437	Chrnc care mgmt phys ea addl 30	63.13
99439	Chrnc care mgmt staf ea addl 20	50.44
99453	Rem mntr physiol param setup	21.71
99454	Rem mntr physiol param dev	47.43
99457	Rem physiol mntr 1st 20 min	51.77
99458	Rem physiol mntr ea addl 20	41.42
99470	Rem physiol mntr 1st 10 min	26.05
99474	Self-meas bp 2 readg bid 30d	18.37
99484	Care mgmt svc bhvl hlth cond	57.45
99487	Cplx chrnc care 1st 60 min	144.29
99489	Cplx chrnc care ea addl 30	78.16

Medicare

Care Coordination Services Payment Rates CY 2026

HCPCS	Short Descriptor	NonFac Payment CY 2026
99490	Chrnc care mgmt staff 1st 20	66.13
99491	Chrnc care mgmt phys 1st 30	89.18
99492	1st psych collab care mgmt; CocM first Month, 70 min pr m	160.32
99493	Sbsq psych collab care mgmt; CoCM sbsq month, 60 min pr m	144.96
99494	1st/sbsq psyc collab care, add-on CoCM, add'l 30 min pr m	61.46
G0019	Comm hlth intg svs sdoh 60 mn	86.51
G0022	Comm hlth intg svs addl 30 m	54.11
G0023	Pin srv 60 min pr m	87.18
G0024	Pin srv addl 30 min pr m	54.44
G0140	Nav srv peer sup 60 min pr m	89.18
G0146	Nav srv peer sup addl 30 pr m	53.44
G0323	Care manage beh svs 20mins	57.78
G0556	Adv prim care mgmt lvl 1	16.37
G0557	Adv prim care mgmt lvl 2	53.78
G0558	Adv prim care mgmt lvl 3	117.24
G0568	Int psych care mng, 1 cal mo	161.66
G0569	Subs psych care mng, subs mo	145.96
G0570	Care manage serv, pr cal mo	57.78
G2010	Remote image submit by patient	13.03
G2025	Dis site tele svcs rhc/fqhc	97.53
G2214	Init/sub psych care m 1st 30; Initial or sbsq psych collab care m, 30 min pr m	60.79
G2250	Remote image submit by patient, non-E/M	13.03
G3002	Chronic pain mgmt 30 mins	86.17
G3003	Chronic pain mgmt addl 15m	31.73

Medicare

Care Coordination Services – Transitional Care Management (TCM)

- Can be billed as an encounter if it is the only service provided on the day
- If occurs on the same date as another visit, only one encounter is allowed
- Only one TCM visit paid and allowed for a 30-day post discharge period
- Subject to coinsurance
- Must be furnished within 30 days of date of discharge from hospital (including outpatient observation), SNF, or Community Mental Health Center Direct contact
- Telephone or electronic communication with patient/caregiver must begin within two business days of discharge
- Face-to-face visits must occur within seven days of discharge for high complexity decision making (CPT code 99496) or within 14 days of discharge for moderate complexity decision making (CPT code 99495).
- Submit on UB-04/837I
- Revenue Code 0521
- Qualifying G code = G0467

Medicare

Care Coordination Services

- Billing Software Considerations
  - Consent & Documentation:
    - Medicare requires written or verbal patient consent and a comprehensive care plan.
    - The software should store these securely and make them easily retrievable for audits.
    - Audit Readiness: Ensure the system provides detailed logs of activities, time spent, and care plan updates to meet CMS compliance standards.
  - Integration/Interoperability with EHR/PMS
  - Features
    - Care plan management
    - Task automation
    - Patient engagement

Medicare

Care Coordination Services

- Billing Software Considerations
  - Security & Privacy
    - HIPAA and other data secure platform requirements
  - Reporting
    - Extractable data
    - Dashboards
  - Maintenance

Medicare

Care Coordination Services

- Medicare Advantage Plan Contracting Elements
  - Is the payor reimbursing Fee For Service or PPS?
    - If PPS, ensure appropriate services are separately reimbursed including care coordination
    - PPS is NOT an all-inclusive rate
  - Care coordination is preventive in nature – tied to quality? Incentive?
  - Follow traditional Medicare?
  - What are the allowed amounts?
    - Less than Medicare
    - Greater than Medicare
  - Who can render care?

Contact

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CARE MANAGEMENT

MELLISSA KENNEY, BILLING MANAGER

EASTPORT HEALTH CARE

AGENDA

- Care Management Programs
- EHC Workflow
- EHR Documentation
- CM Billing

EASTPORT HEALTH CARE
CARE MANAGEMENT PROGRAMS

Started with Chronic Care management (99490; 99439)

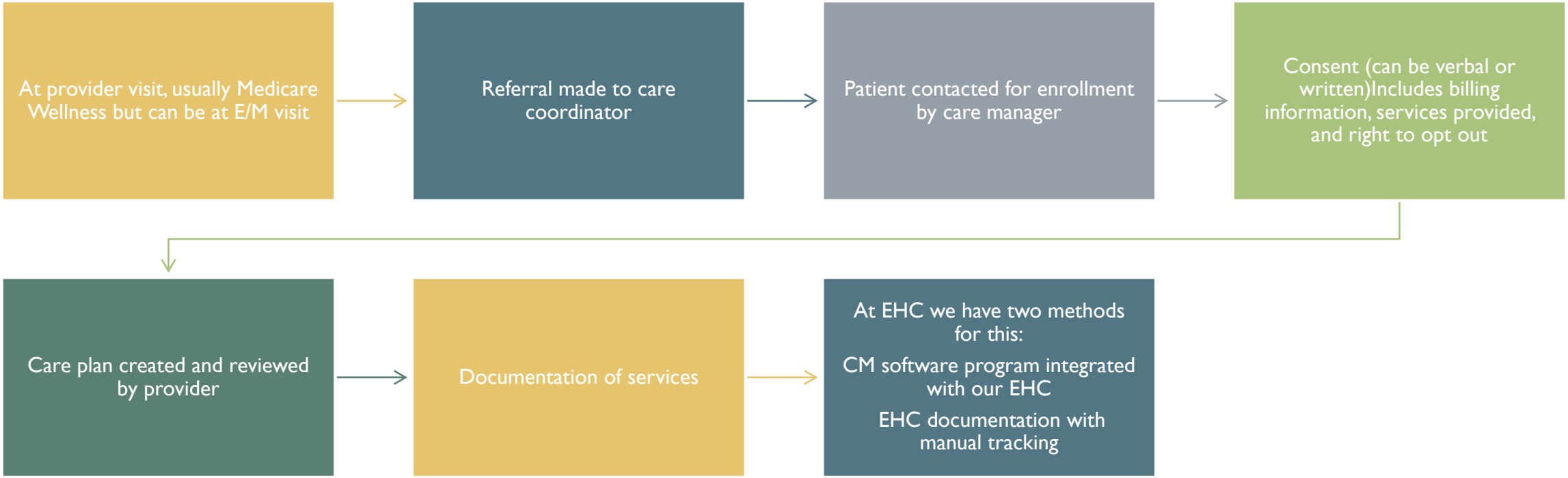
- 2 RN Coordinators
- Over 300 patients enrolled

Community Health Integration (G0019; G0022)

- Community Health Worker

Behavioral Health Integration (99484)

- Registered Nurse


At provider visit, usually Medicare Wellness but can be at E/M visit
Referral made to care coordinator
Patient contacted for enrollment by care manager
Consent (can be verbal or written)Includes billing information, services provided, and right to opt out
Care plan created and reviewed by provider
Documentation of services
At EHC we have two methods for this:
CM software program integrated with our EHC
EHC documentation with manual tracking

CM WORKFLOW

Claim Detail | Problems | **Timer Activities** | Claim History

Activity Date	User	Activity	Duration	Notes
11/24/2025 11:57 AM	Kelly, Deborah	CCM, Order Meds, Patient Case	1:15	
11/21/2025 07:13 AM	Woodman, Jessica	CCM, Order Meds	0:50	
11/20/2025 05:24 PM	Stanhope, Kaloua	CCM, Coordination of care, Patient Case	2:02	
11/20/2025 04:35 PM	Stanhope, Kaloua	CCM, Coordination of care	23:20	
11/04/2025 04:12 PM	Richardson, William	CCM, Patient Care	1:04	

Claim Detail | Problems | Timer Activities | **Claim History**

Date	User	Note	User Note
12/01/2025 11:31 AM	Dulcian Health	The practice settings require approval for 99490 claim.	
12/01/2025 11:31 AM	Dulcian Health	Claim created as 99490	

EHC DOCUMENTATION

Chronic Care Management:

- EHR-AthenaHealth
- CM Software- Dulcian
  - Integrated & Templated:
    - Built In Care Plans
    - Automated Time Tracking
    - Claim Creation Que
    - Reports

EHC DOCUMENTATION

CHI & BHI:

- EHR-AthenaHealth
  - Manual:
    - Create Care Plan templates
    - Time Tracking
    - Claim Creation
    - Reports-Excel

SDOX dx: 10/15/2025 Food insecurity

Patient Need:Patient is running out of food the last 3-4 days of the month. He needs resource food.

Goal: For patient to verbalize he is not running out of food at all in the month.

CHW tasks: Give patient names of food pantry closes to patients home as well as hours of ope and contact number. Make patient aware of dates/times of free fresh produce days as well as emergency food bags and community table here at EHC. Assist patient in filling out DHHS app for SNAP benefits.

Patient tasks: To gather financial information required for DHHS application. Schedule an appointment with CHW to assist with application as soon as possible. Go to food pantry EHC f products.

Outcome:10/30/2025 Patient verbalized items from food pantry and EHC have closed the gap insecurity this month. DHHS application has been completed. Pt is waiting to see if he qualifie SNAP benefits.

Time Frame to completion:30 days

Time spent with patient (each date/time this month):
10/15/2025 33 minutes initial interaction with patient to identify needs and complete PRAPAI
45 minutes assisting with DHHS application

CM BILLING

- All claims process through EHR/billing system-AthenaHealth
- Scrubs claims with up-to-date coding and payer edits
- Can drop claim when time threshold is reached or at the end of month
- If minimum minutes not reached for BHI/CHI, we enter a $0 charge code for tracking purposes
- With our workflows we capture all components needed for billing whether manual entry on billing system or dropping an integrated claim.

CM BILLING

Challenges:

- ICD-10 code specificity
- Changing to Medicare Advantage plans
- Copay barriers for patients
- Changing of billing provider-obtain new consent
- Paid at incorrect rate

CM BILLING

Steps for success

- ‘Walk’ through your workflows as a team
- Automated systems-timekeeping, templates, claim scrubbing
- Check your payers and contracts
- Start small, flexible
- Deliver effective care management with minimal additional staffing

THANK YOU

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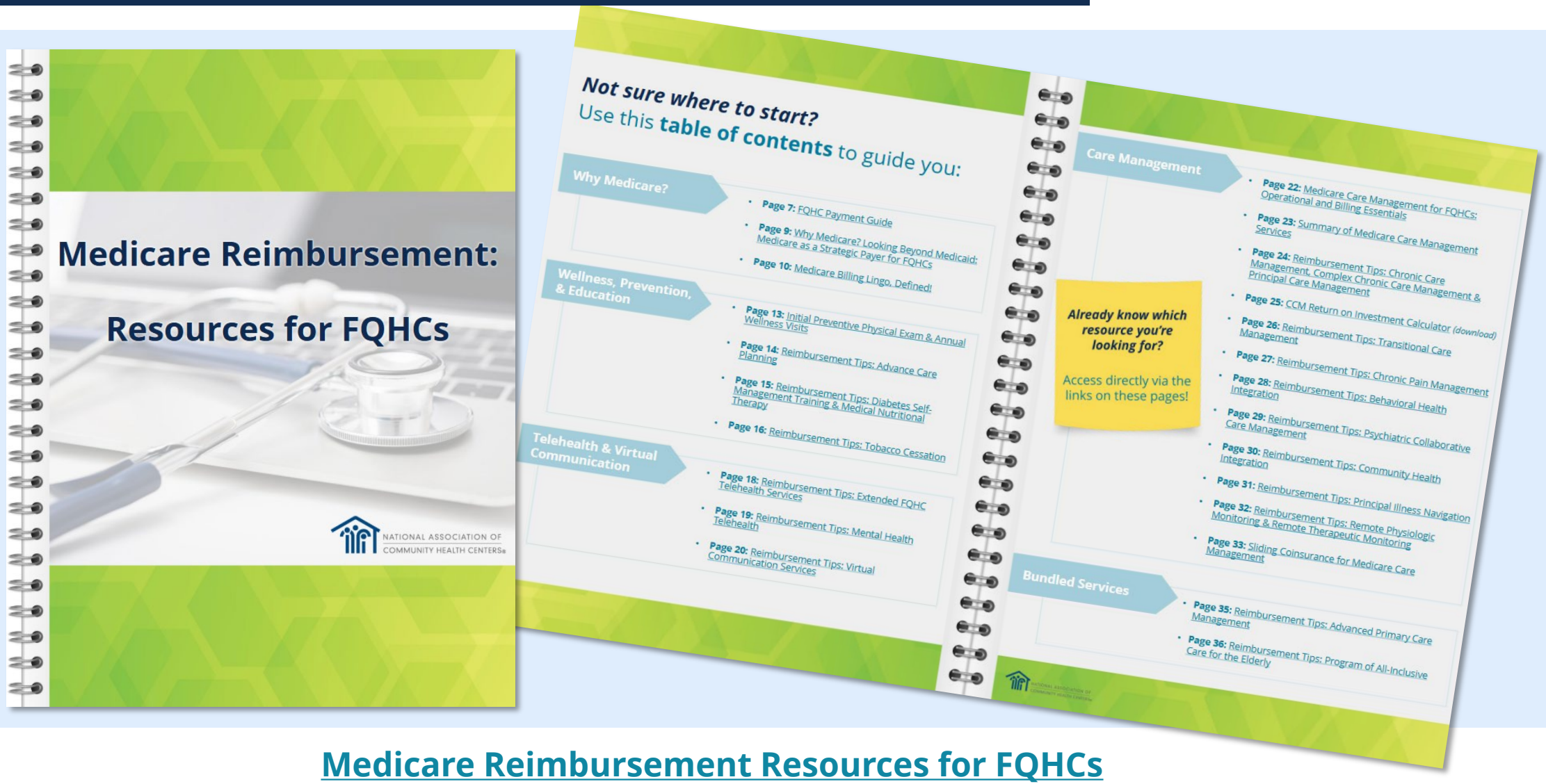
QUESTIONS?

Resources



[Medicare Reimbursement Resources for FQHCs]

Be sure to join us for the final webinar in this series!

Missed Part I? Review the recording and slides from our November 6th webinar on the basics of Medicare care coordination.

Thursday, January 8, 2026 | 4:00 PM ET

- PACE Programs & Other Options for Community Health Centers

Thank You!

Elizabeth Linderbaum

Director of Regulatory Affairs

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