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AN INTRODUCTION TO

Chronic Care Management & Principal Care Management

for Community Oncology Practices

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Inside

Background

First introduced by the Centers for Medicare & Medicaid Services (CMS) in January of 2015, Chronic Care Management (CCM) is based on evidence that providing proactive care management services to patients with multiple chronic conditions can improve patient outcomes and reduce the overall cost of care. CMS released an analysis in 2017 showing significant results—per-beneficiary-per-month expenditures decreased by $74 after 18 months, primarily realized in inpatient and post-acute care while Medicare payments to physicians actually increased.

In 2020, CMS introduced Principal Care Management (PCM). While closely mirroring CCM in many ways, PCM enables specialists to provision proactive patient management services to patients with a single, complex chronic condition. Today, CMS continues to expand these programs to a set of comprehensive codes for services that remain beneficial for both the patient and the provider.

PCM	CCM
Care for patients with a single chronic condition	Care for patients with multiple chronic conditions
Up to 60 minutes per month	Up to 60 minutes per month
30 minute increments	20 minute increments
Multiple providers can bill for PCM services concurrently, so long as unique conditions are being managed by each provider	Only one provider can bill for CCM per patient at any given time

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Codes and Reimbursement Rates

PRINCIPAL CARE MANAGEMENT

CPT Code	Description	2022 Payment (Non-Facility)
99426	Initial 30 minutes of care, clinical staff	$61.49
99427	Subsequent 30 minutes, clinical staff	$47.04
99424	Initial 30 minutes of care, physician or NPP	$80.98
99425	Subsequent 30 minutes of care, physician or NPP	$58.46

CHRONIC CARE MANAGEMENT

CPT Code	Description	2022 Payment (Non-Facility)
99490	First 20 minutes of care	$60.17
99439	Second and third 20 minutes of care	$47.04
99491	CCM performed by a provider (MD/APP) (can't be billed in same month as 99490)	$82.35

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Patient Eligibility

CMS only lists a set of examples that qualify as complex chronic conditions. Below are the patient eligibility criteria for each program:

PCM

- One diagnosis expected to last three months to a year, or until the death of the patient
- Diagnosis may have led to a recent hospitalization, and/or place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline

CCM

- Multiple (2 or more) chronic conditions expected to last at least 12 months or until death of the patient
- These chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline

Patient Consent

For both CCM and PCM, explicit patient consent is required; however, as of 2017, consent no longer needs to be written. The following information must be covered when obtaining consent:

1. Patient to be informed about the availability of CCM/PCM services and what that entails, including any cost sharing implications
2. Patient has the right to stop CCM/PCM services at any time, effective at the end of the calendar month
3. FOR CCM ONLY: Patient must be notified that only one physician can provision and be reimbursed for CCM services at any given time

Additional Considerations:

The same practitioner cannot bill for CCM and any of the following in the same calendar month:

- Home Healthcare Supervision
- Hospice Care Supervision
- Certain end-stage renal disease (ESRD) services

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The Care Plan

In addition to obtaining patient consent, a requirement for both CCM and PCM programs is the creation and continuous updating of a patient-specific **Care Plan**. The **Care Plan** should consist of physical, mental, cognitive, psychosocial, functional, and environmental components, and should be made available to the patient and/or any collaborative caregivers. In addition to those broader elements, the **Care Plan** should include components such as:

- A problem list addressing all health issues (not just chronic conditions)
- Measurable treatment goals
- Symptom management and planned interventions
- Medication management
- Interaction and coordination with external resources and clinicians
- Requirements for periodic review/revision

Care Management Staff

Medicare has created distinct CCM and PCM codes depending on the type of person delivering the services. For example, both PCM 99426 and PCM 99424 provide reimbursement for the initial 30 minutes of care, with the first requiring care be performed by clinical staff whereas the second requires care be performed by a physician or NPP.

While codes for care delivered by a physician or NP seem more defined, the definition for "clinical staff" varies on a state-by-state basis. Examples include: MAs, LPNs, RNs, NPs, CNSs, PAs, CSWs, PTs, etc. As such, we encourage practices to research and define which staff they include as part of that, taking into account any regional or payer differences.

Additional Considerations:

In addition to acquiring patient consent and creating a **Care Plan**, it is advised that providers furnishing CCM and/or PCM should provide the below services:

1. Provide a means for the beneficiary to access a member of the care team on a 24/7 basis to address acute or urgent needs (e.g. ePRO digital symptom monitoring)
2. Ensure the beneficiary can receive successive routine appointments with a designated practitioner or member of the care team
3. Provide enhanced opportunities for beneficiary-provider (or caregiver-provider) communication by telephone and asynchronous consultation methods (e.g., secure messaging)

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FAQs

Is there a list of chronic conditions that are covered under CCM/PCM?

CMS has not provided a definition or definitive list of chronic conditions for purposes of CCM or PCM; however, a list of set examples for complex chronic conditions is available. CMS has stated it intends for CCM and PCM services to be broadly available.

Can I use the same staff that I did for OCM?

Staff utilized for OCM, like value-based care teams, can perform many of the activities required to implement a successful CCM/PCM program. For example, these staff members can manage eligibility verification, enrollment and consent. We encourage practices to research the programs to ensure the correct staff is being employed for the various clinical activities.

How do these programs differ from OCM in terms of the scope and type of work?

While OCM required a predetermined set of activities, the CCM/PCM requirements center around time spent with the patient. This provides practices with the flexibility to customize their programs in a way that most benefits patients.

Will commercial payers pay for these services or is this just for Medicare patients?

CCM is covered by Medicare, the majority of commercial Medicare Advantage plans, and a number of commercial plans. PCM adoption is generally limited to Medicare and Medicare Advantage plans. We encourage practices to look into which of their local payers cover these activities.

What happens if two providers try to bill for CCM at the same time? Is it “first come, first paid" every month?

CMS will make payment on the first claim received and deny a claim subsequently received from another provider. It would be up to this provider to appeal the denial and raise the issue of beneficiary consent. It is unclear how competing claims will be resolved, but it is thought that the practitioner with the most recent valid written consent will receive payment. It is estimated that under 10% of patients are already getting CCM.

Can the same practitioner bill for CCM and TCM in the same calendar month?

CCM and TCM may be billed by the same practitioner in the same calendar month for the same beneficiary if the 30-day, post-discharge service period for TCM concludes before the end of that calendar month, and at least 20 minutes of CCM services are furnished between that time and the end of that month.

Contact Canopy at **info@canopycare.us** to learn how we can help your practice implement CCM or PCM.

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References

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