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# Care Management: Principal Care Management

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

# Care Management Team

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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
  - Documentation
  - Resources

# Care Management: Principal Care Management Services (PCM)

# 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

# Comprehensive Care Management for Single High-Risk Disease Elements

- 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 AWV 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: Resources

- NGSMedicare.com > Education > Medicare Topics > Care Management > Principal Care Management
- Calendar Year (CY) 2022 Medicare Federal register
- MLN® Booklet: *Chronic Care Management Services*

# Thank You!

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


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