

When patients have complex chronic conditions, it can be easy for a minor disruption in their care to cause a major setback. A few missed doses of medication or a cold picked up from a grandchild can quickly lead to ER visits and hospitalizations. Managing care between office visits helps patients get the care they need in the most appropriate setting. Specialists and their clinic teams can now provide this care using new reimbursable codes from Medicare.

Eligibility Requirements:

- Single high-risk or complex chronic condition, expected to last at least 3 months, or until the death of the patient
- Condition the cause of a recent hospitalization or increases the risk of hospitalization, acute exacerbation and decompensation, or functional decline
- Condition requires disease-specific care plan
- Management of the condition is complex due to comorbidities or frequent medication adjustments

Performing & Documenting Principal Care Management (PCM)

- Consent for services must include:
 - Notification of cost-sharing obligations
 - Only one practitioner may bill PCM per month
 - Patients may stop services at any time
- Documentation of verbal consent meets requirements
- New patients, or patients not seen within the past year, must have an initiating visit ; Initiating visits include
 - Hospital consultations
 - Face to face clinic visits
 - Telehealth visits
- Disease specific care management may include systematic needs assessments, planning and provision of preventive services, medication reconciliation and management, oversight of patient self-management, and other targeted interventions for the disease being managed

G2064 - Care management of single condition, provider only, 30 minutes monthly

G2065 - Care management of single condition, clinical staff time, 30 minutes monthly

G0511 - General care management in RHC/FQHC

30 minutes of provider or clinical team time can include time spent:

- Coordinating care with other providers or community services/resources
- Sharing and obtaining patient records
- Updating or checking progress against the care plan
- Performing assessments of barriers to care or self-management
- Addressing patient knowledge deficits
- Coaching patients in self-management plan and therapeutic lifestyle change
- Other activities between members of the care team that are dedicated to helping patients achieve care plan goals or coordinating the patient's care

- An electronic disease-specific care plan is required to be created and shared within and outside of the practice, including a copy shared with the patient/caregiver. Practices may share the care plan electronically including via fax
- Certified EHR Technology, 24/7 “On call” service, a designated care team member who serves as the patient’s main point of contact, home and community care coordination, management of care transitions/referrals, and enhanced communication option requirements are the same as those [required under Chronic Care Management](#).
- **G2064** requires 30 minutes of provider-only care management time, in a calendar month
- **G2065** requires 30 minutes of clinical staff time, operating under general supervision, in a calendar month

Care management services are often provided over the telephone, but interactions with patients or other members of the care team may also be face-to-face or via other secure methods, such as the patient portal.

Billing Tips

- **G2064** and **G2065** are not separately billable in Rural Health Clinics (RHC) or Federally Qualified Health Centers (FQHC). CMS guidance about billing G0511 when PCM requirements are met is unclear; check with your local MAC to determine coverage.
- **G2064** and **G2065** are intended for specialist use only; limited use in fee-for-service primary care settings may be appropriate when managing patients with a single serious medical condition
- PCM codes are not subject to the CPT time rule. When billing **G2064**, 30 minutes or more of provider-only care management should be documented in the chart. When billing **G2065**, 30 minutes or more of clinical team time, including provider time, should be documented in the chart.
- Depending on the needs of the patient, any enrolled patient may be billed for **G2064** or **G2065** from month to month, but these codes may not be billed in the same month by the same provider
- PCM may *not* be billed in the same month as Chronic Care Management and a provider may not bill PCM for two separate diseases
- PCM may be billed concurrently with Remote Patient Monitoring as long as the care management time is tracked separately and meets requirements for each service; it may be possible that PCM is billed concurrently by separate specialists focused on different complex chronic diseases (e.g. a cardiologist may bill PCM for managing heart failure in the same month that a nephrologist bills PCM for managing chronic kidney disease)
- PCM codes are not subject to the CPT time rule; the full 30 minutes of care management must be reached and documented each month
- During the National Public Health Emergency, providers [may waive cost sharing](#) for this service

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