

CMS Chronic & Principal Care Management Services: Implementation Guidance

Implementing the Centers for Medicare and Medicaid Services' (CMS) chronic and principal care management (CCM/PCM) services provides an opportunity to put a framework around care coordination, chronic disease management and care management for high-risk patients. Additionally, CCM/PCM services lead to enhanced reimbursement, including for team-based care and work that the care team is already performing. In response to our clients' needs and requests, we have compiled short, straightforward guidance for implementing and capturing reimbursement for the CMS CCM and PCM services. In the spirit of brevity, we leave requirements and details of CCM/PCM to the guidance documents listed below in Chronic Care Management Must-Have Resources.

Note that CMS has yet to add PCM details to their CCM resources, but the requirements and workflows are essentially the same as for CCM. PCM describes "care management services for one serious chronic condition. A qualifying condition will typically be expected to last between three months and one year, or until the death of the patient, may have led to a recent hospitalization, and/or place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline"¹.

Define the Business Case

Some health care organizations implement a care management program because they feel it's the "right thing to do" regardless of whether there's a business case, noting that only providing CCM/PCM for patients who have the insurance to cover those services contributes to health inequity. However, there definitely is a business case for implementing CCM/PCM and for increasing revenue for work that is often already underway, supporting patients with chronic conditions.

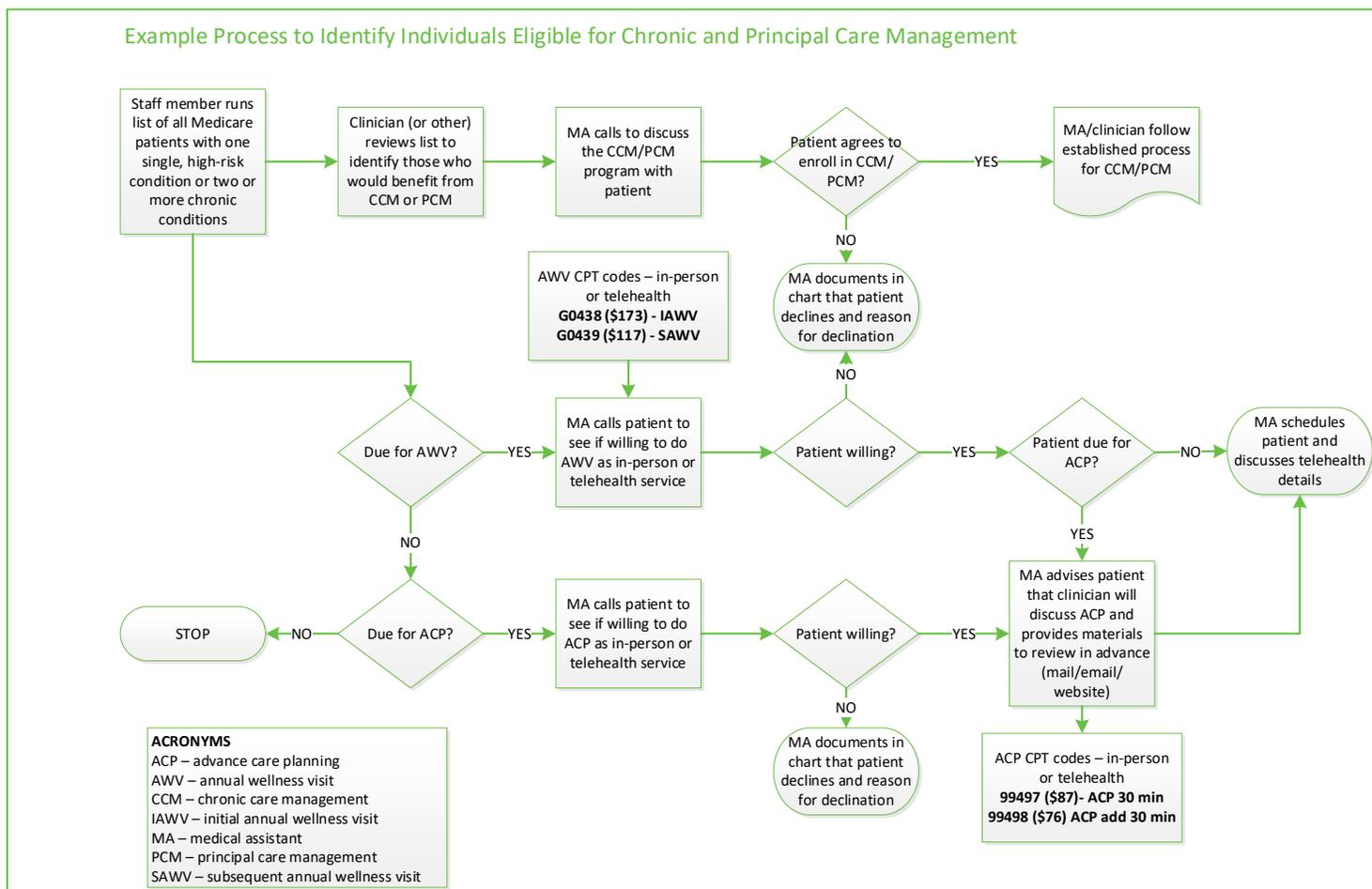
Identify the target population

While CMS estimates that at least two-thirds of Medicare beneficiaries have at least two or more chronic conditions², CCM/PCM can only be furnished on an "as-needed" basis – that is, only billed when services are provided. However, it is reasonable to start with this target population – Medicare patients with two or more chronic conditions expected to last at least 12 months or until the death of the patient. We have found that one clinical staff member (e.g., medical assistant) can manage 50 – 100 patients, working with the billing clinician(s).

¹ CY 2020 Physician Fee Schedule Final Rule published November 15, 2019.

² Centers for Medicare and Medicaid Services. [Chronic Conditions among Medicare Beneficiaries. Chartbook, 2012 Edition.](#) Baltimore, MD. 2012.

Figure 1. Example of a process to identify the target population



Estimate Revenue

This may be easier than it sounds, but based on the target population, estimate which CPT codes (see Table 1) might be billed on a monthly or other basis to estimate the revenue that could be generated by providing CCM/PCM services. There are currently only two codes for PCM – G2064 and G2065 for practices that are not Federally Qualified Health Centers (FQHCs) or Rural Health Clinics (RHCs). G0511 is the only code that FQHCs and RHCs may use for both CCM and PCM. It is reasonable to check whether other health plans besides Medicare will reimburse for these services and associated codes. Take a deeper dive into the additional revenue capture opportunities noted in the section below. Another consideration is that while most health care organizations can implement CCM/PCM on their own, there is no shortage of vendors willing to provide and bill for these services for a hefty percentage of the revenue.

Identify Additional Opportunities

The CCM/PCM services can be augmented with additional virtual services to ensure holistic and convenient service delivery and increased reimbursement for chronic care management. As noted in the flow diagram above, it is possible to ensure those receiving CCM/PCM are also current on their annual wellness exams and have received advance care planning. In addition, CCM/PCM can be

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augmented using virtual service delivery options, including virtual check-ins, e-visits, telephone evaluation and management (E/M) services, behavioral health integration services and remote patient monitoring. Please contact Comagine Health for guidance on how to build these services into a chronic care management program or visit the Comagine health Telemedicine and Virtual Resources website at <https://comagine.org/program/covid19/telemedicine>

Table 1. CCM and PCM codes with brief description and CMS price.

CCM/PCM Code	Description	CMS Price
CPT 99490 (non-complex CCM)	20 minutes or more of CCM for clinical staff time directed by a physician or other qualified health care professional, per calendar month	\$42
CPT 99491 (non-complex CCM)	30 minutes or more of CCM furnished by a physician or other qualified health care professional, per calendar month	\$84
HCPCS G2058 (non-complex CCM)	Add-on code to CPT 99490 for each additional 20 minutes of clinical staff time; reportable up to two times per month (after 99490) CMS is proposing to replace this code in 2021 with a CPT code	\$38
CPT 99487 (complex CCM)	60 min or more of complex CCM for clinical staff time directed by a physician or other qualified health care professional, per calendar month	\$92
CPT 99489 (complex add-on CCM)	Add-on code to CPT 99487 for each additional 30 minutes of clinical staff time	\$45
G2064 (PCM)	30 minutes or more of physician or other qualified health care professional time, per calendar month	\$92
G2065 (PCM)*	30 minutes or more of clinical staff time directed by a physician or other qualified health care professional, per calendar month	\$40
G0506 (CCM add-on code)	Add-on code to the CCM initiating visit that describes the work of the billing practitioner for a comprehensive assessment and care planning to patients outside of the usual effort described by the initiating visit code	\$64
G0511 (CCM and PCM)	This is the only code that FQHCs and RHCs may bill for CCM and PCM (may bill for PCM as of Jan 1, 2021). The payment rate is set at the average of the national non-facility payment rates for CPT codes 99490, 99487, 99484, and 99491 and is updated annually. CMS is proposing to include G2064 and G2065 in the average rate starting in 2021.	\$67

National payment amount for the non-facility price from the [Physician Fee Schedule Search](#) as of September 8, 2020, rounded to the nearest dollar. Do not rely on these. Have your biller/coder double-check.

*CMS has added G2065 to the list of designated care management services for which they allow general supervision.

Identify Staff Needed to Deliver CCM/PCM

It can be challenging to make staff estimates. However, use the target population and anticipated revenue to develop an informed estimate as best as possible. Include estimates of both clinician and clinical staff time. Be creative in considering who can deliver CCM/PCM services (e.g., registered dietitians, pharmacists, medical assistants, nurses, etc.).

Empower an Internal Subject Matter Expert or Team

If the organization decides to move forward with CCM/PCM, find a staff member or small team willing to learn the CCM/PCM requirements, identify the operational considerations, ensure that needed changes occur, communicate with staff, and identify training needs. Consider whether this is the same team who will deliver the CCM/PCM services. The internal subject matter expert or team can get up to speed with the Chronic Care Management Must-Have Resources below.

Consider Operational Changes and Supports

Consider a simple project plan that lists all changes needed to accommodate this new service and to capture the required elements and documentation, including who will do what and when. Below are several to consider, but this is not an exhaustive list of the CCM/PCM requirements.

Enroll patients in the CCM/PCM program

Successful organizations include CCM/PCM in pre-visit planning by reviewing eligible patients in the schedule, taking an opt-out approach in addition to referrals by clinicians for patients without a visit, meaning that patients will be invited to receive CCM/PCM services if needed and appropriate unless the primary care clinician opts them out.

Clarify how verbal consent is obtained and documented in the electronic health record (EHR)

Consent must be obtained and documented prior to delivering CCM/PCM. Some care teams do this for all Medicare patients on an annual basis as part of check-in with reception staff. Another option is to have CCM/PCM staff have a short conversation with patients being enrolled during their office visit to obtain consent and discuss the program and services. For both CCM and PCM, patients must be educated as to what PCM and/or CCM are and any cost sharing that may apply. Check the full consent requirements in the must-have resources listed below.

Track time spent by clinicians and by clinical staff

This can be challenging if the EHR does not have an easy method for tracking the required time increments to bill the CCM/PCM codes (e.g., date/time stamped signature at start and finish). If there is not an easy way to do this, staff need to document start and end times for time spent directly by the billing clinician or clinical staff. Non-clinical staff time does not count (i.e., reception staff time for obtaining informed consent).

Create EHR templates

Again, this may depend on the EHR. Templates that guide the clinician and clinical staff to document all required elements are ideal. Consider having the subject matter expert draft the initial iterations in Word, Visio or another program to provide line of sight on usability and fidelity with the CCM/PCM requirements.

Draft billing workflows

Consider how to make it as easy as possible for the clinician, clinical staff or billers/coders to know which codes to use and when those codes can be billed (i.e., once the requisite number of minutes are reached, the associated code can be submitted). Best practice: close the loop to ensure that

reimbursement for each code occurs and at the rate expected. On average 5% of CCM claims are denied³; troubleshoot any denials to ensure a denial rate of 0% with minimal administrative burden.

Provide 24/7 access

Check the details of what is required by CMS in materials referenced below, but this does not need to be a showstopper. There are creative ways to meet this requirement that address patients' urgent needs regardless of the time of day or day of week. Some organizations have trained staff take turns with a phone after hours to deal with any incoming calls. Feedback from the field indicates that these calls are few and far between.

Streamline documenting and sharing the care plan

While a clinician should review and approve (not required by CMS) the care plan, others on the care team can develop meaningful care plans with training and feedback. Because care plans can be a sticking point, confer with clinicians and other care team member to develop an efficient process and template to develop and share the care plan with patients and care givers.

Identify and manage transitions

Know how the team will receive reliable notifications of referrals to clinicians, emergency department visits, inpatient stays, and other transitions (e.g., home to assisted living, rehabilitation facility to home, etc.). Clarify the lines and modes of communication to share and exchange continuity of care documents. Leverage a source like a health information exchange (HIE), which provides access to and sharing of test results, consult/referral notes, continuity of care documents (required by CCM and PCM), and event notifications – admissions, discharges, and transfers (ADTs) – when a patient has received care at a different setting. (Hospitals are required to provide event notifications to community providers (as identified by the patient) as of May 1, 2021.) An HIE can provide automated feeds of information that is often integrated into the EHR and contributes to processes to address when patients need or receive care at different settings.

Coordinate with home- and community-based service providers

This coordination requires deliberate action to know which service providers are involved and to build communication with those providers. Identify how the team will learn which service providers are involved, how to document them in the patient's electronic chart (not required by CMS), and how to communicate in a way that is best for the patient, care givers and the service providers.

Chronic Care Management Must-Have Resources

- **Connected Care: The Chronic Care Management Resource**
<https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/chronic-care-management.html>
 - **Connected Care Toolkit**
<https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/CCM-Toolkit-Updated-Combined-508.pdf>
- **CMS Care Management (also includes Advance Care Planning, Behavioral Health Integration and Transitional Care Management)**
<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Care-Management.html>

³ Reddy A, et al. [Use of Chronic Care Management Among Primary Care Clinicians](#). Ann Fam Med. 2020;18(5):455-457.

- CCM Services – CMS Jul 2019
<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf>
- FAQs about Billing for CCM Services – Jan 2019
[https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Payment for CCM Services FAQ.pdf](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Payment%20for%20CCM%20Services%20FAQ.pdf)
- Care Coordination Services and Payment for RHCs and FQHCs – revised Nov 2017
<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10175.pdf>
- Care Management Services in RHCs and FQHCs – FAQs Dec 2019
<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf>
- Specific Payment Codes for the FQHC PPS
<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-PPS-Specific-Payment-Codes.pdf>
- **Principal Care Management Service Requirements**
PCM services are for one serious chronic condition, and the PCM billing codes listed in Table 1 were available as of January 1, 2020. Because CMS has not added the details of PCM to their existing CCM resources as of September 2020, we provide the following summary of the PCM requirements as outlined in the CY 2020 Physician Fee Schedule Final Rule.
 - At least 30 minutes of physician or other qualified health care professional time per calendar month (G2064) or at least 30 minutes of clinical staff time (G2065) directed by a physician or other qualified health care professional, per calendar month
 - One complex chronic condition lasting at least three months and expected to last at least a year or until the death of the patient, which is the focus of the care plan
 - Condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization, and/or may place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
 - Condition requires development or revision of disease-specific care plan
 - Condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities
 - Must include coordination of medical and/or psychosocial care related to the single complex chronic condition
 - Ongoing communication and care coordination between all practitioners furnishing care to the beneficiary must be documented by the practitioner billing for PCM in the patient's medical record
 - The full CCM scope of service requirements applies to PCM, including documenting the patient's verbal consent in the medical record as noted in Table 2.
 - "...PCM services should not be furnished with other care management services by the same practitioner for the same beneficiary, nor should PCM services be

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furnished at the same time as interprofessional consultations for the same condition by the same practitioner for the same patient.”⁴

- Remote patient monitoring (RPM) may be billed concurrently with PCM as long as the time is not counted twice.

⁴ CY 2020 Physician Fee Schedule Final Rule p. 62697.

Table 2. PCM and CCM Services Summary Crosswalk from Tables 23 and 24 in the CY 2020 Physician Fee Schedule Final Rule

PCM Services Summary*	CCM Services Summary
<p>Verbal Consent</p> <ul style="list-style-type: none"> Inform regarding availability of the service; that only one practitioner can bill per month; the right to stop services effective at the end of any service period; and that cost sharing applies (if no supplemental insurance). Document that consent was obtained in the medical record. 	
<p>Initiating Visit for New Patients (separately paid)</p>	
<p>Certified Electronic Health Record (EHR) Use</p> <ul style="list-style-type: none"> Structured recording of core patient information using EHR (demographics, problem list, medications, allergies). 	
<p>24/7 Access (“On Call” Service)</p>	
<p>Designated Care Team Member</p>	
<p>Disease-Specific Care Management Disease-specific care management may include, as applicable:</p> <ul style="list-style-type: none"> Systematic needs assessment (medical and psychosocial). Ensure receipt of preventive services (<i>as applicable to the condition being treated and is not a requirement to bill for PCM services</i>)[†]. Medication reconciliation, management and oversight of self-management. 	<p>Same as PCM, just not disease specific.</p>
<p>Disease-Specific Electronic Care Plan</p> <ul style="list-style-type: none"> Plan is available timely within and outside the practice (can include fax). Copy of care plan to patient/caregiver (format not prescribed). Establish, implement, revise or monitor the plan. 	<p>Same as PCM, just not disease specific.</p>
<p>Management of Care Transitions/Referrals (e.g., discharges, ED visit follow up, referrals, as applicable).</p> <ul style="list-style-type: none"> Create/exchange continuity of care document(s) timely (format not prescribed). 	<p>Same as PCM, but does not include “as applicable”</p>
<p>Home- and Community -Based Care Coordination</p> <ul style="list-style-type: none"> Coordinate with any home- and community-based clinical service providers, and document communication with them regarding psychosocial needs and functional deficits, as applicable. 	<p>Same as PCM, but does not include “as applicable”</p>
<p>Enhanced Communication Opportunities Offer asynchronous non-face-to-face methods other than telephone, such as secure email.</p>	
<p>*All elements that are medically reasonable and necessary must be furnished during the month, but all elements do not necessarily apply every month. Consent need only be obtained once, and initiating visits are only for new patients or patients not seen within a year prior to initiation of PCM or CCM.</p>	

[†]Note that italicized text is added directly from the final rule text and is not included in Table 24.