



Care Management: Principal Care Management

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Objectives

- **Care Management:** Making all-inclusive care plan a reality and by offering these sessions, we hope that our J6 and JK providers have a better understanding on codes available that describe care management

Agenda

- Care Management Continued Series
- Principal Care Management
 - General
 - Coding
 - Billing
 - Resources

Care Management: PCM Services



Why PCM and not CCM?

- Specialty care practitioners often care for patients with a single high-risk disease and do not meet the criteria for reporting other types of care management services that require management of multiple conditions

Principal Care Management Services: General

- Treatment of beneficiaries with single, serious, chronic condition
- Diagnosis expected to last between three months, a year or until death of patient
 - May have led to recent hospitalizations
 - Places patient at significant risk of death, acute exacerbation, decompensation or functional decline

Principal Care Management Services: Benefits

- Stabilization of patient's chronic condition by providing comprehensive care plan for single high-risk condition
- Prevention of new diagnosis arising
- Reimbursement opportunities
- Integral part of primary care, resulting in better health outcomes for patients while reducing overall healthcare costs

2022 Coding

- For CY 2022, the RUC resurveyed the CCM code family including PCM
 - 99424: PCM services for a single high-risk disease first 30 minutes provided personally by a physician or other qualified health care professional, per calendar month
 - 99425: PCM services for a single high-risk disease each additional 30 minutes provided personally by a physician or other qualified health care professional, per calendar month. List separately in addition to primary

2022 Coding

- 99426: PCM, for a single high-risk disease first 30 minutes of clinical staff time directed by physician or other qualified health care professional, per calendar month
- 99427: PCM services, for a single high-risk disease each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month. List separately in addition to primary

Comprehensive Care Management for Single High-Risk Disease Elements

- Complex chronic condition lasting at least three months
- Condition sufficient severity to place patient at risk of hospitalization or have been cause of recent hospitalization
- Condition requires development or revision of disease-specific care plan
- Condition requires frequent adjustments in medication regimen
- Management of condition is unusually complex due to comorbidities

Principal Care Management Services: Billing

- Billing PCM codes requires the practitioner to develop a disease-specific care plan
- At initiating visit (face-to-face), obtain patient's verbal or written consent
 - Educate patient on PCM
 - Document medical record
 - Dates and times

Principal Care Management Services: Billing

- Develop a care plan in electronic health record
 - Patient's demographics
 - List of medical problems
 - Medications (allergies)
- Must inform of applicable cost sharing
 - Deductible and coinsurance apply
- May initiate at AWW or other billable visit

Principal Care Management Services: Billing

- 24/7 access to dedicated care team member
- Frequent adjustments to medication
- Condition unusually complex due to comorbidities
- Timed services managing patients with single complex chronic condition
 - 30 minutes of clinical staff or physician time performing qualifying activities per month
 - 60 additional minutes per month

Principal Care Management Services: Billing

- Patient or primary care practitioner may involve another clinician to provide care
 - Specialist eventually returns patient to primary care practitioner once condition is stable
- Goal is to manage condition benefiting from non-face-to-face services
- Time accumulates throughout month
 - Once threshold met, claim may be submitted

Principal Care Management Services: Billing

- Who can bill Part B PCM?
 - Physicians
 - Certain nonphysician practitioners
 - Physician assistants
 - Clinical nurse specialist
 - Nurse practitioners
 - Certified nurse midwives

Principal Care Management: Documentation

- PCM Care Plan
 - List of patient's problems and conditions
 - Expected outcome and prognosis with measurable treatment goals
 - Cognitive and functional assessments
 - Symptoms management
 - Planned interventions
 - Identification of individuals responsible for interventions

Principal Care Management: Documentation

- Medication management
- Environmental evaluation
- Caregiver assessment
- Coordination with outside resources and providers
- Requirements for periodic review and revision of plan
- Referrals applicable to condition
- Support of referral by creating and exchanging summary of care document

Principal Care Management: References

- [Calendar Year \(CY\) 2022 Medicare Federal register](#)

Thank You!

- Follow-up email
 - Attendees will be provided a Medicare University Course Code
- Questions?

