CMS' Care Management Services - Implementation Guidance

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Introduction

The list of codes and services classified by the Centers for Medicare & Medicaid Services (CMS) as care management seems to grow every year[1]. Several of these services have resources created and published by CMS, while the details of other services are buried in rulemaking text, primarily the Calendar Year Physician Fee Schedule Final Rules. Please only use this resource as a guide; the information included here should not be considered legal advice nor a guarantee of reimbursement.

Implementing these services provides an opportunity to put a framework around care coordination, chronic disease management and care management for high-risk patients, which can also lead to enhanced reimbursement, including for team-based care and work that the care team is already performing. In response to our clients' needs and requests, we have compiled this straightforward guidance for implementing and capturing reimbursement for several of the CMS care management services that do not have existing CMS-supported resource materials.

Note that Chronic and Principal Care Management (CCM and PCM) are included, recognizing that CMS has ample resources for CCM but not for PCM services. In the spirit of brevity, we leave full requirements and details of CCM/PCM to the guidance documents listed below in Chronic Care Management Must-Have Resources.

The following implementation guidance can be applied to any code or service, but here we use CCM and PCM as the example.

[1] Current care management services include but are not limited to advance care planning services (CPT codes 99497–99498), chronic care management services (CPT codes99490, 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), and transitional care management services (CPT codes 99495–99496).

DEFINE THE BUSINESS CASE

Some health care organizations implement a care management program because they feel it's the "right thing to do" regardless of whether there's a business case, noting that only providing CCM/PCM and other care management services for patients who have the insurance to cover those services contributes to health inequity. However, there definitely is a business case for implementing the suite of care management codes and services and for increasing revenue for work that is often already underway, supporting patients with chronic conditions.

IDENTIFY THE TARGET POPULATION

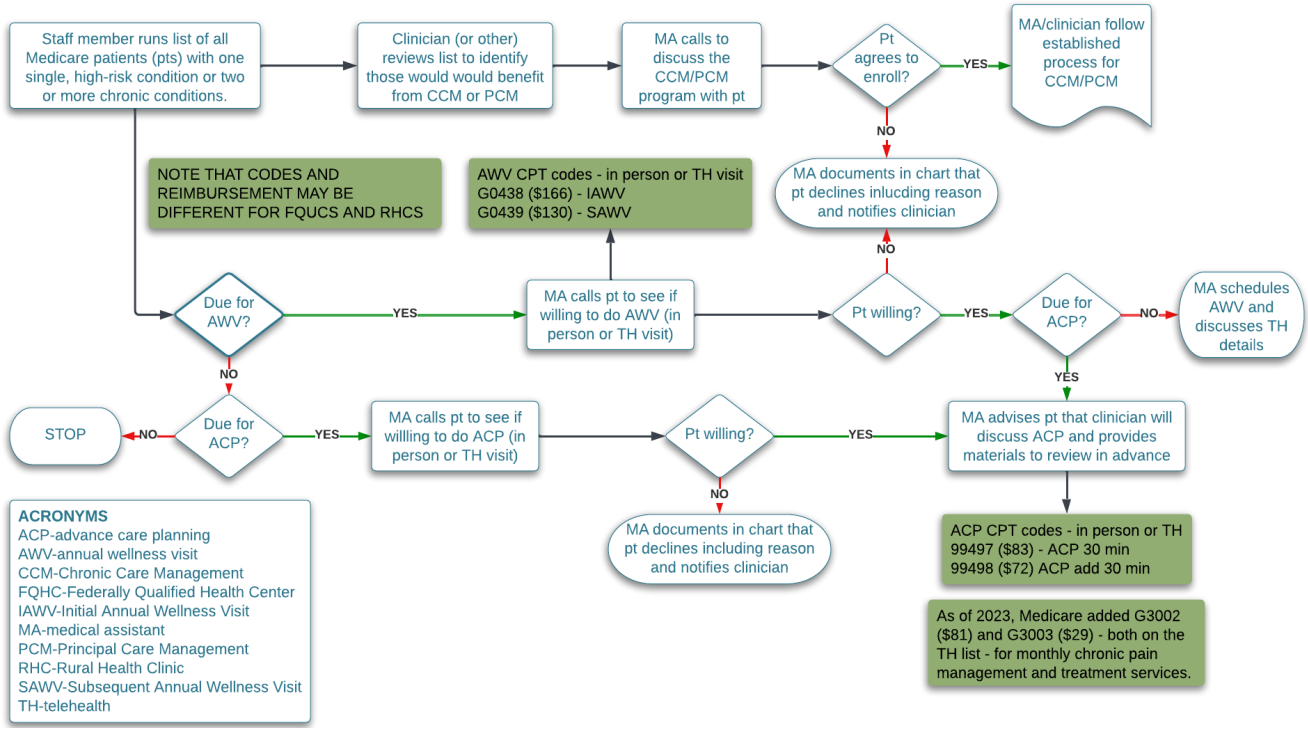
While CMS estimates that at least two-thirds of Medicare beneficiaries have at least two or more chronic conditions[2], CCM/PCM can only be furnished on an "as-needed" basis – that is, only billed when services are provided. However, it is reasonable to start with these target populations.

- CCM - Medicare patients with two or more chronic conditions expected to last at least 12 months or until the death of the patient.
- PCM – Medicare patients with at least one serious chronic condition expected to last between three months and one year, or until the death of the patient, may have led to a recent hospitalization, and/or place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline[3].

We have found that one clinical staff member (e.g., medical assistant) can manage 50 – 60 patients, working with the billing clinician(s). Below is an example of a process to identify Medicare beneficiaries for CCM/PCM while also assessing whether those patients are due for wellness visits or advance care planning, which can be delivered by telehealth. Note that many state Medicaid agencies and other insurers also reimburse for CCM and PCM.

[2] Centers for Medicare and Medicaid Services. Chronic Conditions among Medicare Beneficiaries, Chartbook, 2012 Edition. Baltimore, MD. 2012.
[3] CY 2020 Physician Fee Schedule Final Rule published November 15, 2019.

Figure 1. Example Process to Identify Medicare Patients Eligible for CCM, PCM & Wellness Visits



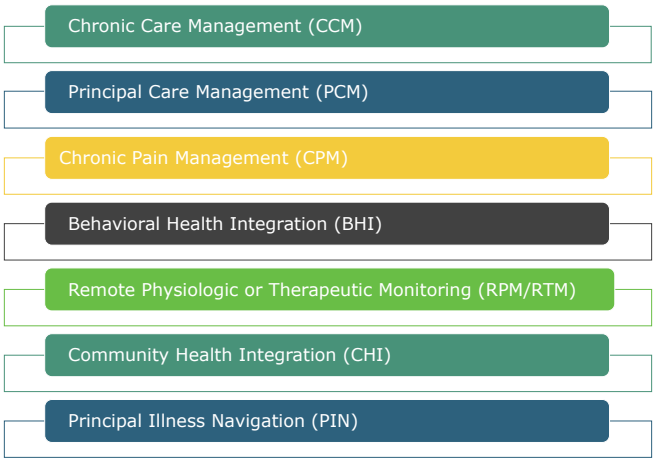
Note that CMS' national payment amount (rounded) for 2023 is listed above. While those amounts change from year to year, it is usually a change of only a few dollars.

ESTIMATE REVENUE

This may be easier than it sounds, but based on the target population, estimate which CPT codes (see Table 1) might be billed on a monthly or other basis to estimate the revenue that could be generated by providing CCM/PCM services. G0511 is the only code that Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) may use for both CCM and PCM (and for Behavioral Health Integration services). Starting in 2023, G0511 includes the services covered by G0323, describing General Behavioral Health Integration performed by clinical psychologists (CP) or clinical social workers (CSW) to account for monthly care integration where the mental health services provided by a CP or CSW are serving as the focal point of care integration[4]. G0511 also includes (as of 2023) the telehealth codes and services G3002 and G3003 that provide monthly chronic pain management and treatment services[5].

[4] CY 2023 Physician Fee Schedule Final Rule. CMS.
[5] Ibid.

Figure 2. Care Management Services Reimbursed under G5011 for FQHCs and RHCs



For Medicare beneficiaries, FQHCs and RHCs may be reimbursed for these services under G0511. Check CMS' Rural Health Clinics Center or Federally Qualified Health Centers for the most current reimbursement rate for G5011 ($71.71 for 2024). RTM or RPM services may be billed concurrently with Transitional Care Management (TCM), CCM, PCM, CPM, BHI[6], CHI and PIN provided the time or effort is not counted twice.

Only FQHCs and RHCs may bill for the monthly chronic pain management services using G0511. Other providers will use the codes G3002 and G3003, which are both listed as permanent codes on CMS' List of Telehealth Services.

It is reasonable to check whether other health plans besides Medicare will reimburse for these services and associated codes; several state Medicaid agencies do so. Take a deeper dive into the additional revenue capture opportunities noted in the section below. Another consideration is that while most health care organizations can implement CCM/PCM on their own, there is no shortage of vendors willing to provide and bill for these services for a hefty percentage of the revenue.

IDENTIFY ADDITIONAL OPPORTUNITIES

The CCM/PCM services can be augmented with additional virtual services to ensure holistic and convenient service delivery and increased reimbursement for chronic care management. As noted in the flow diagram above, it is possible to ensure that those receiving CCM/PCM are also current on their annual wellness exams and have received advance care planning both of which can be delivered by telehealth. In addition, CCM/PCM can be augmented using virtual service delivery options, including virtual check-ins, e-visits, telephone evaluation and management (E/M) services, behavioral health integration services and remote physiologic (patient) and therapeutic monitoring (RPM and RTM).

[6] Ibid. pp. 69528–69539.

Table 1. CCM and PCM codes with brief description and CMS price.

CCM/PCM Code	Description	CMS Price
99490 (non-complex CCM)	20 min or more of CCM for clinical staff time directed by a physician or other qualified health care professional (QHP), per calendar month	$63
99439 (non-complex CCM)	Add-on code to CPT 99490 for each additional 20 min of clinical staff time; reportable up to two times per month (after 99490)	$47
99491 (non-complex CCM)	30 min or more of CCM furnished by a physician or other QHP, per calendar month	$85
99437 (non-complex CCM)	Add-on code to CPT 99491 for each additional 30 minutes by a physician or other QHP, per calendar month	$60
99487 (complex CCM)	60 min or more of complex CCM for clinical staff time directed by a physician or other QHP, per calendar month	$134
99489 (complex CCM)	Add-on code to CPT 99487 for each additional 30 min of clinical staff time	$71
G0506 (CCM add-on code)	Add-on code to the CCM initiating visit that describes the work of the billing practitioner for a comprehensive assessment and care planning to patients outside of the usual effort described by the initiating visit code (CMS Chronic Care Management Services MLN Booklet)	$62
99424 (PCM)	30 min or more of physician or other QHP time, per calendar month	$81
99425 (PCM)	Add-on code to CPT 99424 for each additional 30 minutes by a physician or other QHP, per calendar month	$59
99426 (PCM)	30 min or more of clinical staff time directed by a physician or other QHP, per calendar month	$61
99427 (PCM)	Add-on code to CPT 99426 for each additional 30 min of clinical staff time	$47
G0511 CCM/PCM	This is the only code that FQHCs and RHCs may bill for CCM and PCM.	$72

National payment amount for the non-facility price from the Physician Fee Schedule Search as of January 29, 2024, rounded to the nearest dollar. Do not rely on these. Have your biller/coder double-check.

IDENTIFY STAFF NEEDED TO DELIVER CCM/PCM

It can be challenging to make staff estimates. However, use the target population and anticipated revenue to develop an informed estimate as best as possible. Include estimates of both clinician and clinical staff time. Be creative in considering who can deliver CCM/PCM services (e.g., registered dieticians, pharmacists, medical assistants, nurses, etc.).

Empower an internal subject matter expert or team

If the organization decides to move forward with CCM/PCM, find a staff member or small team willing to learn the CCM/PCM requirements, identify the operational considerations, ensure that needed changes occur, communicate with staff, and identify training needs. Consider whether this is the same team who will deliver the CCM/PCM services. The internal subject matter expert or team can get up to speed with the Chronic Care Management Must-Have Resources below.

Consider operational changes and supports

Consider a simple project plan that lists all changes needed to accommodate this new service and to capture the required elements and documentation, including who will do what and when. Below are several to consider, but this is not an exhaustive list of the CCM/PCM requirements.

Enroll patients in the CCM/PCM program

Successful organizations include CCM/PCM in pre-visit planning by reviewing eligible patients in the schedule, taking an opt-out approach in addition to referrals by clinicians for patients without a visit, meaning that patients will be invited to receive CCM/PCM services if needed and appropriate unless the primary care clinician opts them out.

Clarify how verbal consent is obtained and documented in the EHR

Consent must be obtained and documented prior to delivering CCM/PCM. Some care teams do this for all Medicare patients on an annual basis as part of check-in with reception staff. Another option is to have CCM/PCM staff engage in short conversations with patients being enrolled during their office visit to obtain consent and discuss the program and services. For both CCM and PCM, patients must be educated as to what PCM and/or CCM are and any cost sharing that may apply. Check the full consent requirements in the must-have resources listed below.

Track time spent by clinicians and by clinical staff

This can be challenging if the EHR does not have an easy method for tracking the required time increments to bill the CCM/PCM codes (e.g., date/time stamped signature at start and finish). If there is not an easy way to do this, staff need to document start and end times for time spent directly by the billing clinician or clinical staff. Non-clinical staff time does not count (i.e., reception staff time for obtaining informed consent).

Create EHR templates

Again, this may depend on the EHR. Templates that guide the clinician and clinical staff to document all required elements are ideal. Consider having the subject matter expert draft the initial iterations in

Word, Visio or another program to provide line of sight on usability and fidelity with the CCM/PCM requirements.

Draft billing workflows

Consider how to make it as easy as possible for the clinician, clinical staff or billers/coders to know which codes to use and when those codes can be billed (i.e., once the requisite number of minutes are reached, the associated code can be submitted). Best practice: close the loop to ensure that reimbursement for each code occurs and at the rate expected. On average 5% of CCM claims are denied[7]; troubleshoot any denials to ensure a denial rate of 0% with minimal administrative burden.

Provide 24/7 access

Check the details of what is required by CMS in materials referenced below, but this does not need to be a showstopper. There are creative ways to meet this requirement that address patients' urgent needs regardless of the time of day or day of week. Some organizations have trained staff take turns with a phone after hours to deal with any incoming calls. Feedback from the field indicates that these calls are few and far between.

Streamline documenting and sharing the care plan

While a clinician should review and approve (not required by CMS) the care plan, others on the care team can develop meaningful care plans with training and feedback. Because care plans can be a sticking point, confer with clinicians and other care team member to develop an efficient process and template to develop and share the care plan with patients and care givers.

Identify and manage transitions

Know how the team will receive reliable notifications of referrals to clinicians, emergency department visits, inpatient stays, and other transitions (e.g., home to assisted living, rehabilitation facility to home, etc.). Clarify the lines and modes of communication to share and exchange continuity of care documents. Leverage a source like a health information exchange (HIE), which provides access to and sharing of test results, consult/referral notes, continuity of care documents (required by CCM and PCM), and event notifications – admissions, discharges, and transfers (ADTs) – when a patient has received care at a different setting. (Hospitals are required to provide event notifications to community providers (as identified by the patient) as of May 1, 2021.) An HIE can provide automated feeds of information that are often integrated into the EHR and contribute to processes to address when patients need or receive care at different settings.

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[7] Reddy A, et al. Use of Chronic Care Management Among Primary Care Clinicians. Ann Fam Med. 2020;18(5):455-457.

Coordinate with home- and community-based service providers

This coordination requires deliberate action to know which service providers are involved and to build communication with those providers. Identify how the team will learn which service providers are involved, how to document them in the patient's electronic chart (not required by CMS), and how to communicate in a way that is best for the patient, care givers and the service providers.

Chronic Care Management Must-Have Resources

- Manage Your Chronic Condition. CMS. Resource for patients.
- Connected Care Toolkit – Chronic Care Management Resources for Health Care Professionals and Communities. CMS.
- CMS Care Management. CMS. Includes Advance Care Planning, Behavioral Health Integration and Transitional Care Management.
- Chronic Care Management Services. CMS. Sep 2022.
- Care Coordination Services and Payment for RHCs and FQHCs. CMS.
- Care Management Services in RHCs and FQHCs – FAQs Dec 2019. CMS.
- Specific Payment Codes for the FQHC PPS. CMS.

Principal Care Management Service Requirements

PCM services may be provided to patients with one serious chronic condition; see PCM billing codes listed in Table 2. Below is a summary of the PCM requirements as outlined in the CY 2020 Physician Fee Schedule Final Rule.

- At least 30 minutes of physician or other qualified health care professional time per calendar month or at least 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month
- One complex chronic condition lasting at least three months and expected to last at least a year or until the death of the patient, which is the focus of the care plan
- Condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization, and/or may place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
- Condition requires development or revision of disease-specific care plan
- Condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities
- Must include coordination of medical and/or psychosocial care related to the single complex chronic condition
- Ongoing communication and care coordination between all practitioners furnishing care to the beneficiary must be documented by the practitioner billing for PCM in the patient's medical record
- The full CCM scope of service requirements apply to PCM, including documenting the patient's verbal consent in the medical record as noted in Table 2 below.
- "…PCM services should not be furnished with other care management services by the same practitioner for the same beneficiary, nor should PCM services be furnished at the same time as interprofessional consultations for the same condition by the same practitioner for the same patient."[8]
- RPM or RTM may be billed concurrently with CCM or PCM as long as the time is not counted twice.

[8] CY 2020 Physician Fee Schedule Final Rule p. 62697.

Table 2. PCM and CCM Services Summary Crosswalk from Tables 23 and 24 in the CY 2020 Physician Fee Schedule Final Rule

PCM Services Summary*	CCM Services Summary
Verbal Consent • Inform regarding availability of the service; that only one practitioner can bill per month; the right to stop services effective at the end of any service period; and that cost sharing applies (if no supplemental insurance). • Document that consent was obtained in the medical record.	
Initiating Visit for New Patients (separately paid)	
Certified Electronic Health Record (EHR) Use • Structured recording of core patient information using EHR (demographics, problem list, medications, allergies).	
24/7 Access ("On Call" Service)	
Designated Care Team Member	
Disease-Specific Care Management Disease-specific care management may include, as applicable: • Systematic needs assessment (medical and psychosocial). • Ensure receipt of preventive services *(as applicable to the condition being treated and is not a requirement to bill for PCM services)*†. • Medication reconciliation, management and oversight of self-management.	Same as PCM, just not disease specific.
Disease-Specific Electronic Care Plan • Plan is available timely within and outside the practice (can include fax). • Copy of care plan to patient/caregiver (format not prescribed). • Establish, implement, revise or monitor the plan.	Same as PCM, just not disease specific.
Management of Care Transitions/Referrals (e.g., discharges, ED visit follow up, referrals, as applicable). • Create/exchange continuity of care document(s) timely (format not prescribed).	Same as PCM, but does not include "as applicable"
Home- and Community-Based Care Coordination • Coordinate with any home- and community-based clinical service providers, and document communication with them regarding psychosocial needs and functional deficits, as applicable.	Same as PCM, but does not include "as applicable"
Enhanced Communication Opportunities Offer asynchronous non-face-to-face methods other than telephone, such as secure email.	
*All elements that are medically reasonable and necessary must be furnished during the month, but all elements do not necessarily apply every month. Consent need only be obtained once, and initiating visits are only for new patients or patients not seen within a year prior to initiation of PCM or CCM.	

†Note that italicized text is added directly from the final rule text and is not included in Table 24.

COMMUNITY HEALTH INTEGRATION SERVICE REQUIREMENTS

Community Health Integration (CHI) services may be provided to patients with one serious chronic condition; see CHI billing codes listed in Table 3. Below is a summary of the CHI requirements as outlined in the CY 2024 Physician Fee Schedule Final Rule.

- Furnished monthly, as medically necessary, following an initiating Evaluation and Management (E/M) - CHI initiating visit - during which the practitioner identifies the presence of social drivers or determinants of health (SDOH) need(s) that significantly limit the practitioner's ability to diagnose or treat the problem(s) addressed in the visit (e.g., food, transportation or housing insecurity, unreliable access to public utilities).
- The same practitioner who provides the E/M initiating visit also furnishes the CHI services during the subsequent calendar month(s).
- Annual Wellness Visits (AWV) and the E/M visit furnished as part of a Transitional Care Management (TCM) services can serve as a CHI initiating visit.
- When the AWV is provided by a type of health care professional who does not have an ''incident to'' benefit for their services under the Medicare program, including, for example, a health educator, a registered dietitian, or nutrition professional, the AWV would not serve as an initiating visit for CHI because the furnishing professional could not then furnish and bill for CHI services incident to their professional services.
- Auxiliary personnel may provide these services under general supervision; the codes were specifically designed to capture services commonly performed by community health workers but do not limit the types of other health care professionals.
- Inpatient/observation visits, emergency department visits and skilled nursing facility visits cannot serve as a CHI initiating visit because those settings do not typically provide continuing care to the patient.
- CHI services may be performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner.
- "…a billing practitioner may arrange to have CHI services provided by auxiliary personnel who are external to, and under contract with, the practitioner or their practice, such as through a community-based organization (CBO) that employs CHWs, if all of the ''incident to'' and other requirements and conditions for payment of CHI services are met, and that there must be sufficient clinical integration between the third party and the billing practitioner in order for the services to be fully provided." (CY 2024 FR p.78931)
- Written or verbal consent may be obtained provided it is documented in the medical record; consent may be obtained by auxiliary personnel and only needs to be obtained once (rather than annually) unless there is a change in the billing practitioner; consent process must include explaining to the patient that cost sharing applies and that only one practitioner may furnish and bill the services in a given month.
- Those activities must address social determinants of health (SDOH) need(s) that are significantly limiting the ability to diagnose or treat problem(s) in an initiating visit.
- Those activities include:

- "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 goalsetting 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." (CY 2024 PFS FR p. 78927)

Table 3. Community Health Integration (CHI) codes with brief description and CMS price.

CHI Code	Description	CMS Price
G0019 - CHI	**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 (includes numerous activities)	$79
G0022 - CHI	**Community Health Integration services** each additional 30 minutes per calendar month (List separately in addition to G0019); there are no frequency limitations.	$49

National payment amount for the non-facility price from the Physician Fee Schedule Search as of January 29, 2024, rounded to the nearest dollar. Do not rely on these. Have your biller/coder double-check.

Principal Illness Navigation Service Requirements

Principal Illness Navigation (PIN) services may be provided by patient navigators or certified peer specialists, under the direction of a billing practitioner, to patients with a serious, high-risk disease[9] (expected to last at least three months) that places the patient at significant risk of hospitalization or nursing home placement, acute exacerbation/decompensation, functional decline, or death. CMS notes that PIN services a parallel set of services to the CHI services, but focuses on patients with a serious, high-risk illness who may not necessarily have SDOH need. PIN billing codes listed in Table 4. Below is a summary of the PIN requirements as outlined in the CY 2024 Physician Fee Schedule Final Rule.

- Furnished monthly, as medically necessary, following an initiating (E/M) visit that addresses:
  - One serious, high-risk condition expected to last at least three months and that places the patient at significant risk of hospitalization, nursing home placement, acute exacerbation/decompensation, functional decline, or death.
  - 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.
  - CMS clarifies that a definitive diagnosis is not required before the practitioner makes a clinical determination that the patient has a serious high-risk condition.
- The same practitioner who provides the E/M initiating visit also furnishes the PIN services during the subsequent calendar month(s), and only one practitioner per beneficiary per calendar month can bill for PIN services for a given serious, high-risk condition.
- Written or verbal consent may be obtained – either before or at the same time services begin - provided it is documented in the medical record; consent may be obtained by auxiliary personnel and must be obtained annually; consent process must include explaining to the

[9] Examples include cancer, chronic obstructive pulmonary disease, heart failure, dementia, HIV/AIDS, severe mental illness, and substance use disorder (SUD).

patient that cost sharing applies and that only one practitioner may furnish and bill the services in a given month.

- CPT code 90791 (Psychiatric diagnostic evaluation) and the Health Behavior Assessment and Intervention (HBAI) services utilized by clinical psychologists can serve as an initiating visit.
- Annual Wellness Visits (AWV) and the E/M visit furnished as part of a Transitional Care Management (TCM) services can serve as a PIN initiating visit.
- When the AWV is provided by a type of health care professional who does not have an ''incident to'' benefit for their services under the Medicare program, including, for example, a health educator, a registered dietitian, or nutrition professional, the AWV would not serve as an initiating visit for PIN because the furnishing professional could not then furnish and bill for PIN services incident to their professional services.
- Auxiliary personnel may provide these services under general supervision
- Inpatient/observation visits, emergency department visits and skilled nursing facility visits cannot serve as a PIN initiating visit because those settings do not typically provide continuing care to the patient.
- The training and certification for providing PIN services must be consistent with the National Model Standards for Peer Support Certification published by SAMHSA.
- Written or verbal consent may be obtained provided it is documented in the medical record; consent may be obtained by auxiliary personnel and only needs to be obtained once (rather than annually) unless there is a change in the billing practitioner; consent process must include explaining to the patient that cost sharing applies and that only one practitioner may furnish and bill the services in a given month.
- Time spent furnishing PIN services for purposes of billing codes G0023 and G0024 must be documented in the medical record in its relationship to the serious, high-risk illness. CMS requires that identified SDOH need(s), if present, to be recorded in the medical record, and for data standardization, practitioners would be encouraged to record the associated ICD–10 Z-codes (Z55–Z65) in the medical record and on the claim. To reduce administrative burden, CMS does not require that all auxiliary personnel performing PIN services must document the services in the medical record themselves but that the billing practitioner is responsible for ensuring appropriate documentation of the PIN services provided to the patient is included in the medical record.
- PIN activities include:
    - "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 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) 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." (CY 2024 PFS FR p. 78945)

Table 4. Principal Illness Navigation (PIN) codes with brief description and CMS price.

PIN Code	Description	CMS Price
G0023 - PIN	**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 (includes numerous activities)	$79
G0024 - PIN	**Principal Illness Navigation services**, additional 30 minutes per calendar month (List separately in addition to G0023).	$49
G0140 - PIN	**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 (includes numerous activities)	$79
G0146 - PIN	Principal Illness Navigation - Peer Support, additional 30 minutes per calendar month (List separately in addition to G0140); there are no frequency limitations.	$49

National payment amount for the non-facility price from the Physician Fee Schedule Search as of January 29, 2024, rounded to the nearest dollar. Do not rely on these. Have your biller/coder double-check.

Community Health Integration and Principal Illness Navigation Services Resources and Final Rule References

We strongly encourage reading the relevant sections in the CY 2024 Physician Fee Schedule Final Rule for the full details on the CHI and PIN services that are available January 1, 2024. To ensure billing, coding and documentation compliance, check the most recent CPT® Code Book for guidance on these services and codes.

- Health Equity Services in the 2024 Physician Fee Schedule Final Rule. CMS MLN Booklet. Includes information on the set of codes and services launched Jan 1, 2024, **including details for Community Health Integration and Principal Illness Navigation services**.
- Health-Related Social Needs FAQ. CMS. This resource answers frequently asked questions about a set of codes and services launched Jan 1, 2024, **including Community Health Integration and Principal Illness Navigation services**.
- Calendar Year 2024 Physician Fee Schedule Final Rule
    - Community Health Integration (CHI) Services pp. 78921-32
    - Principal Illness Navigation (PIN) pp. 78937-49

Additional CMS Care Management Services

The following care management services have existing resources created by CMS.

- Advance Care Planning Services Fact Sheet. CMS. These services may also be provided by telehealth.
- Advance Care Planning Services FAQs. CMS.
- Behavioral Health Integration Services Booklet. CMS.
- Behavioral Health Integration FAQs. CMS.
- Transitional Care Management Services Fact Sheet. CMS.
- Billing FAQs for Transitional Care Management