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Figuring out which of the codes from the Current Procedural Terminology (CPT®) code set to use when billing for care-management services can be complex. It can also be “chronic” or even “principal.”

Principal care management (PCM), chronic care management (CCM) and complex chronic care management (CCCM) are three categories of CPT codes that address services that are typically performed after the face-to-face patient encounter is over—such as developing a care plan and coordinating with other professionals to execute that plan.

PCM services focus on one medical condition that a patient has, while CCM addresses all of a patient’s medical conditions and requires high to moderate levels of decision-making. CCM addresses similar services that are typically performed in a shorter time threshold with lower levels of medical decision-making.

Each of these are subdivided further into services performed by a physician or qualified health professional (QHP) or by supervised clinical staff.

For 2022, new codes have been added to this group, some have been modified for clarity, and others have been tweaked to better match their Medicare G-code counterparts.

Peter Hollmann, MD, former chair of the CPT Editorial Panel, explained the history and nuances behind the codes during the CPT and RBRVS 2022 Annual Symposium. The event was held virtually due to the COVID-19 pandemic.

Medicare requires an initiating evaluation and management (E/M) visit before care-management activities can start as well as patient consent for work that will most likely be done outside of an in-person encounter.
“You have to assess the patient before you can determine that they need a care plan and before you create the care plan,” said Dr. Hollmann, who co-chaired an initiative involving an AMA-convened coalition of 170 state and medical specialty societies to produce E/M office-visit and outpatient documentation and coding reforms (PDF) that took effect in 2021.

Dr. Hollmann is a geriatrician and chief medical officer of the Brown Medicine faculty medical group, and also vice chair of the AMA/Specialty Society RVS Update Committee (RUC). Dr. Hollmann also co-chaired the Chronic Care Coordination Workgroup, also known as C3W, with Barbara Levy, MD, who was then the RUC chair and with whom he later co-chaired the E/M-reform workgroup.

This effort led the Centers for Medicare & Medicaid Services (CMS) to recognize payment for nonface-to-face activities. CMS would later accept CPT codes for transition-care management and complex chronic care coordination while also accepting the RUC-recommended values for those services.

CMS also began to support chronic care management services with a monthly payment in 2015.

**Getting specific**

Four PCM codes, which were developed with primary pediatric care in mind, took effect Jan. 1 and were included in the 2022 Medicare physician payment schedule.

The codes represent services focusing on the medical or psychological needs manifested by a single, complex chronic condition expected to last at least three months.

“The condition requires development, monitoring or revision of a disease-specific care plan,” Dr. Hollmann explained. Typically, the condition requires frequent adjustments to the medication regimen and ongoing communication and coordination between professionals furnishing care.

These codes are:

- **99424** for at least 30 minutes of physician or QHP time in care-management activities during a calendar month.
- **99425** is an add-on for **99424** for when at least another 30 minutes of physician or QHP time is spent on care management during the month.
- **99426** is for the first 30 minutes of clinical staff time spent in care management during the month.
- **99427** is an add-on for **99426**, when at least another 30 minutes of clinical staff time is spent in care management during the month.

A new CCM code, **99437**, designed as an add-on to **99491**, takes effect this year and supports an additional 30 minutes of physician or QHP time each month for patients with two or more chronic
conditions. Its use requires establishing, implementing, revising or monitoring a comprehensive plan.

Two new codes for outpatient pulmonary rehabilitation services—\texttt{94625} and \texttt{94626}—were also added this year.