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Care Management: Principal Care Management

10/10/2023

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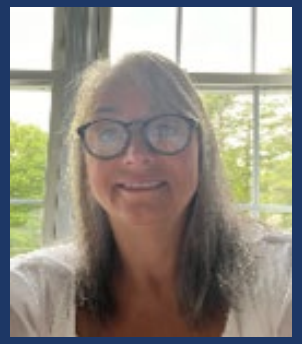
Today's Presenter

Provider Outreach and Education Consultants

- Carleen Parker



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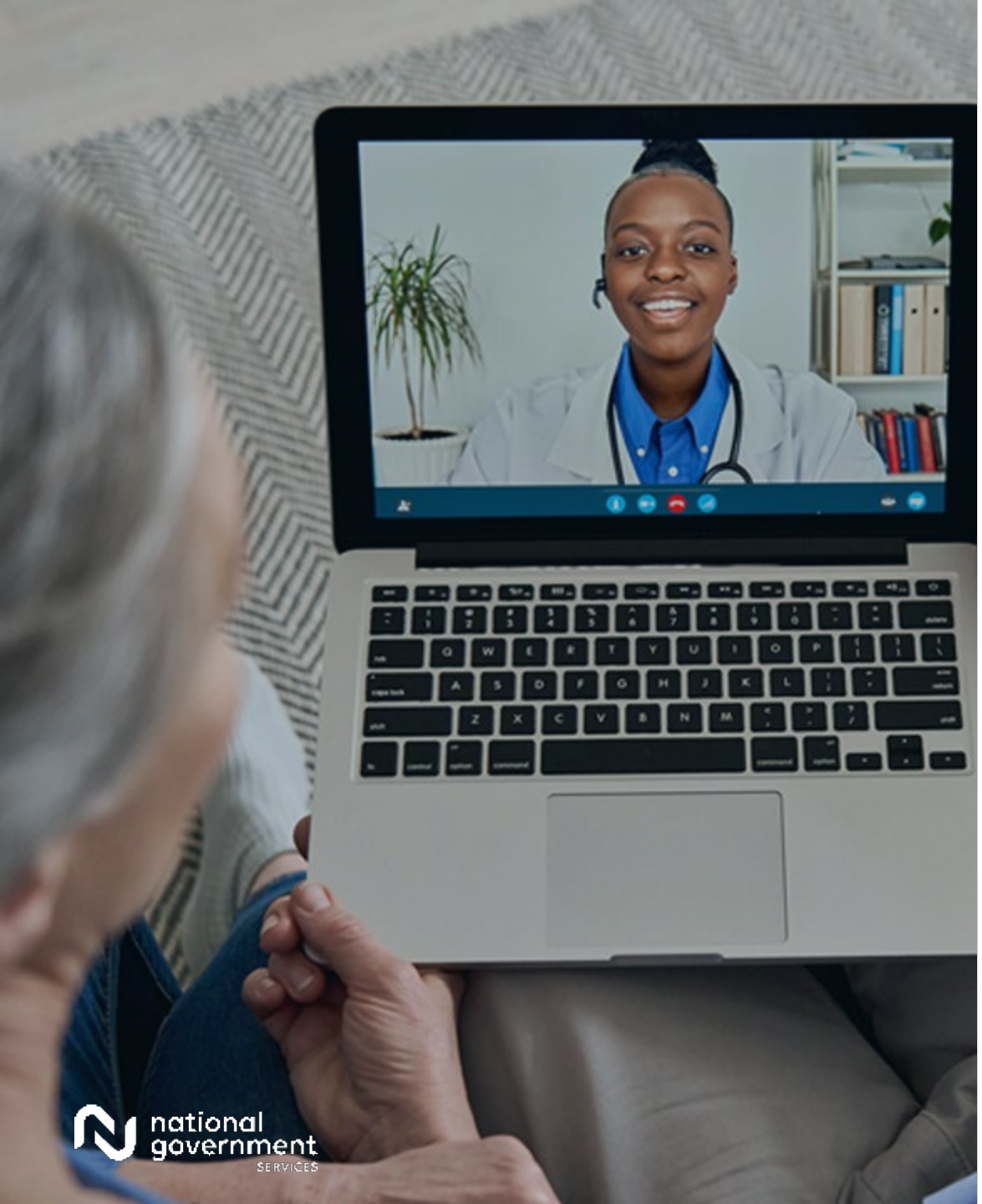

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Objective

- 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 PCM

Care Management Continued Series
Agenda

Principal Care Management

General

Coding

Billing

Documentation

Resources

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Care Management: Principal Care Management Services

PCM Versus 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

PCM: Single high-risk disease

CCM: Multiple (two or more) chronic conditions

PCM General

Treatment of beneficiaries with single, serious, chronic condition

Diagnosis expected to last between three months, one 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

Establishing, implementing, revising and monitoring care plan specific to single disease

Goal is to manage condition

Who can bill Part B PCM?

- PCM Physicians, NPP, and Clinical Staff
- Physicians and certain nonphysician practitioners
  - MD and DO
  - Physician assistants
  - Clinical nurse specialist
  - Nurse practitioners
  - Certified nurse midwives
- Clinical staff members
  - Under the supervision of physician/NPP who is allowed by law, regulation, and facility policy to perform or assist in performance of specified professional service, but who does not have an individual PTAN

PCM Benefits

- Improving patient quality of life, medical status and avoiding costly decompensations in patient's health
- Integral part of primary care, resulting in better health outcomes for patients while reducing overall healthcare costs
- Stabilization of patient's chronic condition by providing comprehensive care plan for single high-risk condition
- Prevention new diagnosis arising
- Provider reimbursement opportunities

PCM Requirements

- Billing PCM codes requires practitioner to develop disease-specific care plan
  - Consent
  - Documents dates and times
  - Educate patient on PCM and cost sharing
  - List care medical problem
  - Medications (allergies)
  - Patient's demographics
  - Requires documentation to substantiate time and patient facts

PCM Billing Codes

Code	Description
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
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

PCM and E/M Billing

- May initiate at AWV or with another billable E/M visit as long as requirements met for both PCM and E/M
- 24/7 access to dedicated care team member
- Condition unusually complex due to comorbidities
- Timed services managing patients with single complex chronic condition
  - 99424 and 99425: physician/NPP
  - 99426 and 99427: clinical staff
- Time accumulates throughout month
  - Once threshold met, claim may be submitted

Comprehensive Care Management for Single High-Risk Disease Elements

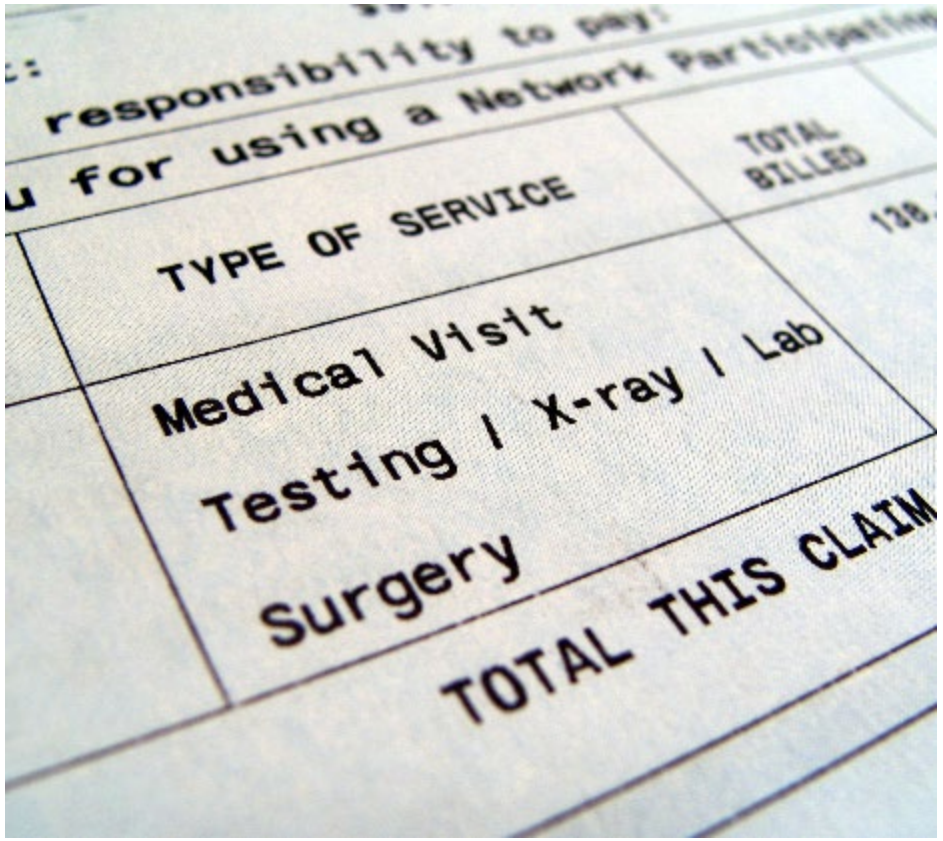
- Record patient's demographics, problems, medications, and allergies using certified Electronic Health Record (EHR) technology
  - Cognitive assessment
  - Develop problem list
  - Environmental evaluation
  - Expected outcome and prognosis
  - Frequent adjustments to medication
  - Measurable treatment goals
  - Medication symptom management
  - Planned interventions
  - Requirements for periodic review
  - Revision of care plan, when applicable

FAQs

PCM Qualifications

- To qualify for PCM, your patient must have multiple diagnoses that is expected to last between three months to a year or is life-long
  - TRUE or FALSE

PCM Codes



- CPT codes 99424 and 99425 describe physician and NPP services
- CPT codes 99426 and 99427 describe clinical staff time directed by physician/NPP
  - TRUE or FALSE

PCM Consent

- Patient consent is required for principal care management?
  - TRUE or FALSE

PCM Billing

- Can CCM and PCM be billed concurrently, and can they be billed for same practice in multispecialty group that has PCP and specialist?
  - Yes, CMS notes (84 FR 62697), CCM and PCM cannot be billed by same practitioner for same patient in same month
  - However, it is allowable, for instance, for primary care practitioner to offer CCM and specialist to offer PCM
  - Note: conditions being addressed by CCM and PCM must be different
- Reference
  - Frequently Asked Questions About Practitioner Billing for Chronic Care Management Services

PCM or CCM

- What is the difference between principal care management and chronic care management?
  - Under CCM guidelines, patients must have two or more chronic conditions
  - Under PCM guidelines, treatment of patients with just one, single high-risk disease

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*

Questions?

Thank you! A follow-up email will be sent to attendees with the Medicare University Course Code.

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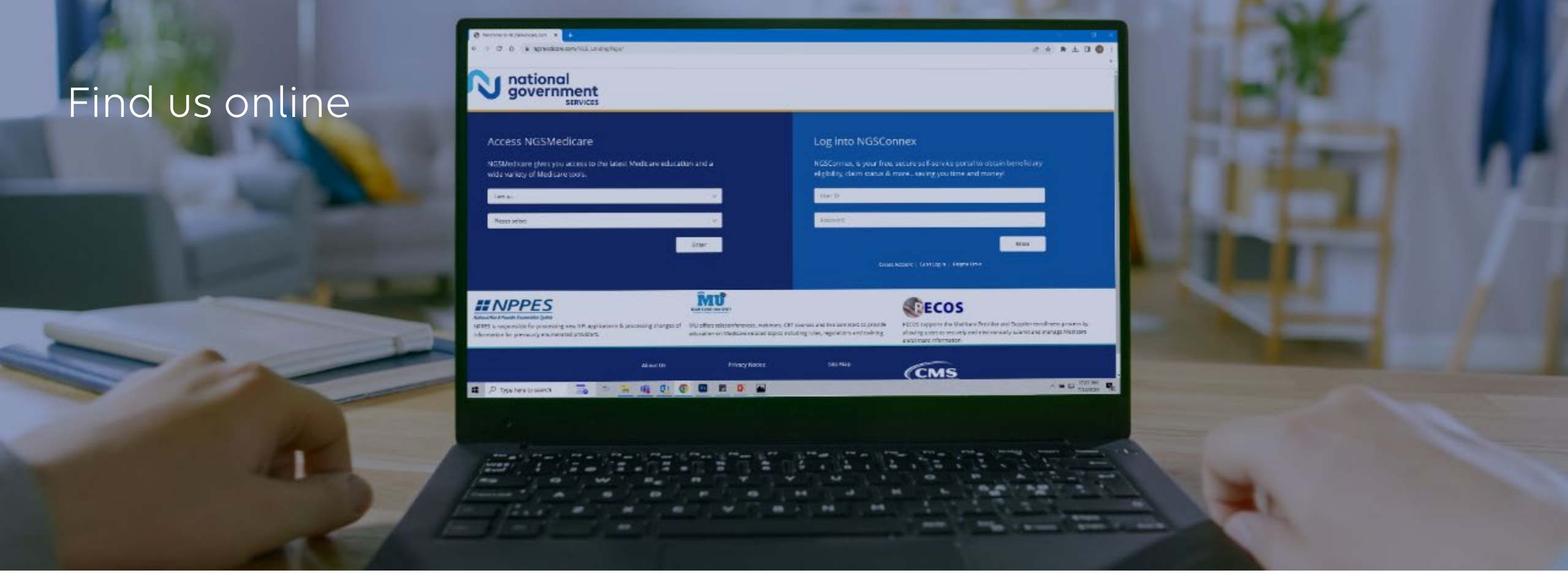

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