ACCC 2023

Oncology Reimbursement MEETINGS

Coding and Billing for Chronic Care Management Services

Association of Community Cancer Centers

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Revenue Cycle Coding Strategies

Agenda

ACCC 2023 Oncology Reimbursement MEETINGS

- Defining Chronic Care Management
- Available CPT® Codes
- New HCPCS Codes for 2024
- Q&A

Defining Chronic Care Management

Association of Community Cancer Centers

Acronyms

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- AMA – American Medical Association
- CPT® - Current Procedural Terminology
- CMS – Centers for Medicare and Medicaid Services
- HCPCS – Healthcare Common Procedure Coding System
- MPFS – Medicare Physician Fee Schedule
- WPS - Wisconsin Physician Services
- CCM - Chronic Care Management
- CCCM - Complex Chronic Care Management
- SNF – Skilled Nursing Facility
- RHC - Rural Health Clinics
- FQHC - Federally Qualified Health Centers
- HOPD – Hospital Outpatient Department
- NPPs – Non-Physician Practitioners
- NP – Nurse Practitioner
- PA – Physician Assistant
- CHW - Community Health Worker
- E/M – Evaluation and Management
- CHI – Community Health Integration
- SDOH – Social Determinants of Health
- PIN – Principal Illness Navigation

What is Chronic Care Management?

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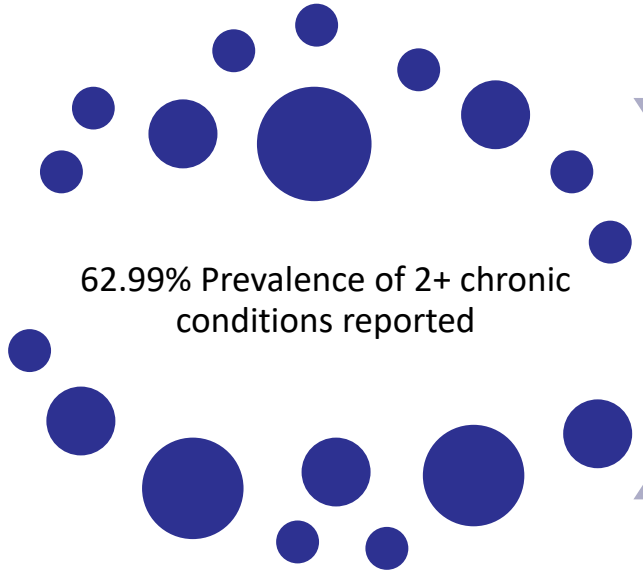
Care Management Services	
Chronic Care Management	Complex Chronic Care Management

Establishing, implementing, revising or monitoring of a care plan	
Coordination of care of other professionals and agencies into the plan	Patients must have 2 or more continuous or episodic chronic health conditions

Chronic Conditions of the Patient	
Last at least 12 months or until the patient dies	Put the patient in significant risk of death, acute exacerbation/decompensation, or functional decline

Prevalence of Chronic Conditions



62.99% Prevalence of 2+ chronic conditions reported

Oncologists managing more than response to treatment

Hematology/Oncology reported 0.1 – 1.1% of the 2021 claims for chronic care management

2021 claims data for WPS covering 6 states

As constant provider oncologists also may be asked to manage chronic conditions, some severe

Work is being done, but not captured/billed for multiple reasons

Why Are Services Not Being Billed?

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- Administrative guidelines for documentation
- Added co-pays for patients
- Reward not worth the work
- Lack of understanding the available codes
- Not aware separate codes exist

Why CCM?

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Providers

- Payment for the work
- More cohesive care
- Utilizing skills of clinical staff

Patients

- Integrated approach to care – holistic, proactive, strengths-based
- Fewer ER visits and/or hospital stays
- Potentially lower out-of-pocket costs

Implementation

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Start with small subset of most ill patients

Establish core group of providers

Build resources, toolkits, referral sources, partners for nutrition, transportation, etc.

Qualifying to Provide Services

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Practitioners

- Physicians
- Non-Physician Practitioners (NPPs)

Sites of Service

- Rural Health Clinics (RHC)
- Federally Qualified Health Center (FQHC)
- Hospital Outpatient Department (HOPD)
- Physician Office/Freestanding Center

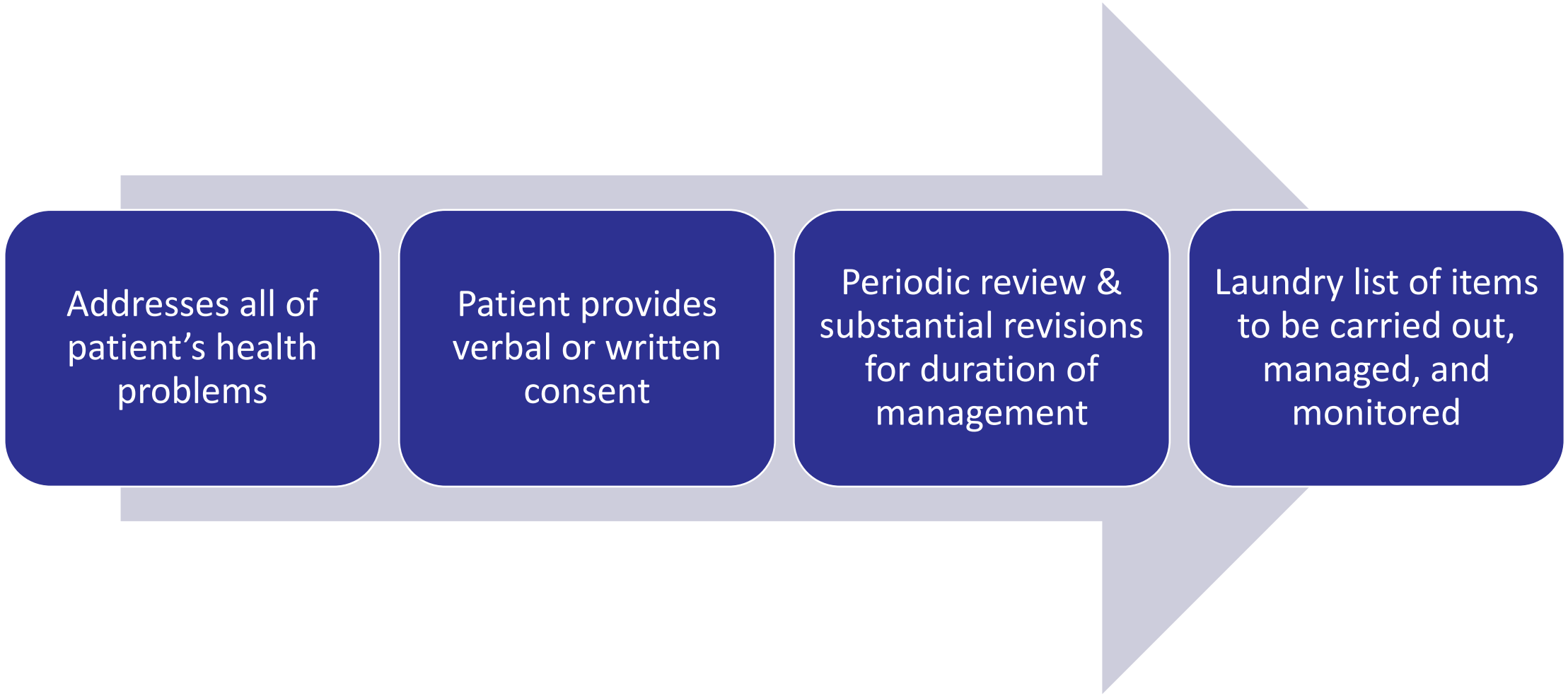
Clinical Staff

- Services provided incident to
- Under **General** Supervision

Available CPT® Codes for Chronic Care Management

Association of Community Cancer Centers

Care Plan Development



Must be Capable to do the Following

Per AMA CPT® Manual

1. Provide 24/7 access to physicians or other qualified health care professionals or clinical staff including providing patients/caregivers with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of the week;
2. Provide continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments. Provide timely access and management for the follow-up after an emergency department visit or facility discharge;
3. Provide timely access and management for follow-up after an emergency department visit or facility discharge;
4. Utilize an electronic health record system for timely access to clinical information;
5. Be able to engage and educate patients and caregivers as well as coordinate and integrate care amount all service professionals, as appropriate for each patient;
6. Reporting physician or other qualified health care professional oversees activities of the care team;
7. All care team members providing services are clinically integrated.

Laundry List for 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 social services, and
- How any services provided by outside organizations will be coordinated and managed in support of the care plan

Chronic Care Management Code Structure

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Primary Codes – Initial Time

- 99490 & 99491
- 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
- Add-on codes
- 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

Physician or Other QHP CCM

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CPT® code	Definition
99491	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 30 minutes **provided personally by a physician or other qualified health care professional**, per calendar month
+99437	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; each additional 30 minutes **by a physician or other qualified health care professional**, per calendar month (List separately in addition to code for primary procedure)

Clinical Staff Directed CCM

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CPT® code	Definition
99490	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 20 minutes **of clinical staff time** directed by a physician or other qualified health care professional, per calendar month
+99439	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; each additional 20 minutes **of clinical staff time** directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)

Complex Chronic Care Management Code Structure

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Primary Code – Initial Time

- 99487
- 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
- Add-on code
- 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

Complex Chronic Care Management (CCCM)

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CPT® code	Definition
99487	Complex chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored, moderate or high complexity medical decision making; first 60 minutes of **clinical staff time directed by a physician or other qualified health care professional**, per calendar month
+99489	Complex chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored, moderate or high complexity medical decision making; each additional 30 minutes of **clinical staff time directed by a physician or other qualified health care professional**, per calendar month (List separately in addition to code for primary procedure)

Care Management Services Coding Examples

Chronic Care Management (CCM)

Unit Duration (Time Spent)	Staff Type	Code & Unit Max per Month
Less than 20 minutes	Clinical staff	Not separately reported
20-39 minutes	Clinical staff	99490 x 1
40-59 minutes	Clinical staff	99490 x 1 and 99439 x 1
60 or more minutes	Clinical staff	99490 x 1 and 99439 x 2
Less than 30 minutes	Physician or other qualified healthcare professional	Not separately reported
30-59 minutes	Physician or other qualified healthcare professional	99491 x 1
60-89 minutes	Physician or other qualified healthcare professional	99491 x 1 and 99437 x 1
90 minutes or more	Physician or other qualified healthcare professional	99491 x 1 and 99437 x 2

Complex Chronic Care Management (CCCM)

Less than 60 minutes	Not separately reported
60-89 minutes	99487 x 1
90-119 minutes	99487 x 1 and 99489 x 1
120 minutes or more	99487 x 1 and 99489 x 2 and 99489 for each additional 30 minutes

Medicare Differences

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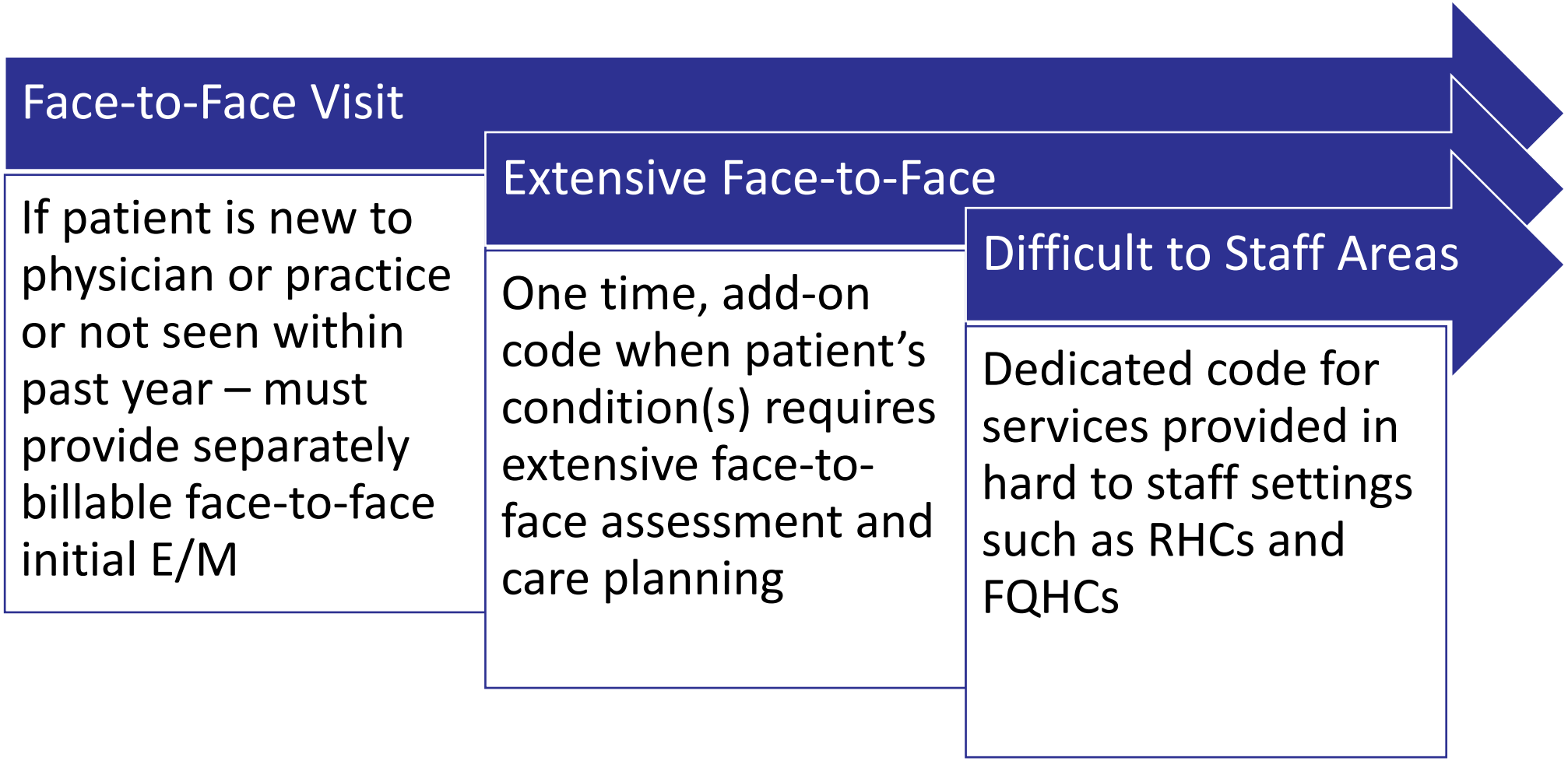

Medicare HCPCS Codes

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CPT® code	Definition
G0506	Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service)
G0511	Rural health clinic or federally qualified health center (RHC or FQHC) only, general care management, 20 minutes or more of clinical staff time for chronic care management services or behavioral health integration services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM), per calendar month

- HCPCS G0506 is not billable in RHCs or FQHCs.
- HCPCS G0511 is paid the non-facility rate of MPFS
- CMS toolkit – 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

Applying in the Real World

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55-year-old male diagnosed with base of tongue cancer, has a history of and mentions current substance abuse while also on medication for depression. They are currently employed in custodial services department of nearby school, they have an aunt who lives in the area, but she lives in a nursing home with dementia, they may have some assistance from friends from time-to-time but are unsure how they will manage everything.

A care plan begins to manage the following 3 chronic conditions

- Cancer
- Depression
- Substance Abuse

Assessing Needs of the Patient

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Questions asked during the visit

What does the patient feel are their immediate needs?
Will they or do they plan to work while undergoing treatment?
Before they were diagnosed with cancer were they experiencing any financial difficulties that may increase if they are not able to work or must reduce work?
What causes them stress and/or how do they manage stress and or factors related to their depression?
Do they have any concerns related to their home environment or health, anything regarding their substance abuse?
Do they understand everything discussed and explained about their cancer, how it will be treated and the potential side effects?

Identified Immediate Needs

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Patient does not understand what side effects of treatment will be, confused about ability to work

Do not have regular dentist, not sure what insurance covers and if the dentist would know how to manage them

Home is paid off, passed to them after mom died 2 years ago, still dealing with grief and drink alcohol to numb – want to try 12-step program but hesitant to go not sure what to expect

Dealing with stress means just doing whatever needs to be done. They eat when they feel like it but have been losing weight last year due to cancer and depression

Patient's Care Plan

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Learning Materials
Explaining head and neck cancer, chemotherapy and radiation treatments are specifically selected and personally reviewed with the patient to explain the process and "what to expect"

Dentist
An appointment is made with a local dentist who is in network and familiar with head and neck cancer patients preparing for radiation treatments

12-Step Program
The clinic has a staff member who actively attends alcoholics anonymous (AA) and spends some time with the patient explaining how it works and setups to attend a meeting that evening together

Nutrition
Local business has pre-made meals, minimal cooking and tailored to dietary needs. Patient is set up with a few vouchers to try out. Patient has a food log they will complete weekly to monitor nutrition

A clinical staff member meets with patient and documents in the medical record over the month. As a time-based service documentation must include time spent, even when non-face-to-face, to appropriately bill.

New HCPCS Codes for 2024

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CMS Focus of Efforts for Beneficiaries

Gaps in Care Management and Primary Care

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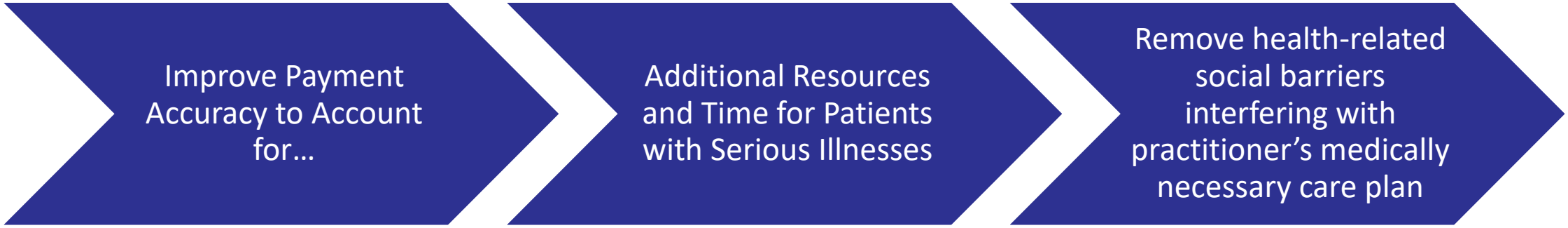

CMS Pillars


Equity
Improve Patient Outcomes
Strategic Plan
Inclusion
Access to Care

New Codes CHI, SDOH and PIN/PIN-PS Services

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Focus on equity in and access of care

How 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

New coding to identify & value from other services

Better recognize Community Health Workers through coding and payment policy when part of multi-disciplinary team

Community Health Integration (CHI)

- 2 new G codes, G0019 and G0022
- Only one practitioner will bill CHI; there is only one initiating visit
- Initiating visit can be an E/M, except CPT® 99211, performed by the billing practitioner who also furnishes the CHI services during the subsequent calendar month(s).
- E/M visits furnished as part of transitional care management (TCM) or an annual wellness visit (AWV) can qualify
- CHI services performed by certified or trained auxiliary personnel, (i.e., community health worker (CHW)) who can perform all included service elements, incident to and under general supervision
- Patient consent (written or verbal) is required – can be obtained by auxiliary personnel, maintained in medical record
    - Any changes in billing practitioner new consent must be obtained
- Practitioner must identify any SDOHs which significantly limit their ability to diagnose or treat the problem(s) addressed in the visit
- Excluded for inpatient, observation, emergency dept., or SNF visit – ongoing care is not provided

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.
    - 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).
    - Facilitating patient-driven goal-setting and establishing an action plan.
    - Providing tailored support to the patient as needed to accomplish the practitioner's treatment plan.
- Practitioner, Home-, and Community-Based Care Coordination
    - 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).
    - 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.
    - 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.
    - 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
    - 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)

Social Determinants of Health (SDOH)

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- 1 new code, G0136
- Risk assessment does not need to be completed on the same date as the associated E/M or behavioral health visit.
  - CMS does not believe this assessment will be provided in advance of the associated E/M visit
- Provided no more than once every 6 months
  - Not intended for routine screening for SDOH at standard intervals or every visit
- Time spent conducting SDOH risk assessment can count towards monthly 60 minutes for CHI and PIN services
- 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)

SDOH Requirements

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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

CMS required elements of the risk assessment to include:

- Administration of any standardized, evidence based SDOH risk assessment tool
  - Must be tested and validated through research, include the domains of food insecurity, housing insecurity, transportation needs, and utility difficulties.
  - Billing practitioners may choose to assess for additional domains beyond those listed if there are other prevalent or culturally salient social determinants in the community being treated by the practitioner
- The assessment can be furnished with hospital discharge visits and billed in outpatient settings.
- CMS encourages use of ICD-10-CM Z codes specific to SDOH, not required, to better understand patient populations enrolled in CMS programs
- Can be provided in-person, audio/video capabilities, or audio-only – permanently added to telehealth list

Principal Illness Navigation (PIN) & (PIN-PS)

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Principal Illness Navigation (PIN)

- G0023 & G0024
- Auxiliary staff trained and certified to follow State requirements to provide PIN services. States without requirements, CMS established competencies
  - Including specific certification or training on the serious, high-risk condition/illness/disease addressed in the initiating visit

Principal Illness Navigation Peer Support (PIN-PS)

- G0140 & G0146
  - Created after proposed rule comments – pulled from PIN codes
- Provided by peer support specialists
- Codes are limited to treatment of behavioral health conditions that satisfy the definitions of high-risk condition(s)
- Auxiliary staff providing services must be trained and certified in all parts of code descriptors
  - If no State requirements, training must be consistent with National Model Standards for Peer Support Certification published by SAMHSA

PIN & PIN-PS Guidelines

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- Established to individualize help the patient identifying 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
- PIN and PIN-PS ***should not*** be billed concurrently for the same serious, high-risk condition
- Practitioners furnishing PIN services may bill care management services as appropriate for managing and treating a patient's illness
- Services provided under general supervision following initiating E/M visit addressing a serious high-risk condition/illness/disease
- Excluded for inpatient, observation, emergency dept., or SNF visit – ongoing care is not provided
- Patient consent (written or verbal) is required – can be obtained by auxiliary personnel, maintained in medical record
    - Any changes in billing practitioner new consent must be obtained
- No duration limit, but new initiating visit must be conducted once per year
- No frequency limit established for add-on codes G0024 & G0146, CMS to monitor utilization

Criteria for PIN Visits

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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.

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.
    - 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).
    - Facilitating patient-driven goal setting and establishing an action plan.
    - 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
    - Coordinating receipt of needed services from healthcare practitioners, providers, and facilities; home- and community-based service providers; and caregivers (if applicable).
    - 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.
    - 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.
    - 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.
    - Helping the patient access healthcare, including identifying appropriate practitioners or providers for clinical care, and helping secure appointments with them.
    - 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)

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.
    - 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).
    - Facilitating patient-driven goal setting and establishing an action plan.
    - 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
    - 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.
    - 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)

CHI, SDOH, and PIN/PIN-PS Highlights

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Type of Visit	Excluded When Patient Visit is...	Initiating E/M Visit Required	Provided by Certified/Trained Auxiliary Staff (Incident to and under General Supervision)	CMS Approved Telehealth Service	2024 Nonfacility Rate	2024 Facility Rate
Community Health Integration (CHI)	Inpatient/observation, emergency department (ED), or SNF	Yes	Yes	No	G0019 = $79.24 G0022 = $49.44	G0019 = $48.79 G0022 = $34.05
Social Determinants of Health (SDOH)	-	No	Yes	Yes	G0136 = $18.66	G0136 = $8.84
Principal Illness Navigation (PIN)	Inpatient/observation, emergency department (ED), or SNF	Yes	Yes	No	G0023 = $79.24 G0024 = $49.44	G0023 = $48.79 G0024 = $34.05
Principal Illness Navigation – Peer Support (PIN-PS)	Inpatient/observation, emergency department (ED), or SNF	Yes	Yes	No	G0140 = $79.24 G0146 = $49.45	G0140 = $48.79 G0146 = $34.05

References

1. American Medical Association. *AMA CPT Professional 2023*. American Medical Association Press; 2023.
2. Wisconsin Physician Services Government Health Administrators, Michigan Society of Hematology and Oncology, 2023, Chronic Care Management
3. Medicare and Medicaid Programs: Calendar Year 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; etc., https://www.federalregister.gov/public-inspection/2023-24184/medicare-and-medicaid-programs-calendar-year-2024-payment-policies-under-the-physician-fee-schedule
4. 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

Questions?

Association of Community Cancer Centers

THANK YOU FOR YOUR PARTICIPATION!

Association of Community Cancer Centers