Navigation Support: Coding and Billing Updates

VAHO

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Presenter

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Why PIN 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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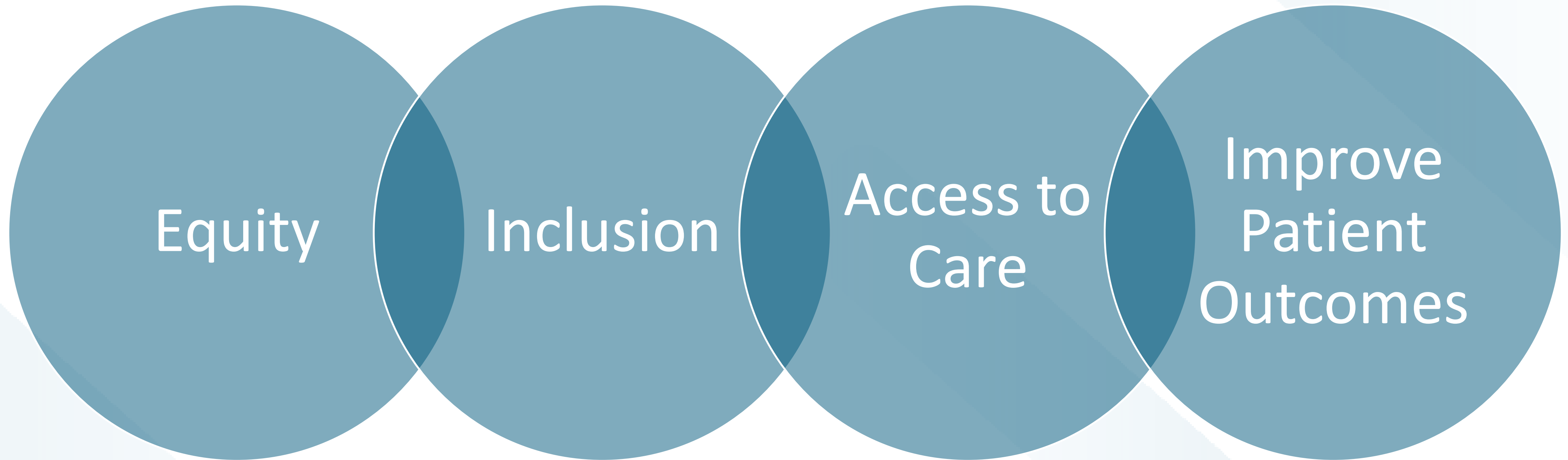
CMS Strategic Plan Pillars



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New Codes from Medicare

CHI

- 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

SDOH

- 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)

PIN & PIN-PS

- 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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Principal Illness Navigation (PIN) Codes

Focus on equity in and access of care

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

Provided incident to, limited only to nonfacility settings even though Medicare has RVUs in facility

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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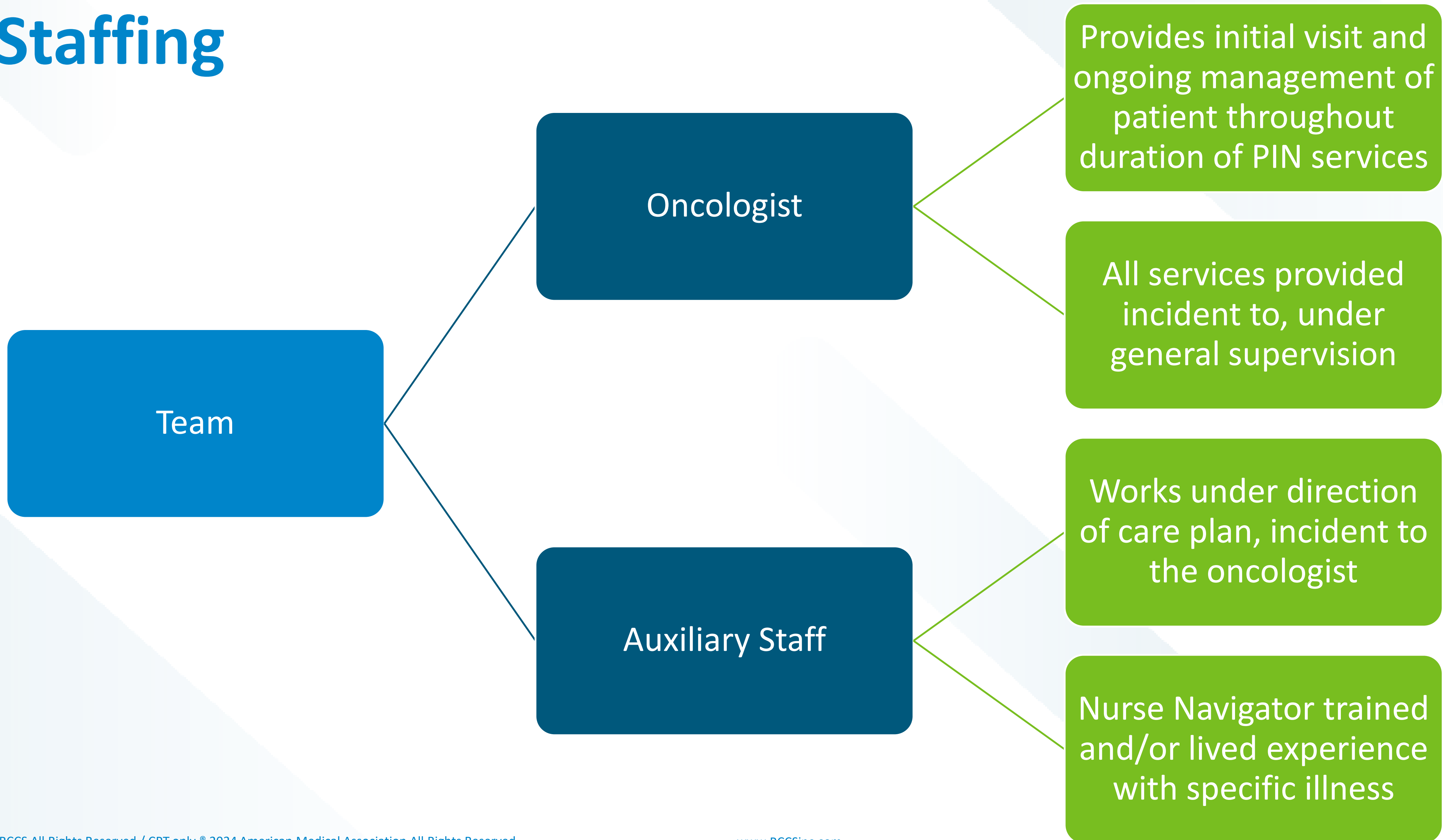
Staffing



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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 (Nurse Navigator) Training

Hours of 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

State Regulations

- Adhere to State regulations for certification and/or licensure
- If no applicable requirements, follow CMS competency requirements

CMS Competency Training

- 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/disease addressed in the initiating visit

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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)

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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Breaking it Down

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Initiating Visit by Billing Practitioner

- Evaluation and Management (E/M) visits provided by the practitioner (CPT 99202-99215)
  - Excluded - low level E/M visits able to be performed by staff, emergency department (ED), inpatient or observation, skilled nursing facility (SNF)
    - These visits do not provide the complexity or continuity of care defined by PIN services
- Annual Wellness Visit (AWV) – if performed by physician who is also managing PIN services and identifies the serious, high-risk condition.
  - Ex. AWV by a dietician does not qualify
- Identifies patient presents with a serious, high-risk illness (i.e., cancer), at significant risk of hospitalization, nursing home placement, acute exacerbation/decompensation, functional decline, or death
- Creates a disease/illness specific care plan

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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

Ask the questions to understand the individual context of the serious, high-risk condition

Find out the patient's life story, strengths, needs, goals, preferences, and desired outcomes, including understanding cultural and linguistic factors and including unmet SDOH needs.

Facilitate patient-driven goal setting and establishing an action plan. Tailored to the patient to accomplish the practitioner's treatment plan.

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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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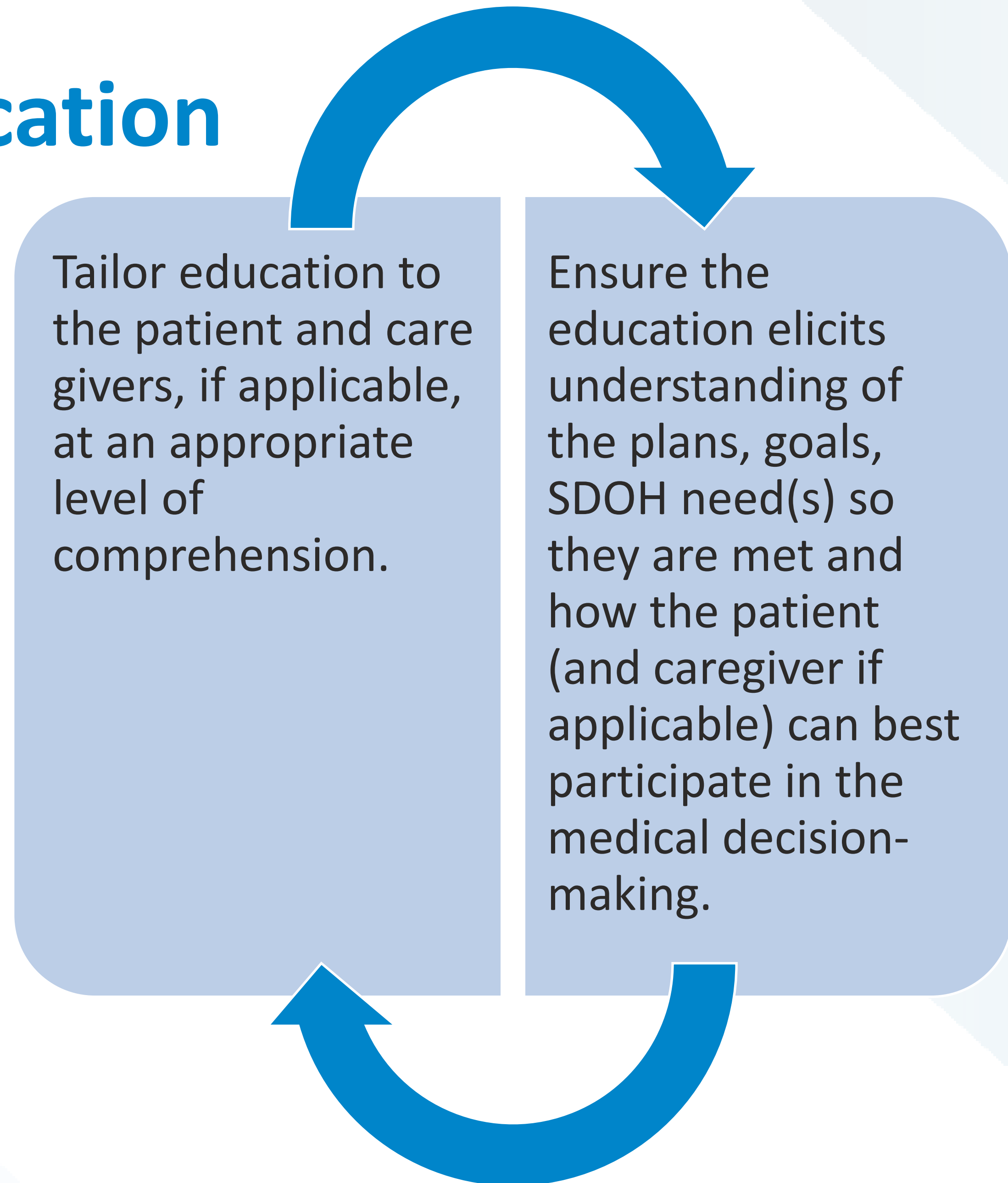
Health Education



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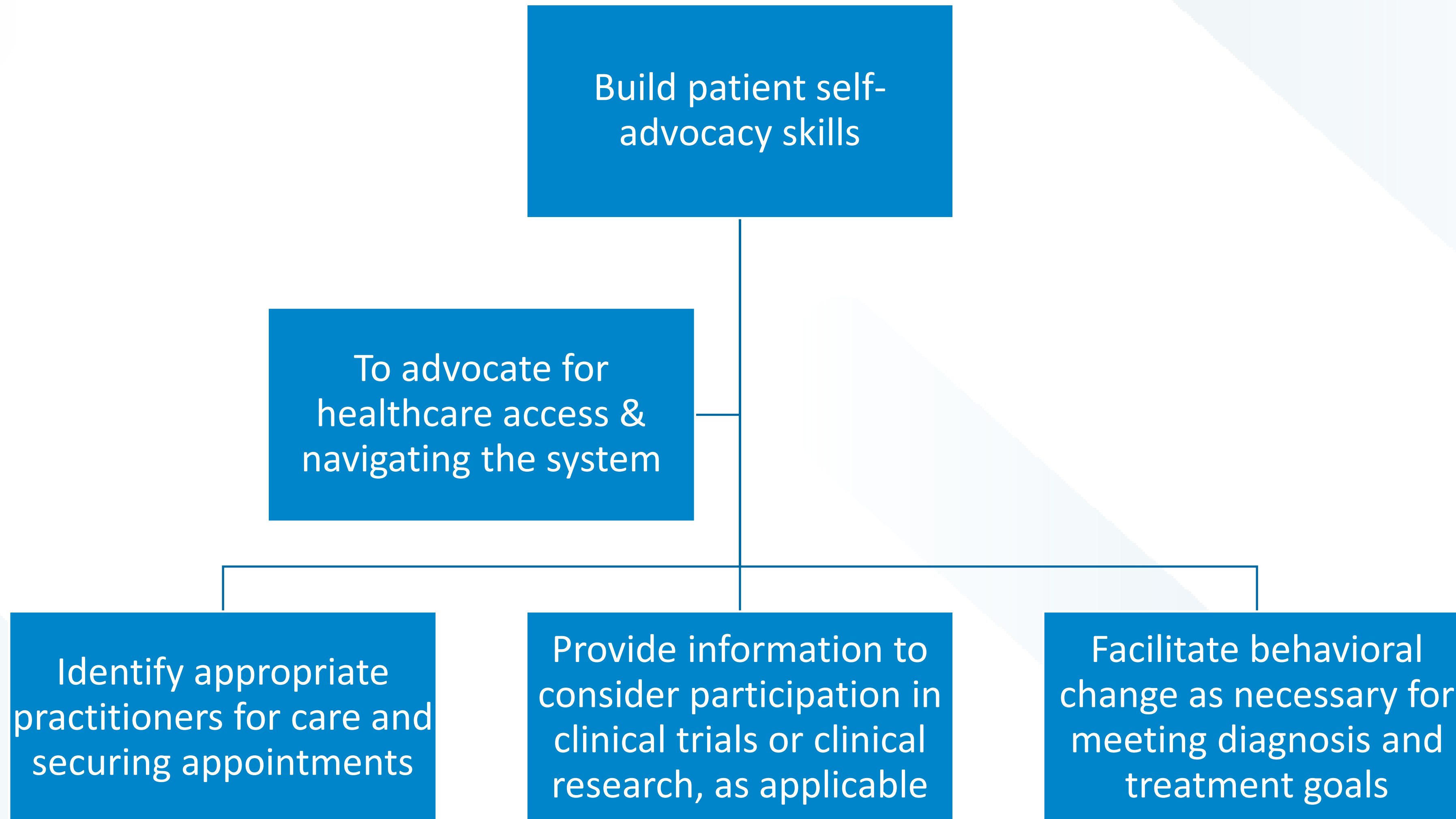
Self-Advocacy



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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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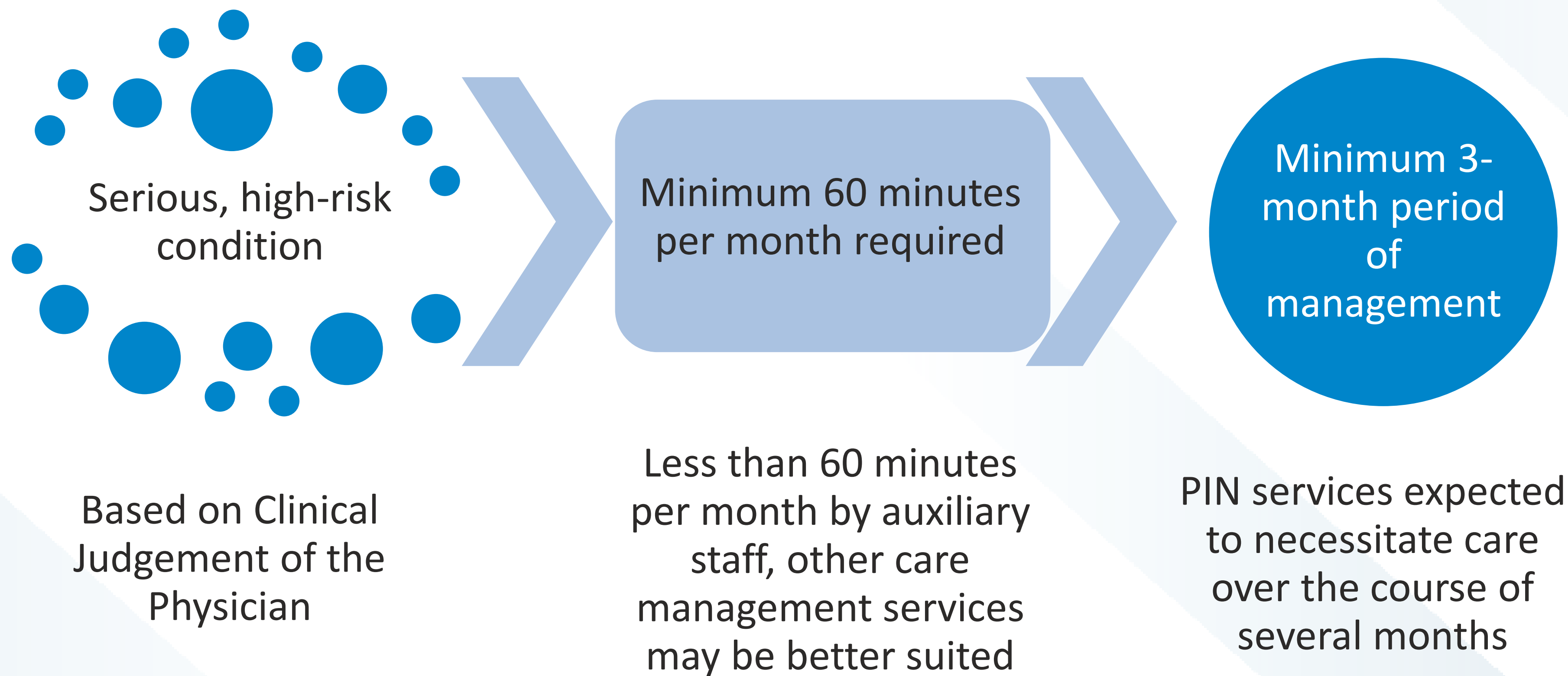
Clarification



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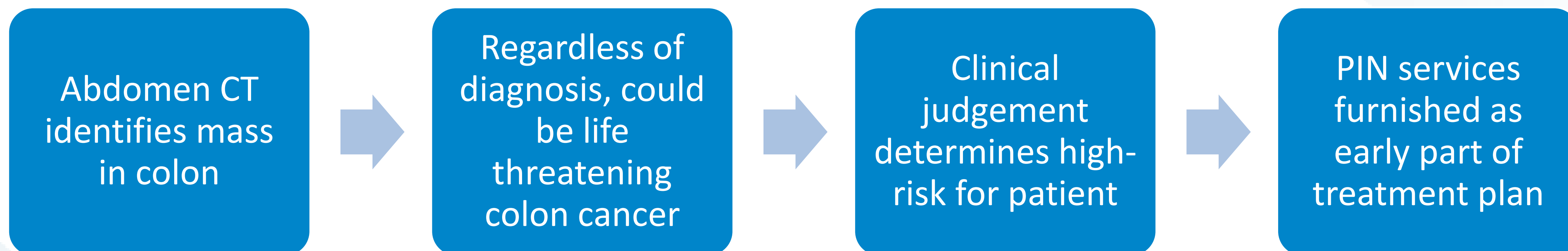
Lack of Clinical Diagnosis Example



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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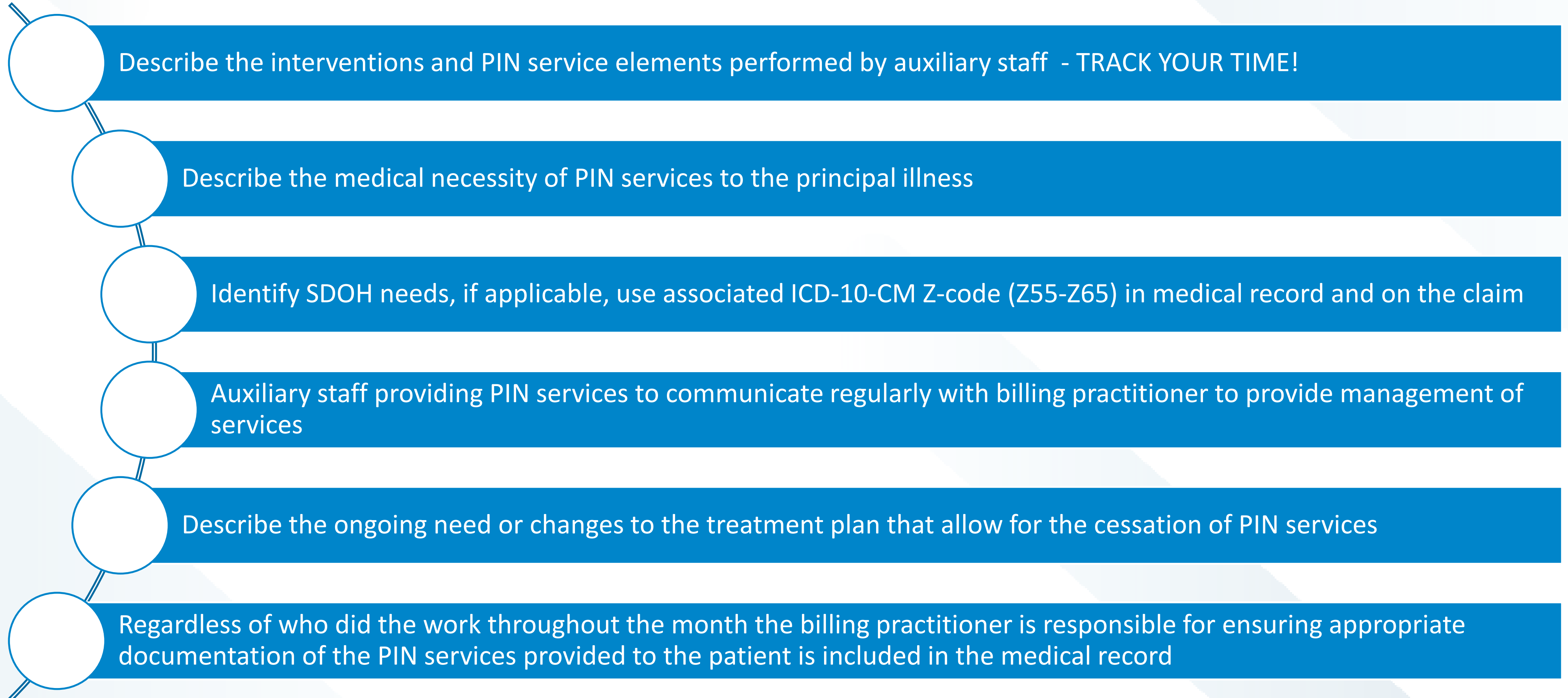
Documentation



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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

Only billable in nonfacility setting*

*CMS is aware this setting limitation may be impactful and is reviewing for future rulemaking

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Thank you for Attending

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