Principal Illness Navigation (PIN) Services Documentation, Coding, and Billing for Oncology Providers and Administrators

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Revenue Cycle Coding Strategies
August 6, 2024

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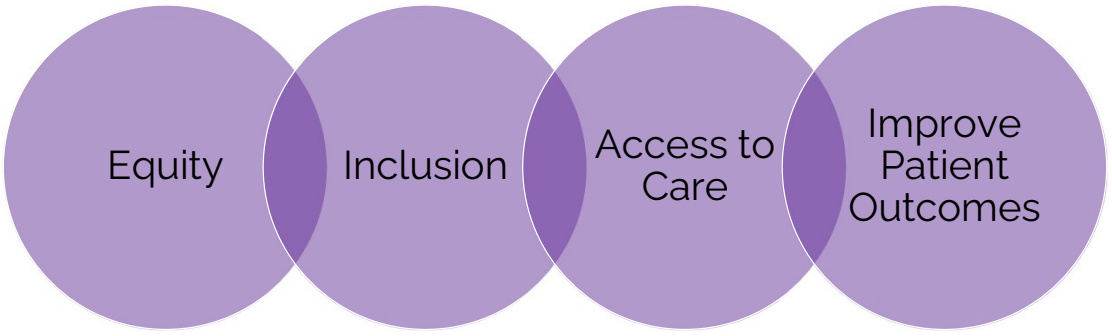
CMS Strategic Plan Pillars



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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

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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

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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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Defining Navigation

"…the process or activity of ascertaining one's position and planning and following a route; the act of directing from one place to another; the skill or process of plotting a route and directing; the act, activity, or process of finding the way to get to a place you are traveling. In the context of healthcare, it refers to providing individualized help to the patient (and caregiver, if applicable) to identify appropriate practitioners and providers for care needs and support, and access necessary care timely, especially when the landscape is complex and delaying care can be deadly."

-CY 2024 Medicare Physician Fee Schedule Final Rule

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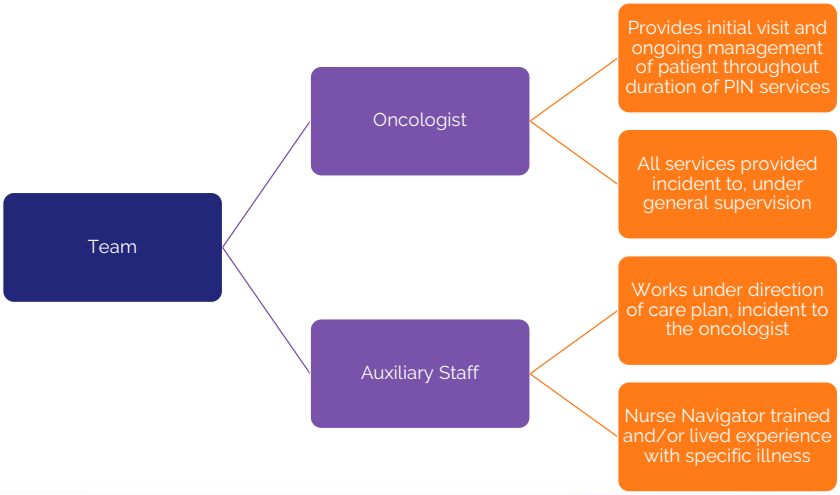
Staffing



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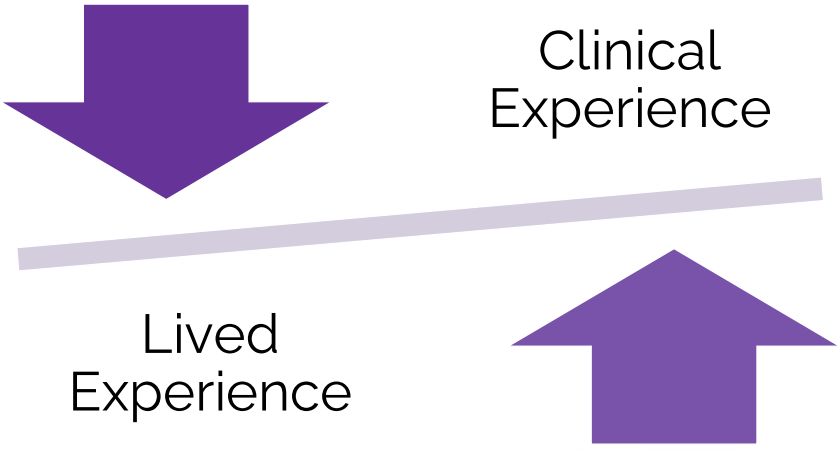
Differing Auxiliary Staff Experiences



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Clinical Experience

Services

- Advance care planning services (CPT codes 99497 -99498)
- Chronic care management services (CPT codes 99490, 99439, 99491, 99437, 99487 and 99489)
- General behavioral health integration care management services (CPT code 99484)
- Home health and hospice supervision (HCPCS codes G0181-G0182)
- Monthly ESRD-related services (CPT codes 90951-90970)
- Principal care management services (CPT codes 99424-99427)
- Psychiatric collaborative care management services (CPT codes 99492- 99494)
- Transitional care management services (CPT codes 99495-99496).

What is different

- May include aspects of navigation services, but heavy focus on clinical aspects of care rather than social aspects
- Auxiliary staff performing services may have little to no lived experience or training in the specific disease or illness
- Gaps in coding and payment for treatment of serious illness not encompassed by current care management services

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Auxiliary Staff Training

Hours of Training	State Regulations	CMS Competency Training
• No set required number of training hours required by CMS • If State requirements identify number of hours to complete training, must abide by State regulations	• Adhere to State regulations for certification and/or licensure • If no applicable requirements, follow CMS competency requirements	• Patient and family communication • Interpersonal and relationship-building • Patient and family capacity building • Service coordination and systems navigation • Patient advocacy, facilitation, individual and community assessment • Professionalism and ethical conduct • Development of an appropriate knowledge base, including specific certification or training on the serious, high-risk condition, illness, or disease being addressed,

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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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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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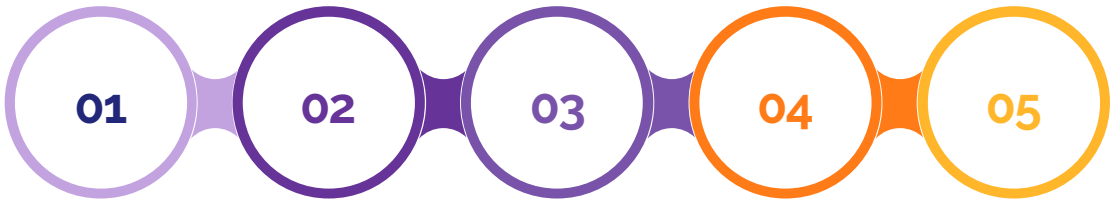
Principal Illness Navigation Peer Support



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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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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PIN-PS Personnel Training

State Regulations

- Adhere to State regulations for certification and/or licensure
- If no applicable requirements, must be trained using the National Model Standards for Peer Support Certification published by the Substance Abuse Mental Health Services Administration (SAMHSA).
- https://www.samhsa.gov/about-us/who-we-are/offices-centers/or/model-standards

SAMSHA Recommended Standards

- 40-60 hours mental health, substance abuse and family peer certifications
- Incorporate accommodations of Diversity, Equity, Inclusion, and Accessibility
- Ensure certified peer workers with relevant lived experience play a leading role in the in the design, application, and revision of peer certification trainings, and state certification entities utilize a clear and transparent process for procuring new training organizations.
- Include principles outlined in SAMHSA's Core Competencies

Core Content Areas (portion of list)

- Role, scope, and purpose of the peer (mental health, substance use, integrated, or family)
- Self-help/mutual-support groups
- Community resources (e.g., social, prevention, education, employment)
- Legal systems and resources
- Ethics
- Harm reduction (including suicide and overdose prevention)
- Communication, language, and group skills (e.g., peer-to-peer engagement, storytelling)
- Trauma-responsive approaches
- https://store.samhsa.gov/sites/default/files/pep23-10-01-001.pdf

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Breaking it Down

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Initiating Visit by Billing Practitioner

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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E/M Code Selection

Time

Medical Decision Making

The extent of history and physical examination is not an element in code selection

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Disease Specific Care Plan

- A problem list,
- 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 specific services (person-centered assessment, health education, etc.), and
- How any services provided by outside organizations will be coordinated and managed in support of the care plan

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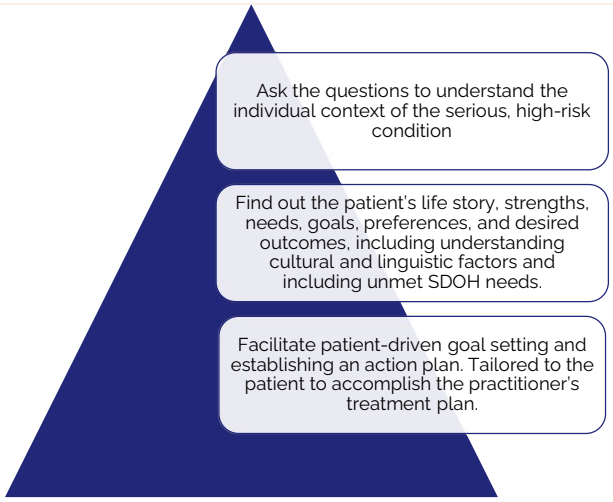
Person-Centered Assessment



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Coordinating Care

Identify or refer to appropriate supportive services

Practitioner, Home, and Community-Based Care Coordination

Coordinating receipt of needed services from healthcare practitioners, providers, and facilities – in the home and/or community based

Communication with team (practitioners, home, other healthcare settings) about patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors

Facilitate access to community-based social services (e.g., housing, utilities, transportation, food assistance) as needed to address SDOH need(s)

Coordinate transition and/or referral of care between the team of health care practitioners and settings; follow-up after any ED visit, facility discharges

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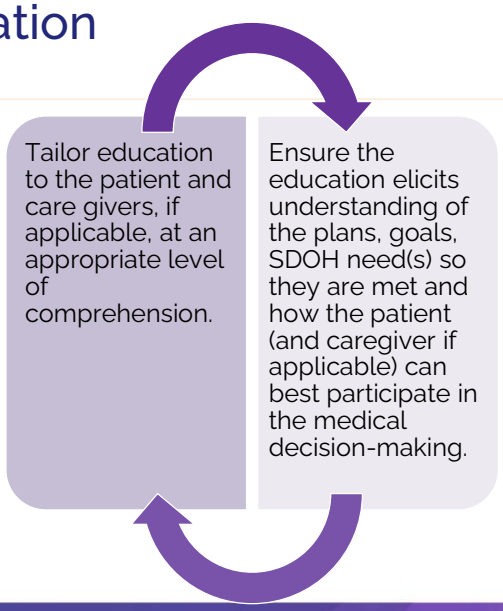
Health Education



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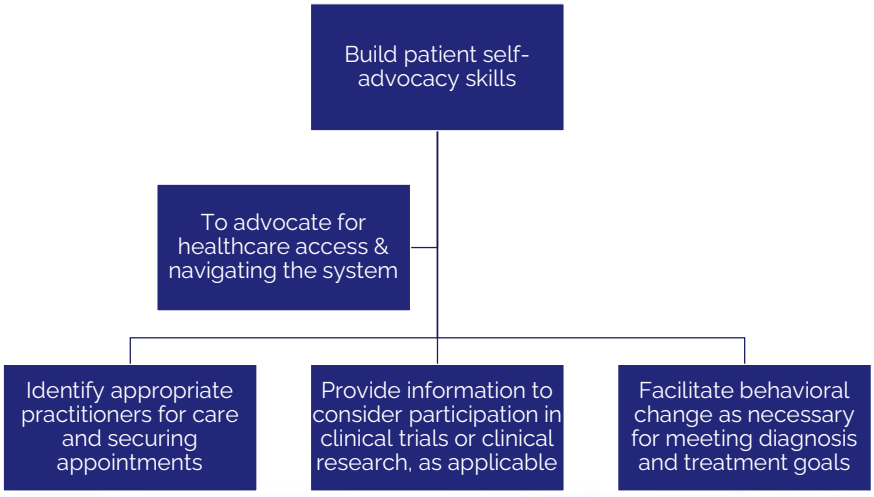
Self-Advocacy



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Social and Emotional Support

- Find ways to help the patient cope with the condition
- Address and manage SDOH need(s)
- Adjust their daily routines to better meet diagnosis and treatment goals

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Mentorship

Auxiliary Personnel

Make it personal – if you can – leverage your personal knowledge of the serious, high-risk condition and/or lived experience when applicable

Provide support, mentorship, or inspiration for the patient to meet their treatment goals

Patient

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Clarification

Based on Clinical Judgement of the Physician

Less than 60 minutes per month by auxiliary staff, other care management services may be better suited

PIN services expected to necessitate care over the course of several months

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Lack of Clinical Diagnosis Example

Abdomen CT identifies mass in colon → Regardless of diagnosis, could be life threatening colon cancer → Clinical judgement determines high-risk for patient → PIN services furnished as early part of treatment plan

A definitive diagnosis is not required before the practitioner makes a clinical determination that the patient has a serious high-risk condition.

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Distinguishing PIN from Other Services

Parallel Services

-Parallel to Community Health Integration (CHI) Services established by Medicare for CY 2024

Focus

-Patients with a serious, high-risk illness, but may not have Social Determinants Of Health (SDOH) needs impacting access etc.

Additional Elements

-Identifying and referring to appropriate supportive services

-Providing information/resources to consider participation in clinical research/clinical trials

-Inclusion of auxiliary personally with lived experience or training in the specific condition being addressed

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Patient Consent

Written or verbal consent is required for PIN services and must be documented in medical record

Must be obtained annually or if billing practitioner changes, and can be obtained by auxiliary staff before or at same time as beginning PIN services

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Documentation

- Describe the interventions and PIN service elements performed by auxiliary staff - TRACK YOUR TIME!
- Describe the medical necessity of PIN services to the principal illness
- Unmet SDOH needs are being addressed – must be documented in medical record and may be documented using associated ICD-10-CM Z-code (Z55-Z65)
- Auxiliary staff providing PIN services to communicate regularly with billing practitioner to provide management of services
- Describe the ongoing need or changes to the treatment plan that allow for the cessation of PIN services
- Regardless of who did the work throughout the month the billing practitioner is responsible for ensuring appropriate documentation of the PIN services provided to the patient is included in the medical record

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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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Billing PIN and Other Care Management Codes

CMS.gov

Can CHI and PIN be billed with other care management codes?

a. Care management services are focused heavily on clinical aspects of care rather than social circumstances that impact clinical care and are generally performed by auxiliary personnel who may not have lived experience or training in the specific illness being addressed. You can furnish CHI services in addition to other care management services if you don't count time and effort more than once, you meet the requirements to bill the other care management services, and the services are reasonable and necessary.

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Limits to Billing PIN Services

CMS.gov

Are there limits on how often I can bill PIN?

a. PIN services cannot be provided more than once per practitioner per month for any single serious high-risk condition, to avoid duplication of PIN service elements when utilizing the same navigator or billing practitioner. PIN and Principal Illness Navigation—Peer Support (PIN–PS) should not be billed concurrently for the same serious, high-risk condition. Beneficiaries can receive more than one PIN service at a time, as long as the services are not treating the same condition or furnished by the same practitioner.

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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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CMS Focus of Efforts for Beneficiaries

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References

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Join Us For A Deeper Dive!

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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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. Register Now

Scan the QR code to register.

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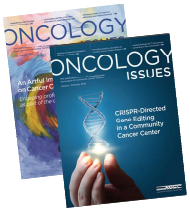

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Leading education and advocacy for the cancer care community

ACCC translates clinical findings into "how-to" action

Designing quality and process improvement programs to help the cancer team accelerate the integration of effective practices, guidelines, new treatment paradigms, and technical solutions into practice.

ACCC is a community of cancer centers

Representing more than 1,700 private practices, hospital-based cancer programs, large healthcare systems, and major academic centers across the country.

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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