ASCO
AMERICAN SOCIETY OF CLINICAL ONCOLOGY

Principal Care Management Services

For calendar year 2020, the Centers for Medicare and Medicaid Services (CMS) introduced two new HCPCS codes to describe care management services for a single, complex chronic condition. These codes differ from Chronic Care Management Services (CCM) which focus on the care of *two or more* chronic conditions.

A qualifying condition for Principal Care Management (PCM) services may be expected to last between three months to one year or until the death of the patient. The initiation of a PCM service will typically be triggered by an exacerbation of the patient's chronic condition or recent hospitalization.

The patient's primary care physician will still supervise the patient's overall care, but a specialist will manage services for the specific chronic condition.

CMS will be providing additional guidance on PCM codes throughout 2020. Questions related to coding and billing can be sent to ASCO at billingandcoding@asco.org.

HCPCS Code Descriptions

G2064- Comprehensive care management services for a single high-risk disease, e.g., Principal Care Management, at least 30 minutes of physician or other qualified health care professional time per calendar month with the following elements:

- One complex chronic condition lasting at least 3 months, which is the focus of the care plan,
- The condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization,
- The condition requires development or revision of disease-specific care plan,
- The condition requires frequent adjustments in the medication regimen, and/or
- The management of the condition is unusually complex due to comorbidities

G2065- Comprehensive care management for a single high-risk disease services, e.g. Principal Care Management, at least 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month with the following elements:

- One complex chronic condition lasting at least 3 months, which is the focus of the care plan,
- The condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization,
- The condition requires development or revision of disease-specific care plan,
- The condition requires frequent adjustments in the medication regimen, and/or
- The management of the condition is unusually complex due to comorbidities

Reporting Information

- In calendar year 2020, PCM services G2064 and G2065 are only reportable to Medicare and may not be accepted by private payers.
- PCM services should not be reported at the same time as Chronic Care Management services or Interprofessional Consultations.
- Patients may receive PCM services from more than one clinician for different conditions.

Reimbursement Information

In calendar year 2020, the reimbursement values for PCM services are as follows:

HCPCS Code	RVU	Facility Payment $	Non-Facility Payment $
G2064	1.28	$79	$92
G2065	0.61	$40	$40

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Principal Care Management Services Summary

☑ **Verbal Consent**

- 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.

☑ **Initiating Visit for New Patients (separately paid)**

☑ **Certified Electronic Health Record (EHR) Use**

- Structured Recording of Core Patient Information Using EHR (demographics, problem list, medications, allergies).

☑ **24/7 Access** ("On Call" Service)

☑ **Designated Care Team Member**

☑ **Disease Specific Care Management**

Disease Specific Care Management may include, as applicable:

- Systematic needs assessment (medical and psychosocial).
- Ensure receipt of preventive services.
- Medication reconciliation, management and oversight of self-management.

☑ **Disease Specific Electronic Care Plan**

- 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.

☑ **Management of Care Transitions/Referrals** (e.g., discharges, ED visit follow up, referrals, as applicable).

- Create/exchange continuity of care document(s) timely (format not prescribed).

☑ **Home- and Community-Based Care Coordination**

- Coordinate with any home- and community-based clinical service providers, and document communication with them regarding psychosocial needs and functional deficits, as applicable.

☑ **Enhanced Communication Opportunities**

- Offer asynchronous non-face-to-face methods other than telephone, such as secure email.

*All elements that are medically reasonable and necessary must be furnished during the month, but all elements do

Source: Centers for Medicare and Medicaid Services CY 2020 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies

TABLE 24: Principal Care Management Services Summary