The New CMS Navigation Reimbursement Billing Codes: A 101

Teri Bedard, BA, RT(R)(T)(ARRT), CPC
Revenue Cycle Coding Strategies

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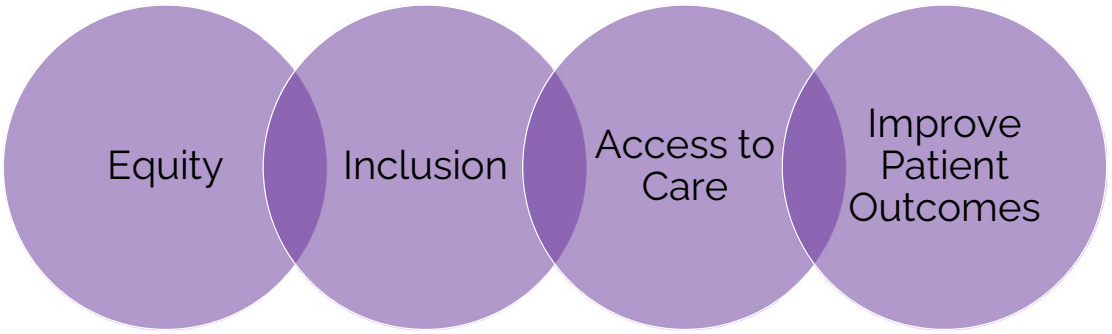
CMS Strategic Plan Pillars



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2024 – New Codes from Medicare

CHI	SDOH	PIN & PIN-PS

• Community Health Integration
  • G0019 and G0022
  • Practitioner must identify any SDOHs which significantly limit their ability to diagnose or treat the problem(s) addressed in the visit
	• Social Determinants of Health
	  • G0136
	  • Risk Assessment
	  • Provided no more than once every 6 months
	  • Include a large set of factors:
	  • Economic stability,
	  • Education access and quality,
	  • Healthcare access and quality,
	  • Neighborhood and build environment,
	  • Social and community context (factors such as housing, food, nutrition access, and transportation needs)
		• Principal Illness Navigation
		  • G0023 and G0024
		  • Cancer (& other serious, high-risk illnesses)
		• Principal Illness Navigation – Peer Support
		  • G0140 and G0146
		  • Behavioral health
		  • Provided by peer support specialists

3

Why Services Established

- Improve Payment Accuracy to Account for…
- Additional Resources and Time for Patients with Serious Illnesses
- Remove health-related social barriers interfering with practitioner's medically necessary care plan

4

CHI, SDOH and PIN Services

- Focus on equity in and access of care
- How do social determinants of health (SDOH) impact the ability to diagnose or treat the patient
- Trying to determine how to improve payment accuracy for additional time and resources
- Payment for many activities currently included in payment for other services
- Proposing to create new coding to identify & value from other services
- Better recognize Community Health Workers through coding and payment policy when part of multi-disciplinary team

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Staff Training

Must meet State requirements - Certification *or* Licensure

If no State requirements must be trained or certified in the following:

Patient and family communication, Interpersonal and relationship building, patient and family capacity-building, Service coordination and system navigation, Patient advocacy, facilitation, individual and community assessment, Professionalism and ethical conduct, and Development of an appropriate knowledge base, including local community-based resources

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G0136

Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment, 5-15 minutes, not more often than every 6 months

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Social Determinants of Health (SDOH)

01

1 New Code

G0136 – billable once/every 6 months

02

Risk Assessment

Part of comprehensive social history in relation to E/M visit (proposed for same date)

03

Specific Factors

Economic stability, Education access and quality, Healthcare access and quality, Neighborhood and building environment, Social and community context

04

Format

Standardized, evidence-based SDOH risk assessment tool tested and validated through research

05

Domains Included

Food insecurity, housing insecurity, transportation needs, and utility difficulties (providers may assess for additional domains as culturally pertinent to community)

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Requirements of SDOH Tool Examples

- CMS Accountable Health Communities (AHC) tool
- Protocol for Responding to & Assessing Patients' Assets
- Risks & Experiences (PREP ARE) tool
- Instruments identified for Medicare Advantage Special Needs Population Special Risk Assessment
- Per CMS – examples are non-exhaustive

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Code	Description

G0019	Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner; 60 minutes per calendar month, in the following activities to address social determinants of health (SDOH) need(s) that are significantly limiting the ability to diagnose or treat problem(s) addressed in an initiating visit:
	• Person-centered assessment, performed to better understand the individualized context of the intersection between the SDOH need(s) and the problem(s) addressed in the initiating visit.
	  o Conducting a person-centered assessment to understand patient's life story, strengths, needs, goals, preferences and desired outcomes, including understanding cultural and linguistic factors and including unmet SDOH needs (that are not separately billed).
	  o Facilitating patient-driven goal-setting and establishing an action plan.
	  o Providing tailored support to the patient as needed to accomplish the practitioner's treatment plan.
	• Practitioner, Home, and Community-Based Care Coordination
	  o Coordinating receipt of needed services from healthcare practitioners, providers, and facilities; and from home- and community-based service providers, social service providers, and caregiver (if applicable).
	  o Communication with practitioners, home- and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors.
	  o Coordination of care transitions between and among health care practitioners and settings, including transitions involving referral to other clinicians; follow-up after an emergency department visit; or follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities.
	  o Facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) to address the SDOH need(s).
	• Health education- Helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, and preferences, in the context of the SDOH need(s) and educating the patient on how to best participate in medical decision-making.
	• Building patient self-advocacy skills, so that the patient can interact with members of the health care team and related community-based services addressing the SDOH need(s), in ways that are more likely to promote personalized and effective diagnosis or treatment.
	• Health care access / health system navigation
	  o Helping the patient access healthcare, including identifying appropriate practitioners or providers for clinical care and helping secure appointments with them.
	• Facilitating behavioral change as necessary for meeting diagnosis and treatment goals, including promoting patient motivation to participate in care and reach person-centered diagnosis or treatment goals.
	• Facilitating and providing social and emotional support to help the patient cope with the problem(s) addressed in the initiating visit, the SDOH need(s), and adjust daily routines to better meet diagnosis and treatment goals.
	• Leveraging lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals.

G0022	Community health integration services, each additional 30 minutes per calendar month (List separately in addition to G0019)

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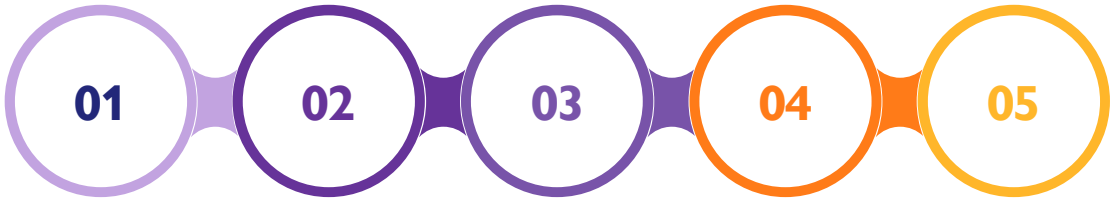
Community Health Interaction (CHI)



2 New Codes
G0019 and G0022

Auxiliary Staff
Certified or trained, provided incident to and under general supervision

Initiating Visit
Continued visits furnished monthly, as needed, following CHI initiating visit

Excluded Visits
Inpatient/observation, emergency department, or SNF

SDOH Identified
Practitioner identify SDOHs which significantly limit ability to diagnose or treat problem(s) addressed in visit

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Criteria for PIN Visits

1. One serious, high-risk condition expected to last at least 3 months and that places the patient at significant risk of hospitalization, nursing home placement, acute exacerbation/decompensation, functional decline, or death;

a. Examples of serious high-risk conditions/illness/disease include, but are not limited to, cancer, chronic obstructive pulmonary disease, congestive heart failure, dementia, HIV/AIDS, severe mental illness, and substance use disorder.

2. The condition requires development, monitoring, or revision of a disease specific care plan, and may require frequent adjustment in the medication or treatment regimen, or substantial assistance from a caregiver.

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Code	Description

G0023	Principal Illness Navigation services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator or certified peer specialist; 60 minutes per calendar month, in the following activities:
	• Person-centered assessment, performed to better understand the individual context of the serious, high-risk condition.
	  o Conducting a person-centered assessment to understand the patient's life story, strengths, needs, goals, preferences, and desired outcomes, including understanding cultural and linguistic factors and including unmet SDOH needs (that are not separately billed).
	  o Facilitating patient-driven goal setting and establishing an action plan.
	  o Providing tailored support as needed to accomplish the practitioner's treatment plan.
	• Identifying or referring patient (and caregiver or family, if applicable) to appropriate supportive services.
	• Practitioner, Home, and Community-Based Care Coordination
	  o Coordinating receipt of needed services from healthcare practitioners, providers, and facilities; home- and community-based service providers; and caregivers (if applicable).
	  o Communication with practitioners, home-, and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors.
	  o Coordination of care transitions between and among health care practitioners and settings, including transitions involving referral to other clinicians; follow-up after an emergency department visit; or follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities.
	  o Facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) as needed to address SDOH need(s).
	• Health education- Helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, preferences, and SDOH need(s), and educating the patient (and caregiver if applicable) on how to best participate in medical decision-making.
	• Building patient self-advocacy skills, so that the patient can interact with members of the health care team and related community-based services (as needed), in ways that are more likely to promote personalized and effective treatment of their condition.
	• Health care access / health system navigation.
	  o Helping the patient access healthcare, including identifying appropriate practitioners or providers for clinical care, and helping secure appointments with them.
	  o Providing the patient with information/resources to consider participation in clinical trials or clinical research as applicable.
	• Facilitating behavioral change as necessary for meeting diagnosis and treatment goals, including promoting patient motivation to participate in care and reach person-centered diagnosis or treatment goals.
	• Facilitating and providing social and emotional support to help the patient cope with the condition, SDOH need(s), and adjust daily routines to better meet diagnosis and treatment goals.
	• Leverage knowledge of the serious, high-risk condition and/or lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals.

G0024	Principal Illness Navigation services, additional 30 minutes per calendar month (List separately in addition to G0023)

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Principal Illness Navigation (PIN)

2 New Codes
G0023 and G0024

Individualized
Help to identify appropriate practitioners for care needs and support, timely access to care, especially when need is complex and delaying care can be deadly

Initiating Visit
Must address a serious high-risk condition/illness/disease

Continued Visits
Continued visits furnished monthly, as needed, following PIN initiating visit

Excluded Visits
Inpatient/observation, emergency department, or SNF

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Code	Description

G0140	Principal Illness Navigation – Peer Support by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a certified peer specialist; 60 minutes per calendar month, in the following activities:
	• Person-centered interview, performed to better understand the individual context of the serious, high-risk condition.
	  o Conducting a person-centered interview to understand the patient's life story, strengths, needs, goals, preferences, and desired outcomes, including understanding cultural and linguistic factors, and including unmet SDOH needs (that are not billed separately).
	  o Facilitating patient-driven goal setting and establishing an action plan.
	  o Providing tailored support as needed to accomplish the person-centered goals in the practitioner's treatment plan.
	• Identifying or referring patient (and caregiver or family, if applicable) to appropriate supportive services.
	• Practitioner, Home, and Community-Based Care Communication
	  o Assist the patient in communicating with their practitioners, home-, and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, goals, preferences, and desired outcomes, including cultural and linguistic factors.
	  o Facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) as needed to address SDOH need(s).
	• Health education—Helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, preferences, and SDOH need(s), and educating the patient (and caregiver if applicable) on how to best participate in medical decision-making.
	• Building patient self-advocacy skills, so that the patient can interact with members of the health care team and related community-based services (as needed), in ways that are more likely to promote personalized and effective treatment of their condition.
	• Developing and proposing strategies to help meet person-centered treatment goals and supporting the patient in using chosen strategies to reach person-centered treatment goals.
	• Facilitating and providing social and emotional support to help the patient cope with the condition, SDOH need(s), and adjust daily routines to better meet person-centered diagnosis and treatment goals.
	• Leverage knowledge of the serious, high-risk condition and/or lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals

G0146	Principal Illness Navigation – Peer Support, additional 30 minutes per calendar month (List separately in addition to G0140)

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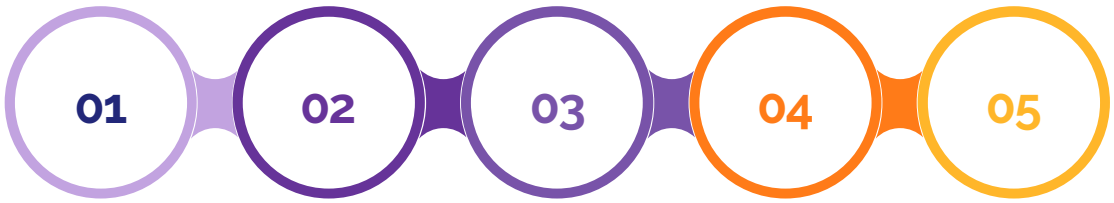
Principal Illness Navigation Peer Support



2 new codes
G0140 and G0146

Individualized
Help to identify appropriate practitioners for treatment of behavioral health conditions that satisfy the definitions of high-risk condition(s)

Initiating Visit
Must address a serious high-risk condition/illness/disease

Continued Visits
Continued visits furnished monthly, as needed, following PIN-PS initiating visit

Excluded Visits
Inpatient/observation, emergency department, or SNF

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Billing

Multiple Conditions

Cannot bill more than one PIN service per practitioner for same beneficiary

*if different practitioners are managing different serious, high-risk illnesses, it is possible the patient may have more than one set of PIN services (i.e., related to oncology and behavioral health services)

Additional Services

Can bill for PIN in addition to other care management services

-No duplication of services can occur

-Must be medically necessary for both

Billing Practitioner

Same practitioner must do initiating visit and manage the services

-Billed incident to the practitioner on claim

-Billable in nonfacility and facility settings

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AMA Care Management Codes

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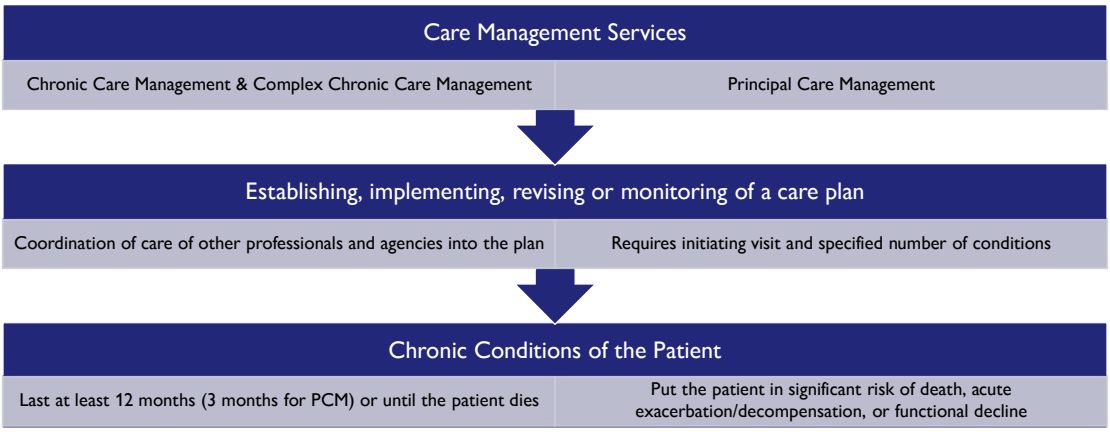
AMA Care Management Codes



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Chronic Care Management

Primary Codes – Initial Time

- 99490 & 99491
- Multiple (2 or more chronic conditions), more than 12 months
- Represent the initial time provided each month
- Require at least 20 or 30 minutes respectively, of staff time over course of one calendar month directed by a physician or other qualified health care professional carrying out the direction of the care plan.
- 99490 – staff provided time
- 99491 – physician or other qualified healthcare professional (QHP) provided time

Add-on Codes – Additional Time

- 99439 & 99437
- Only billable in addition to the primary code when conditions of the code are met as listed in definition
- +99439 – staff provided time
- +99437 – physician or other qualified healthcare professional (QHP) provided time

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Complex Chronic Care Management

Primary Code – Initial Time

- 99487
- Multiple (2 or more chronic conditions), more than 12 months
- Represent the initial time provided each month
- Require at least 60 minutes of clinical staff time over course of one calendar month directed by a physician or other qualified health care professional

Add-on Code – Additional Time

- +99489
- Only billable in addition to the primary code when conditions of the code are met as listed in definition – staff time each additional 30 minutes per calendar month

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Principal Care Management

Primary Code – Initial Time

- 99424 & 99426
- Single high-risk disease with one complex chronic condition, 3 months or more
- Represent the initial time provided each month
- Require at least 30 minutes of staff time over course of one calendar month directed by a physician or other qualified health care professional carrying out the direction of the care plan.
- 99424 – physician or other qualified healthcare professional (QHP) provided time
- 99426 – staff provided time

Add-on Code – Additional Time

- 99425 & 99427
- Only billable in addition to the primary code when conditions of the code are met as listed in definition
- +99425 – physician or other qualified healthcare professional (QHP) provided time
- +99427 – staff provided time

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Initiating Visit

Required when…	Types of initiating visits…	Discussion…	Excluded visits…
• Patient is a new patient or not seen by billing practitioner within a year prior to the beginning of the care management services	• Comprehensive E/M (99212-99205) • Annual Wellness Visit (AWV) • Initial Preventative Physical Exam (IPPE)	• Must discuss the care management services with the patient during the initiating visit or it does not count • Must obtain consent from patient prior to start of care management services	• Low level E/M visits able to be performed by staff, emergency department (ED), inpatient or observation, skilled nursing facility (SNF) • AWV by dietitian

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Laundry List for Care Plan

- A problem list (varies by service – disease specific vs. comprehensive),
- Expected outcome and prognosis,
- Measurable treatment goals,
- How symptoms will be managed, who is responsible for any planned interventions,
- Management of medication(s),
- Any ordered social services, and
- How any services provided by outside organizations will be coordinated and managed in support of the care plan

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PCM vs. PIN

Principal Care Management

- Single high-risk disease, with one complex chronic condition
- Expected to last at least 3 months
- Coordinating care outside physician's office to address clinical needs
- Clinically trained staff

Principal Illness Navigation

- Serious high-risk condition
- Expected to last at least 3 months
- Navigating socioeconomic conditions impacting access to care
- Clinically trained or lived experience staff

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Code Comparison

	Principal Care Management (99426)	Complex Chronic Care Management (99487)	Chronic Care Management (99490/99491)	CHI (G0019)	PIN (G0023)	PIN-PS (G0140)
Threshold Time (minutes)	30	60	20/30**	60	60	60
Expected Duration	At least 3 months	At least 12 months	At least 12 months	At least 3 months	At least 3 months	At least 3 months
Staff Type	Clinical Staff	Clinical Staff	Clinical Staff	Clinical Health Worker (CHW) certified or trained	Certified or trained Navigator	Peer support, State guidelines or SAMSHA*
Patient Conditions	Serious high-risk condition & 1 complex chronic condition	2 or more chronic conditions	2 or more chronic conditions	Social Determinants Of Health	1 Serious high-risk condition	Behavioral health condition
Care Plan	Disease specific	Comprehensive	Comprehensive	Address SDOH	Disease specific	Disease specific

*SAMSHA – Substance Abuse and Mental Health Services Administration
**20-minute threshold clinical staff time per month for CPT 99490, or 30-minute threshold physician/QHP time per month for CPT® 99491

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Medicare Rates and Patient Responsibility

Type of Visit	Initiating E/M Visit Required	Provided by Certified/Trained Auxiliary Staff	2024 MPFS Nonfacility Rate	2024 MPFS Facility Rate	2024 HOPPS Rate
Community Health Integration (CHI)	Yes	Yes	G0019 = $80.56 +G0022 = $50.26	G0019 = $49.60 +G0022 = $34.62	G0019 = $84.93 +G0022 = packaged
Social Determinants of Health (SDOH)	No	Yes	G0136 = $18.97	G0136 = $8.99	G0136 = $27.34
Principal Illness Navigation (PIN)	Yes	Yes	G0023 = $80.56 +G0024 = $50.26	G0023 = $49.60 +G0024 = $34.62	G0023 = $84.93 +G0024 = packaged
Principal Illness Navigation – Peer Support (PIN-PS)	Yes	Yes	G0140 = $79.24 +G0146 = $49.45	G0140 = $48.79 +G0146 = $34.05	G0140 = $84.93 +G0146 = packaged
Principal Care Management	Yes	Yes	99424 = $82.55 +99425 = $59.92 99426 = $61.91 +99427 = $47.27	99424 = $73.57 +99425 = $50.60 99426 = $48.93 +99427 = $34.29	99424 = N/A +99425 = N/A 99426 = $84.93 +99427 = packaged
Complex Chronic Care Management	Yes	Yes	99487 = $134.15 +99489 = $72.23	99487 = $89.21 +99489 = $49.60	99487 = $151.91 +99489 = packaged
Chronic Care Management	Yes	Yes	99490 = $62.58 +99439 = $47.93 99491 = $84.55 +99437 = $59.58	99490 = $49.60 +99439 = $34.62 99491 = $74.56 +99437 = $49.93	99490 = $84.93 +99439 = packaged 99491 = N/A +99437 = N/A

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CMS Focus of Efforts for Beneficiaries

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Join Us For A Deeper Dive!

August 6, 2024
Principal Illness Navigation (PIN) Services Documentation, Coding, and Billing

August 20, 2024
The 2023 American Medical Association (AMA) CPT® Coding Update for Oncology Navigation Services (ONS) and The Cancer Moonshot

September 5, 2024
Reviewing Community Health Integration (CHI), Social Determinants of Health (SDOH) Risk Assessment, Principal Illness Navigation-Peer Support (PIN-PS)

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References

1. American Medical Association. *AMA CPT Professional 2024*. American Medical Association Press; 2024.
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3. Centers for Medicare & Medicaid Services. Connected Care Toolkit Chronic Care Management Resources for Health Care Professionals and Communities, https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/connected-hcptoolkit.pdf

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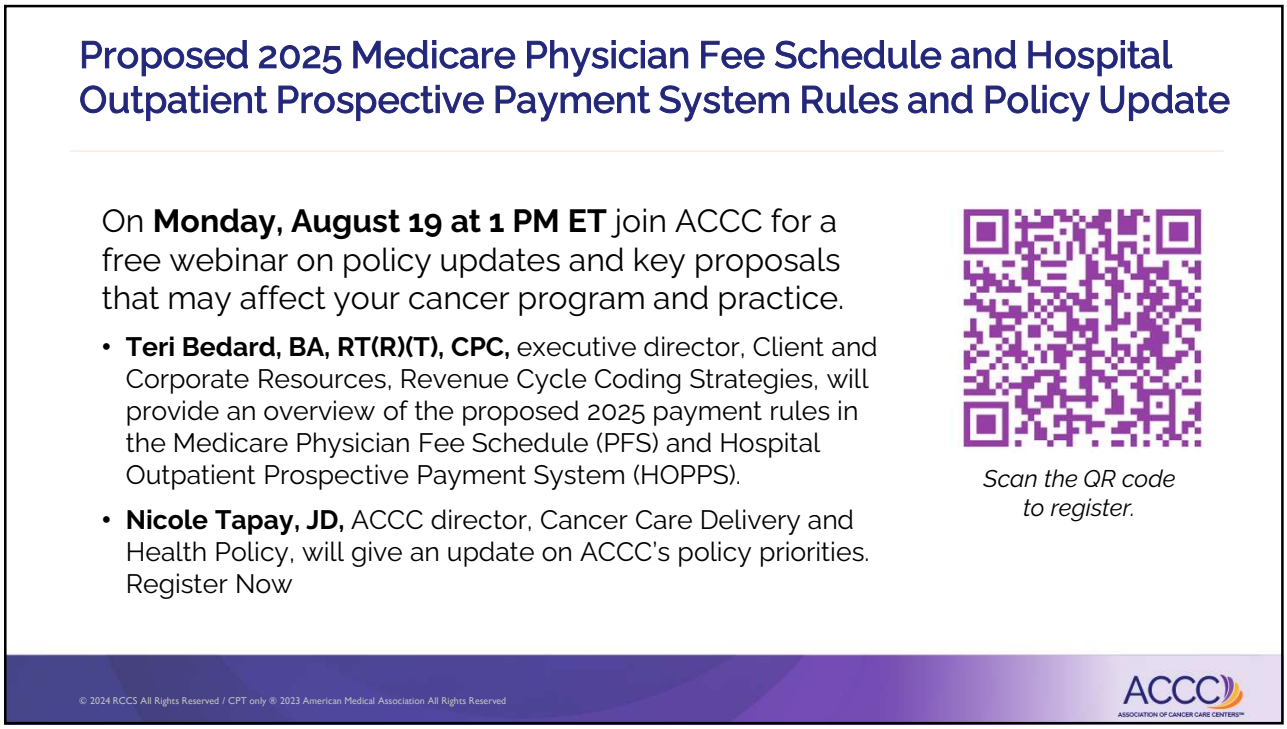
Proposed 2025 Medicare Physician Fee Schedule and Hospital Outpatient Prospective Payment System Rules and Policy Update
On **Monday, August 19 at 1 PM ET** join ACCC for a free webinar on policy updates and key proposals that may affect your cancer program and practice.
• **Teri Bedard, BA, RT(R)(T), CPC,** executive director, Client and Corporate Resources, Revenue Cycle Coding Strategies, will provide an overview of the proposed 2025 payment rules in the Medicare Physician Fee Schedule (PFS) and Hospital Outpatient Prospective Payment System (HOPPS).
• **Nicole Tapay, JD,** ACCC director, Cancer Care Delivery and Health Policy, will give an update on ACCC's policy priorities.
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PATIENT NAVIGATION in Cancer Care
NOC
ACCC 41ST NATIONAL ONCOLOGY CONFERENCE
REALIZING INNOVATION
October 9-11, 2024 • Minneapolis, MN
ACCC Financial Advocacy Network Pre-Conference
Wednesday, October 9
10:00 AM – 12:00 PM
Connect with fellow patient advocates as we discuss the ever-changing field of financial navigation and identify solutions for delivering comprehensive financial advocacy services in your cancer program or practice.
ACS-AONN+ Navigation Pre-Conference: Building Sustainable Navigation
Wednesday, October 9
1:00 PM – 5:00 PM
Explore the key components of a business case for navigation and resources that participants can leverage, including a toolkit and templates developed specifically for navigation.
Innovation In Navigation: An Early Phase Clinical Trial Nurse Navigator
Friday, October 11
2:30 PM – 3:00 PM
Discover how Sanford Cancer Center in Sioux Falls, South Dakota, has expanded its program with the support of a dedicated Early Phase Clinical Trial Nurse Navigator who works closely with patients to remove barriers, educate patients and families, and round with patients in the inpatient and outpatient setting.

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ACCC is a community of cancer centers

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ACCC is a multidisciplinary association

Representing 40,000+ practitioners from clinicians to researchers, hospital executives, administrators, advanced practitioners, financial advocates, supportive care staff, and more.

*ACCC has changed its name in 2024 from "Association of Community Cancer Centers" to the "Association of Cancer Care Centers." The change is a step forward to better align with the dynamic landscape of cancer care, while assuring our members, stakeholders, and the broader community that the values and principles we stand for remain unchanged.

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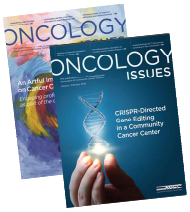

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