# Principal Care Management Success Guide

This guide is intended to help your practice determine whether to adopt Principal Care Management (PCM), how to successfully implement a PCM program, and how to utilize your electronic health record to track patient information and key metrics.

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# PCM Fundamentals

## What is Principal Care Management (PCM)?

Principal Care Management (PCM) refers to disease-specific billable care management services provided to Medicare patients. PCM is part of a relatively new effort by the Centers for Medicare & Medicaid Services (CMS) to improve payment policies around care management and care coordination services for patients with one chronic disease.

PCM services are provided to patients with at least one serious chronic condition expected to last between three months and one year, or until the death of the patient. A serious chronic condition could be one that led to a recent hospitalization or places the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. Oncology and hematology diagnosis that may fall into this category include advanced stage cancers and serious blood disorders such as Myelodysplastic syndrome and autoimmune hemolytic anemias.

CMS reimburses clinicians on a fee-for-service (FFS) basis for various types of care management services, including PCM, chronic care management (CCM), remote patient monitoring (RPM), and transitional care management (TCM). If you're familiar with Chronic Care Management (CCM), you may be wondering, *"how does PCM differ from Chronic Care Management (CCM)?"* We lay out five key differences between PCM and CCM in this table.

Flatiron created this success guide to help you navigate deciding whether and how to implement PCM at your clinic. In a constantly evolving reimbursement landscape of new FFS care management codes from CMS and an unclear path for oncology specific value-based contracting with Medicare, it can be difficult to understand whether to implement new opportunities.

## The 10 Components of PCM:

1. **Verbal Consent**: Patients must be informed about at least three aspects of receiving PCM services: the fact that only one practitioner can bill per disease per month; that they have the right to stop services; and that they are responsible for any cost sharing based on their insurance. Consent to receive PCM services must be documented in the patient's chart.
2. **Initiating Visit for New Patients:** Patients not seen within a year of enrollment for PCM must have an initiating visit that occurs face-to-face such as an annual wellness visit, which is billed and paid separately from PCM services.
3. **Use a Certified Electronic Health Record (EHR):** Practices must document core patient information in structured fields within a certified EHR.

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4. **24/7 Access to Care via Phone:** Patients need to be able to reach someone who can access their health record 24 hours per day.
5. **Designated Care Team Member:** One primary designated care team member must be assigned to the patient as their care manager
6. **Disease Specific Electronic Care Plan:** The care plan must include the patient's diagnosis and treatment plan, treatment goals, allergies, care team, a psychosocial assessment, recent hospitalizations, and advanced directives
7. **Disease Specific Care Management**: Clinical staff or a clinician must provide appropriate care management for the patient's disease and personal needs. This might include performing a systemic needs assessment, ensuring the patient receives preventive services, and/or medication management, reconciliation, or oversight.
8. **Management of Care Transitions/Referrals:** As applicable, the care manager should create and exchange CCDs with other providers, ensure ED visit follow-up, track hospitalizations and discharges, or manage referrals
9. **Home and Community-based Care Coordination:** As applicable, coordinate and document communication with home and community-based service providers for psychosocial needs and functional deficits
10. **Enhanced Communication Opportunities:** Offer patients asynchronous communication options other than telephone calls such as secure email

## Why Should You Consider Implementing PCM?

### Reimbursement Potential

The reimbursement for PCM services should outweigh the salary and staffing costs of the program, offering a new revenue potential for your practice. For practices that were in the Oncology Care Model (OCM), this could help offset some of the MEOS payments you are no longer receiving. Providing care management will also be an integral part to billing MEOS for beneficiaries in the upcoming Enhancing Oncology Model (EOM).

### Potential Reduction in Total Cost of Care

By providing consistent communication and support to high risk patients, you may be able to prevent unnecessary utilization of higher cost facilities such as the Emergency Department by intervening before an issue becomes an emergency and educating patients on resources available in your clinic such as same day appointments. A reduction in total cost of care would improve your MIPS scores in the Cost Category and improve your financial gains in commercial value-based payment arrangements.

### Patient Experience

When patients feel heard and supported, they are more satisfied with their care and overall healthcare experience. Patients actively involved in their healthcare tend to have better

outcomes and lower costs,[1] making patient engagement an integral piece of providing high value care.

## Reimbursement & Revenue Potential

PCM billing codes depend on the role of the person managing patient care and how much time is spent with each patient during a calendar month. Below are the four PCM common procedural technology (CPT) codes for 2022 along with the national payment rate.

**Physician or Qualified Professional**

- 99424: First 30 minutes of physician or qualified health professional personal time per calendar month (national payment rate: $83.40)
- 99425: Next 30 minutes of physician or qualified health professional personal time per calendar month (national payment rate: $60.22)

**Clinical Staff under Supervision**

- 99426: First 30 minutes of clinical staff time directed by a physician or other qualified health care professional per calendar month (national payment rate: $63.33)
- 99427: Next 30 minutes of clinical staff time directed by a physician or other qualified health care professional per calendar month (national payment rate: $48.45)

Revenue potential varies based on the number of patients enrolled in PCM and the person running the program at your practice. To estimate revenue, consider how many patients you have the capacity to provide PCM services to in a month, the local payment rate in your area, and any downstream effects you want to track such as an increase in on-site hydration, labs, etc. that may arise from patient conversations.

## Practice Redesign Requirements

A practice offering PCM must provide the following access to care:

- **24/7 access** to physicians or other qualified health care professionals or clinical staff, including providing patients with a means to make contact with health care professionals in the practice to address
- Ensure **continuity of care** with a designated member of the care team with whom the patient is able to schedule successive routine appointments
- Provide **enhanced opportunities to communicate** with the practitioner regarding the patient's care by telephone and also through secure messaging, secure internet, or other asynchronous non-face-to-face consultation methods

[1] https://www.healthaffairs.org/do/10.1377/hpb20130214.898775/full/.

urgent needs regardless of the time of day or day of week

# 5 Steps to Implementing a Successful Program

## Step 1: Align on Goals and Achieve Buy-in

### Goals and Objectives

The first step is to clearly articulate why you want to implement PCM. What is your (or your team's) overall intent of implementing this program? PCM can help your practice achieve various goals which might include increasing revenue, reducing utilization of high cost care such as the emergency room, improving patient experience, and/or demonstrating high quality care to payers. It's best to align on a single goal with multiple objectives that help you achieve the goal. For example, this could look like:

> **Goal:** Maintain a consistent line of communication with high-risk/complex patients between office visits
>
> **Objectives:** Provide referral management for patient needing psychosocial support; maintain consistent communication with patients recently discharged from the hospital; Offer medication management and adherence support

By establishing your goal and objectives, you can determine what data needs to be tracked and begin to think about how to measure success. In this example, perhaps one measure of success is enrolling 50% of patients discharged from the hospital into PCM within one week of discharge. Flatiron can help you set goals, objectives, and success measures as well as provide the data needed to track progress.

### Achieve Buy-in from Key Stakeholders

Get the right people on board with your plan for implementation by involving them early in decision-making and sharing key educational information along the way. By including practice leadership, clinical staff, and physicians from the start, the implementation process will be made smoother by gathering early feedback to incorporate and addressing any concerns along the way.

## Step 2: Determine Scope and Success Metrics

**Scope**

Once goals and objectives are determined, setting the scope of the PCM program will help to inform success metrics and workflow. To determine the scope of your PCM program, think through questions such as:

- What criteria should be used to identify patients for PCM enrollment?
- Will PCM be implemented at all of our locations or start at one and scale?
- Who is responsible for the success of the PCM program?
- How can this program be integrated with our current care management workflows?
- What is the current bandwidth of our nursing and non-physician provider staff?
- How many team members will be assigned to this program for what amount of time per week?
- Do we have any Value Based Care (VBC) arrangements with commercial payers that may already or be willing to reimburse for PCM services?

**Determine Metrics to evaluate success**

Metrics are critical to determining whether you've successfully implemented PCM in your practice. What metrics will define success for your practice? What data and information do you need to track to ensure the goals and objectives are met? Some example goals and ways of measuring success are listed below as a starting point.

Sample goals

- Enroll 60 patients within 1 month
- Enroll 100 patients within 3 months
- Achieve 30% acceptance rate
- Increase annual revenue by $800 per patient per year enrolled (if done by physician or NP) or $400 per patient per year enrolled (if done by clinical staff)

Ways to measure success:

- Number of patients identified for PCM and invited to participate
- Number of patients (% of identified) billed for PCM
    - First month of pilot
    - Monthly cadence (new starts and monthly reimbursement for historic patients)
- Reimbursement
- Utilization of the emergency department
- Same day clinic visits scheduled
- Community referrals made

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## Step 3: Determine Workflow

### Workflow questions

While adopting a PCM workflow, there will be many decisions to make. Be prepared to discuss some of the following questions with the team that will be involved in the PCM program.

1. If there is already care management offered to patients, how will PCM be different and how can it be similar to avoid confusion?
2. Do we have any technology, methodology, or interfaces in place to identify patients that have recently been admitted to the hospital?
3. Who will be responsible for identifying eligible patients for PCM?
4. Should enrollment be done in person or over the phone? Who should be responsible for enrolling patients?
5. Who will develop the disease specific care plan for patients receiving PCM? Will the care plan be reviewed in person or remotely?
6. Who will be the patients' primary contact for monthly calls and care management?
7. How should PCM work be scheduled (e.g., schedule time to call individual patients, set aside time blocks each week)?

### Flatiron's Suggested PCM Workflow

Flatiron's suggested PCM Workflow is broken down into four steps:

1. Identify eligible patients
    a. Utilize a reporting or patient identification tool to identify patients that meet the PCM participation criteria
2. Enroll patients in PCM
    a. Call patients identified as eligible for the program to inform them of the program benefits, cost, and their ability to opt out at any time
    b. Clearly document patient acceptance or declination in their electronic medical record (EMR)
    c. Manually add patients or use a reporting tool to track patients that have accepted enrollment and need to have a care plan developed
3. Develop and review a disease specific care plan
    a. Call or schedule an appointment with each patient new to PCM to establish a disease specific care plan
    b. Document the care plan and time spent with the patient in the patient's EMR
    c. Manually add patients or use a reporting tool to track patients that have a completed care plan and need to be called on a monthly basis
4. Provide ongoing care management, billed on a monthly basis

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a. Call patients at least monthly to check in, update the care plan, provide referrals, etc. as needed
b. Document any actions taken, discussion had, and time spent in the patient's EMR
c. Bill monthly based on the appropriate CPT code for the clinician performing the work and the amount of time spent with the patient that month

## Step 4: Configure Electronic Health Record

Step 4 is specific to your electronic health record vendor. We encourage you to reach out to your vendor contact to discuss what workflow and configuration support they can provide.

## Step 5: Implement Workflow

Review your implementation checklist to ensure you're ready to go live with the PCM workflow (sample checklist available below).

**Implementation Checklist**

- ☐ Determine goals, scope, and metrics of PCM program
- ☐ Achieve buy-in from practice stakeholders to implement PCM
- ☐ Configure activities and regimen (if applicable)
- ☐ Create a standard PCM note for documenting patient encounters
- ☐ Customize PCM note to your preferences, ensuring PCM requirements are all still met
- ☐ Customize PCM Workflow, confirm roles and responsibilities within the clinic
- ☐ Create and disseminate training/reference document for PCM team
- ☐ Meet live with PCM team to answer questions and prepare for go-live
- ☐ Go-live with at least one staff member to test workflow

Once the PCM program is live, check-in frequently with the team operationalizing PCM, track metrics, and share results broadly across the practice.

- ☐ After 2 weeks, meet with PCM team to discuss initial experience and make any necessary adjustments
- ☐ After first month, compile first round of success metrics and share with stakeholders (request support from Flatiron, if needed)
- ☐ Hold monthly check-ins with PCM team to review metrics, discuss workflow, and handle questions or issues

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# Appendix

## PCM and CCM Comparison

CMS reimburses clinicians for various types of care management services, including PCM, chronic care management (CCM), remote patient monitoring (RPM), and transitional care management (TCM). CMS implemented billing codes for PCM services for Medicare beneficiaries for the first time in 2020 after identifying a gap in coding and payment for care management services for only one chronic condition.

If you're familiar with CCM, you may be wondering, *"how does PCM differ from Chronic Care Management (CCM)?"* The table below lays out five key differences between PCM and CCM.

| PCM | CCM |
|---|---|
| PCM is the care management of **one chronic condition** expected to last three months to a year | CCM is the care management of **two or more chronic conditions** expected to last at least 12 months |
| PCM requires a **"disease-specific" care plan** as the practitioner will be providing care coordination and management for a single condition | CCM requires a **comprehensive care plan** to address two or more comorbidities |
| "Systematic needs assessment" and "receipt of preventive services" are **furnished as applicable** for PCM and not required for billing | "Systematic needs assessment" and "receipt of preventive services" are **mandatory** aspects of CCM |
| **More than one provider can bill for PCM** in a given month as long as they are for different diseases | **Only one provider can bill for CCM** services in a given month |
| PCM is specifically geared toward the management of a disease managed by a **specialist** | CCM is geared more toward **primary care** |

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## Frequently Asked Questions

**How does a patient qualify for PCM?**

- A qualifying condition will typically be expected to last between 3 months and 1 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. The condition requires development, monitoring, or revision of a disease-specific care plan, may require frequent adjustments of the medication regimen, or the management of the condition is unusually complicated by comorbidities.
- CMS expects that in most instances, the initiation of PCM will be triggered by an exacerbation of the patient's complex chronic condition or recent hospitalization such that disease-specific care management is warranted.
- In the majority of instances, PCM services will be billed when a single condition is of such complexity that it cannot be managed as effectively in the primary care setting, and instead requires management by another, more specialized, practitioner.
- PCM is not limited to patients with only one condition – The Final Rule implies that it is possible for a patient to receive PCM services from multiple specialists for multiple different conditions simultaneously (e.g. a cardiologist for arrhythmia and an endocrinologist for diabetes); however PCM services should not be furnished or billed at the same time as:
    - Other care management services by the same practitioner for the same beneficiary; nor
    - Interprofessional consultations for the same condition by the same practitioner for the same patient

**How is PCM initiated?**

A practitioner must obtain patient verbal or written consent before furnishing or billing PCM; consent must be documented in the patient's medical record.

For new patients or patients not seen within 1 year prior to the commencement of PCM, Medicare requires initiation of PCM services during a face-to-face visit with the billing practitioner (an Annual Wellness Visit [AWV] or Initial Preventive Physical Exam [IPPE], or other face-to-face visit with the billing practitioner). This initiating visit is not part of the PCM service and is separately billed.

**What does patient consent involve?**

A practitioner must obtain patient consent *before* furnishing or billing PCM. Consent may be verbal or written but must be documented in the medical record. Informed patient consent is only required once prior to furnishing PCM services. The patient must be educated about:

- The availability of PCM services and applicable cost sharing
- That only one practitioner can furnish and be paid for PCM services during a calendar month for the same condition
- The right to stop PCM services at any time (effective at the end of the calendar month)

**Required Documentation:**

- Consent – The billing practitioner must obtain the patient's informed consent and document that consent in the patient's medical record.
- Disease-specific Care Plan – Under PCM, billing practitioners should develop a disease-specific care plan for patients receiving PCM services. A disease-specific care plan is more limited than a comprehensive care plan, focusing only on the disease or condition requiring PCM services.
- 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.

**Who can furnish PCM services?**

- MAs
- RNs
- Physicians
- Non-physician practitioners:
    - Certified Nurse Midwives
    - Clinical Nurse Specialists
    - Nurse Practitioners
    - Physician Assistants

Note that clinical staff may furnish services, but it must be billed as Incident To to a physician or non-physician practitioner.

**Who can bill for PCM?**

- Physicians
- Non-physician practitioners:
    - Certified Nurse Midwives
    - Clinical Nurse Specialists
    - Nurse Practitioners
    - Physician Assistants

**Can enrollment and care plan happen on the same day?**

Yes, as long as verbal consent is gained and documented before a care plan is generated, this can happen on the same day.

**Can the care plan be created by anyone clinical?**

Yes, the care plan can be created by anyone clinical.

**Can I bill for the PCM Care Plan?**

No

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**Since I can't bill for the PCM Care Plan, can the PCM Care Plan and first Monthly discussion happen on the same day?**
Yes

**Is there a requirement for who is listed as members of the Care Team?**
No requirement from CMS

**Can you bill PCM and TCM in the same month?**
Yes

**Can you bill PCM for a patient that is enrolled in CCM with another practice?**
Yes

**Can you bill PCM for a patient that is enrolled in PCM with another practice?**
Yes, if the other physician/practice is providing PCM for a different disease than you are (e.g., Cardiology and Oncology).

**Are there any billing restrictions or considerations to be aware of?**
*Please note that these are intended to be informational and not specific billing advice/instructions. All billing decisions should be made directly by the practice billing department.*

- PCM codes can be billed only by a physician or other qualified health care practitioner (QHCP); if clinical staff is providing the services, it needs to be overseen and billed by a physician or QHCP.
- The practitioner cannot bill for interprofessional consultations or other care management services (excluding remote patient monitoring) for the same beneficiary for the same time period as PCM
- The practitioner cannot bill PCM more than one time per month per patient
- Concurrent Billing with Remote Patient Monitoring (RPM): PCM services *can* be billed in the same month or billing period as RPM services, so long as the time spent providing services under each is not counted twice. In other words, the time requirements set forth under each applicable code must be met separately in order for the services to be billable.