ASCO®
AMERICAN SOCIETY OF CLINICAL ONCOLOGY
KNOWLEDGE CONQUERS CANCER

CMS' Navigation Codes

Rachael Willeford, Senior Coverage and Reimbursement Specialist

Florida Society of Clinical Oncology
Oncology Administrator Webinar

June 12th, 2024

Topics

Services Addressing Health-Related Social Needs

Care Management Services

Reporting and Reimbursement

What are Social Determinants of Health (SDOH)?

Conditions of an individual's **living**, **learning**, and **working** environments that affect one's health risks and outcomes.

Recognized as **important predictors in clinical care** and positive conditions are associated with **improved patient outcomes** and **reduced costs**.

ASCO®
AMERICAN SOCIETY OF CLINICAL ONCOLOGY
KNOWLEDGE CONQUERS CANCER

Services Addressing Health-Related Social Needs

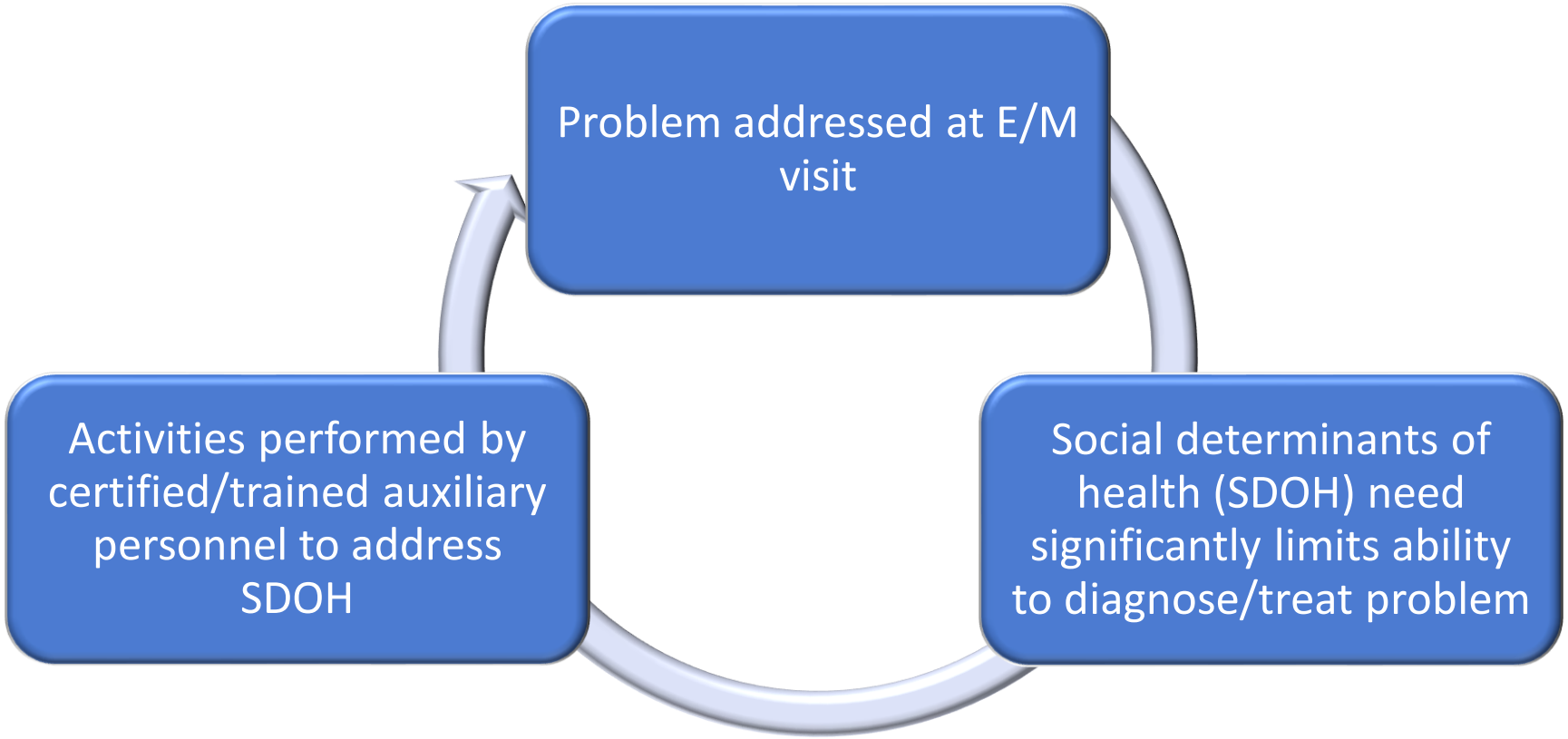
New Services in 2024

Community Health Integration: Address social determinants of health needs that are significantly limited ability to diagnose or treat problems.

Principal Illness Navigation: Services focused on a serious, high-risk illness by certified or trained auxiliary personnel.

Social Determinants of Health Risk Assessment: Administration of a standardized, evidence-based social determinants of health risk assessment tool.

Community Health Integration (CHI)



Principal Illness Navigation (PIN)

Services focused on a serious, high-risk illness

Personnel may include navigator or certified peer specialist

Activities

- Communicate
- Educate
- Coordinate
- Facilitate
- Navigate
- Care Planning

Referring for Services

Community Health Integration

- Facilitate access

Principal Illness Navigation

- Facilitate
- Refer

Social Determinants of Health Risk Assessment
HCPCS Code G0136

Administration of a standardized, evidence-based SDOH assessment tool

Food Difficulties

Housing Difficulties

Transportation Difficulties

Utility Difficulties

ASCO AMERICAN SOCIETY OF CLINICAL ONCOLOGY
KNOWLEDGE CONQUERS CANCER

Documentation Requirements

Community Health Integration	Principal Illness Navigation	SDOH Risk Assessment
✓ Initiating visit identifying SDOH needs that significantly limit ability to treat problem and establishing treatment plan. ✓ SDOH needs recorded in the patient record. ✓ Time spent furnishing services addressing SDOH. ✓ Description of activities performed. ✓ Consent obtained.	✓ Initiating visit identifying medical necessity for navigation services and establishes a treatment plan for problem. ✓ Identification of SDOH needs, if present. ✓ Time spent in relationship to the serious, high-risk illness ✓ Description of activities performed in relation to the treatment plan. ✓ Consent obtained.	✓ Identification of SDOH needs documented in patient record.

ASCO®
AMERICAN SOCIETY OF CLINICAL ONCOLOGY
KNOWLEDGE CONQUERS CANCER

Care Management Services

Care Management Activities
Addressing SDOH

Tool for reducing geographic and racial/ethnic disparities in health.

- Addressing a patient's SDOH may be part of the care plan required as part of a care management service in addition to work performed by the physician/QHP or clinical staff.

- Includes communication and coordination with home- and community-based clinical service providers. Also accounts for non-face-to-face communication with the patient/family/caregiver.

Centers for Medicare and Medicaid Services. "Chronic Care Management".
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf

Care Management Services

Chronic Care Management

Two or more chronic conditions expected to last at least 12 months.

Complex Chronic Care Management

Two or more chronic conditions expected to last at least 12 months.

Moderate or high complexity medical decision making.

Principal Care Management

One high-risk, complex chronic condition expected to last at least 3 months.

Moderate/high complexity due to comorbidities.

Physician and Clinical Staff Activities

Physician/QHP

- Develop a comprehensive care plan and assessment.
- Address all health issues (medical and psychosocial).
- Focus on patient's chronic condition(s).
- Provide guidance and direction to clinical staff.

Clinical Staff

- Educate patient and/or caregiver.
- Respond to patient inquiries.
- Reconcile medications list (including those prescribed by other providers).
- Manage care transitions.
- Share information with other health care providers

Navigation vs. Care Management

Community Health Integration and Principal Illness Navigation	Transitional Care Management, Chronic and Complex Chronic Care Management, Principal Care Management
▪ Certified/trained staff ▪ Identifying and/or referring for services. ▪ Patient centered assessment ▪ Patient education based on contextualizing information from the treatment team, how to best participate in medical decision making, building self-advocacy skills, providing information and resources regarding clinical trials/resources ▪ Social and emotional support	▪ Physician/QHP and/or clinical staff ▪ Ongoing review of patient status ▪ Development and continuous review of the care plan ▪ Assess and support adherence to treatment regimen and medication management; collection of health outcomes data and registry documentation. ▪ Education to support self-management and daily living.

What's included in a comprehensive care plan?

- Problem list
- Outcome and prognosis
- Measurable treatment goals
- Symptom management
- Planned interventions
- Medication management
- Community and social services
- Coordination of care
- Review schedule

Centers for Medicare and Medicaid Services. MLN909188 – Chronic Care Management (cms.gov); Enhancing Oncology Model (EOM) Health Equity Factsheet (cms.gov)
CPT® 2024 Professional Edition. Chicago, IL: American Medical Association, 2023.

Care Management Services
Practice Administration Requirements

24/7 access to physicians or other qualified health care professionals or clinical staff.

A designated member of the care team to provide continuous care.

Timely access and management for follow-ups.

Timely access to clinical information through an EHR.

Coordination and integration of care among all service professionals.

A physician or other qualified health care professional overseeing the activities of the care team.

CPT® 2024 Professional Edition. Chicago, IL: American Medical Association, 2023.

Required Actions for Care Management Services

Obtain patient consent.	Cost sharing.
	Termination of services.
	One practitioner per month (*Applies to chronic care and complex chronic care management services.)
Assign a designated care team lead.	Ensures continuity of care.
	Serve as a point of contact.
Establish, implement, revise, or monitor care plan.	Share with patient and/or caregiver.
	Share with other healthcare providers.
Record data in electronic health record.	Demographics.
	Medications.
	Medical problems.

Centers for Medicare and Medicaid Services. N.d. “MLN Booklet 909188: Chronic Care Management”. MLN909188 – Chronic Care Management (cms.gov)

Steps for Practice Administration

1. Establish a workflow.
2. Define the care management process.
3. Prepare for reimbursement.
4. Establish ongoing monitoring and quality improvement.
5. Identify opportunities with commercial payers.
6. Leverage digital tools.

Health Quality Innovation Network. "Chronic Care Management Toolkit." https://www.khconline.org/files/CCM-Toolkit.pdf

Documentation Requirements

- ✓Narrative detailing need for care management services.
- ✓Beneficiary eligibility for the service.
- ✓Comprehensive care plan (with measurable goals) established, implemented, revised or significantly monitored.
- ✓Patient or caregiver must be given a copy of the care plan.
- ✓Discussion narrative with beneficiary and his/her prior permission acceptance (verbally for patients who have been seen in the practice within past 12 months or written for those who have not).
- ✓Documentation of verbal acceptance and explanation to the patient.
- ✓Note regarding that the beneficiary may terminate consent at any time.
- ✓Support services rendered.
- ✓Time spent on services.

Noridian Healthcare Services. “Chronic Care Management.” June 2019. Chronic Care Management (CCM) - JE Part B - Noridian (noridianmedicare.com)

ASCO®
AMERICAN SOCIETY OF CLINICAL ONCOLOGY
KNOWLEDGE CONQUERS CANCER

Reporting

Time Requirements

Report total time **per calendar month.**

Time requirements must be met or exceeded.

Date of service is the date **the time requirement was reached**.

Consent Requirements

Advance informed consent, either written or verbal, is required to be documented in the patient's medical record before providing services.

Care Management	Patient Navigation
• Availability of care management services • Cost-sharing • Only 1 practitioner can bill chronic care management during a calendar month. • Patient's rights to stop services at any time • Consent only required once unless switching to a different practitioner.	• Cost-sharing • Only 1 practitioner can bill for CHI services in a calendar month. • Patient's rights to stop services. • 1x for CHI, annually for PIN. • Consent documentation not required for SDOH risk assessment.

Patient Navigation Services

Code Comparison – Patient Navigation Services

Community Health Integration	Principal Illness Navigation	SDOH Risk Assessment
SDOH need(s) that significantly limit the ability to diagnose or treat problem.	**Serious, high-risk condition** expected to last at least 3 months and at significant risk of death, acute exacerbation/decompensation or functional decline.	**Administration** of standardized, evidence-based **assessment tool.**
Service time is per calendar month.		Every 6 months.

CPT Codes – Patient Navigation Services

Service	Physician or Qualified Healthcare Professional
Community Health Integration	G0019: CHI services performed by auxiliary personnel under direction of a physician or other practitioner; 60 minutes per calendar month G0022: Each additional 30 minutes (no frequency limit)
Principal Illness Navigation	G0023: PIN services performed by auxiliary personnel under direction of a physician or other practitioner; 60 minutes per calendar month G0024: Each additional 30 minutes (no frequency limit) G0140: Peer support, 60 minutes per calendar month G0146: Each additional 30 minutes
SDOH Risk Assessment	G0136: Administration of a standardized, evidence-based social determinants of health risk assessment, 5-15 minutes

See full CPT ® code descriptions and guidelines in the AMA CPT Professional Edition 2024 CPT® 2024 Professional Edition. Chicago, IL: American Medical Association, 2023.

Concurrent Services

- Advance Care Planning
- Behavioral Health Integration
- Chronic Care Management
- Complex Chronic Care Management
- Principal Care Management
- Transitional Care Management

MLN9201074 Health Equity Services in the 2024 PFS Final Rule

Criteria for Reporting Concurrent Services

- ✓ Services requires separate time/effort
- ✓ Billing requirements met separately
- ✓ Medically reasonable and necessary

CMS Initiating Visit Requirement

Patient Navigation Services

Community Health Integration	Principal Illness Navigation	SDOH Risk Assessment
• E/M visit • AWV visit	• E/M visit • Transitional Care Management E/M Visit • Annual Wellness Visit • Psychiatric Diagnostic Evaluation • Health Behavior Assessment and Intervention	• Does not require an initiating visit

Clinician Restrictions – Patient Navigation

Community Health Integration

Only **one** clinician per beneficiary per calendar month.

Principal Illness Navigation

More than one clinician per beneficiary *if* services related to a different condition

SDOH Risk Assessment

Once per beneficiary per clinician per **6-month** period.

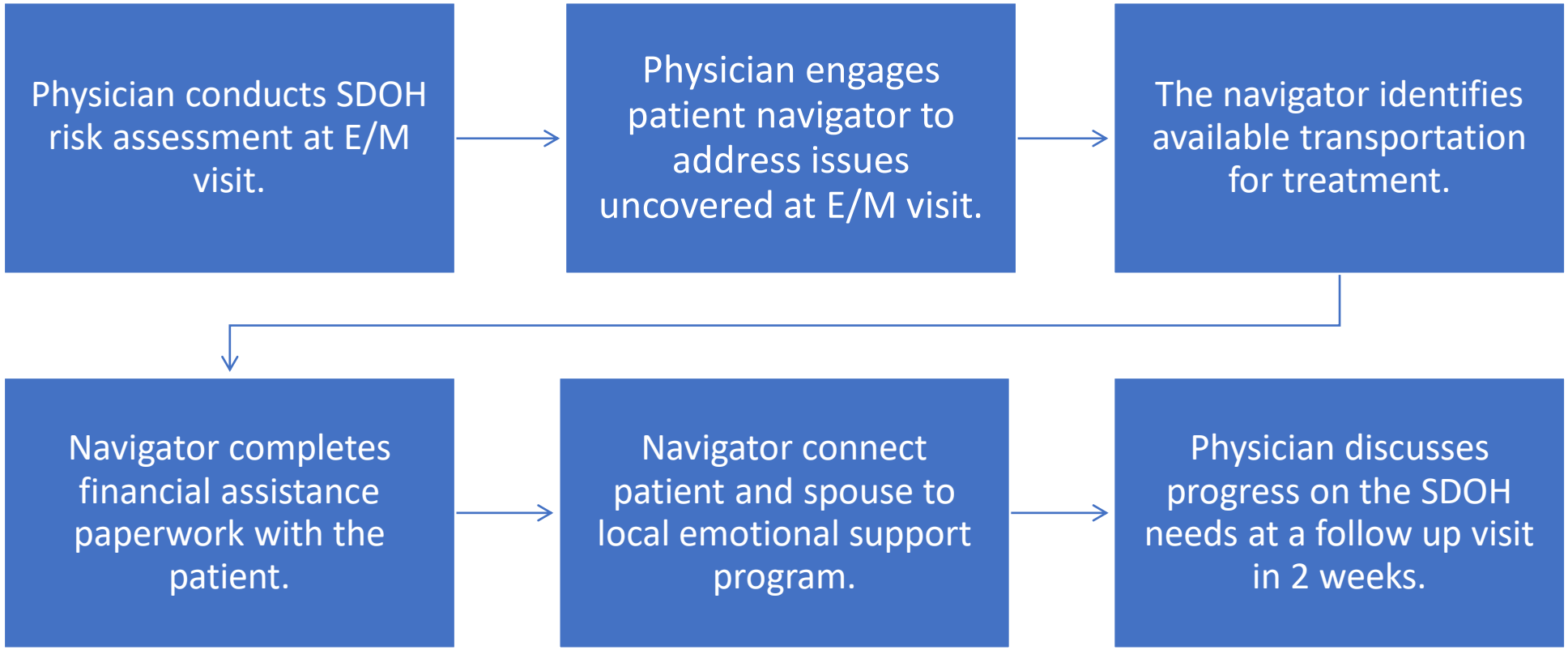
Patient Navigation
Code Selection

What is the reason for the navigation?

Who provided the service?

Were the **time requirements** for the code(s) met?

Principal Illness Navigation Example



- An appropriate E/M code (99202-99215)
- G0136 for the SDOH risk assessment
- G0023 for first 60 minutes

Care Management Services

Code Comparison – Care Management Services

Chronic Care Management	Complex Chronic Care Management	Principal Care Management
Two or more chronic conditions expected to last **at least 12 months** (or until the death of the patient).		**One** complex chronic condition expected to last **at least 3 months**.
Service time is per calendar month.		
Significant risk of death, acute exacerbation/decompensation or functional decline.		
A care plan is established, implemented, revised, or monitored.		
	Moderate or high complexity medical decision making.	Management of the condition is **complex** due to comorbidities.

Code Comparison – Care Management

Service	Physician or Qualified Healthcare Professional	Clinical Staff
Chronic Care Management	99491: First 30 minutes, personally provided by a physician or qualified healthcare professional 99437: Each additional 30 minutes (limited to 2x per month)	99490: First 20 minutes of clinical staff time directed by a physician or qualified healthcare professional 99439: Each additional 20 minutes (limited to 2x per month)
Complex Chronic Care Management	No CPT code. Must still provide direction to clinical staff. Time spent on clinical staff activities personally performed by the physician/QHP may be counted towards the clinical staff time.	99487: First 60 minutes of clinical staff time directed by a physician or other qualified healthcare professional 99489: Each additional 30 minutes
Principal Care Management	99424: First 30 minutes, personally provided by a physician or qualified healthcare professional 99425: Each additional 30 minutes (limited to 2x per month)	99426: First 30 minutes of clinical staff time directed by a physician or qualified healthcare professional 99427: Each additional 30 minutes (limited to 2x per month)

See full CPT ® code descriptions and guidelines in the AMA CPT Professional Edition 2024 CPT® 2024 Professional Edition. Chicago, IL: American Medical Association, 2023.

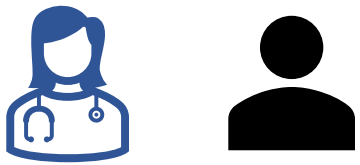
Activities That Do Not Count Towards Time

The time of these services **do not** count towards the time of care management service.

- Telephone E/M services
- Medication therapy management-Pharmacist
- Online digital E/M services
- Prolonged E/M Services (different day than E/M)
- Patient/caregiver training INR monitoring
- ESRD services

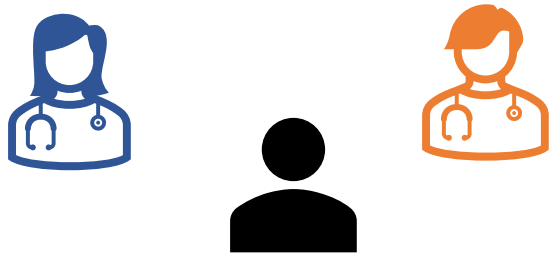
Clinician Reimbursement Care Management

Chronic and Complex Care Management Services



Only **one** clinician per beneficiary per calendar month.

Principal Care Management Services



More than one clinician per beneficiary *if* the patient experiences an exacerbation of more than one complex chronic condition simultaneously.

CMS Initiating Visit Requirement
Chronic Care Management Services

Applies to a **new patient** *or* **patient not seen within 1 year** prior to the start of the chronic care management service. One of the following services must be performed:

- Annual Wellness Visit (AWV).
- Initial Preventive Physical Exam (IPPE).
- E/M visit.

CMS VMCG, CMS/CM/PCG/DPIPD, and CMS. 2016. "Chronic Care Management Services." https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf.

Care Management Services
Code Selection

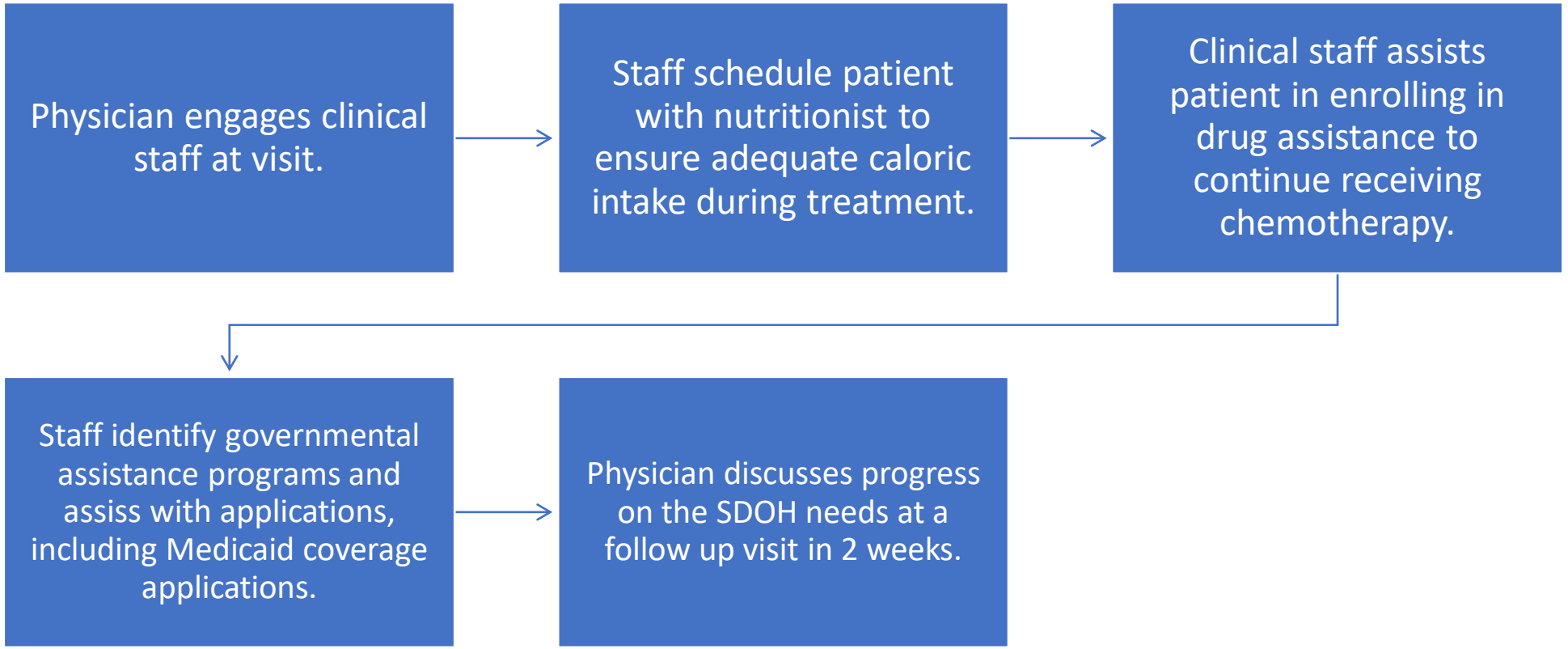
How many conditions are being managed?

How long is the condition expected to last?

Who provided the service?

Were the **time requirements** for the code(s) met?

Principal Care Management Example



- An appropriate E/M code (99202-99215)
- 99426 for first 30 minutes of staff time.
- 99427 for additional 30 minutes.
- Physician follow up either E/M or PCM but not both.

ASCO®
AMERICAN SOCIETY OF CLINICAL ONCOLOGY
KNOWLEDGE CONQUERS CANCER

Reimbursement

Community Health Integration Reimbursement

Service	Reimbursement & RVU
Community Health Integration 60 minutes per calendar month (G0019) Each additional 30 minutes per calendar month (G0022)	G0019: $80.56 (2.42) G0022: $50.26 (1.51)

Reimbursement reflects national amounts for the non-facility setting. Actual amounts will vary by location.
Date of service reporting: Reported per calendar month. No frequency limits. Cost-sharing applies.

Principal Illness Navigation Reimbursement

Service	Reimbursement & RVU
Principal Illness Navigation 60 minutes per calendar month (G0023) Each additional 30 minutes per calendar month (G0024)	G0023: $80.56 (2.42) G0024: $50.26 (1.51)

Reimbursement reflects national amounts for the non-facility setting. Actual amounts will vary by location.
Date of service reporting: Reported per calendar month. No frequency limits. Cost-sharing applies.

Social Determinant Risk Assessment Reimbursement

Service	Reimbursement & RVU
Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment, 5-15 minutes, not more often than every 6 months (G0136)	G0136: $18.97 (0.57)

Reimbursement reflects national amounts for the non-facility setting. Actual amounts will vary by location.
Date of service reporting: Limited to once every 6 months.
Cost-sharing applies unless performed as element of AWV.

Chronic Care Management Reimbursement

Service	Reimbursement & RVU
Chronic Care Management – Staff Time First 20 minutes per calendar month (99490) Each additional 20 minutes per calendar month (99439)	99490: $62.58 (1.88) 99439: $47.93 (1.44)

Reimbursement reflects national amounts for the non-facility setting. Actual amounts will vary by location. Cost-share applies.

Chronic Care Management Reimbursement

Service	Reimbursement & RVU
Chronic Care Management – Practitioner Time First 30 minutes per calendar month (99491) Each additional 30 minutes per calendar month (99437)	99491: $84.55 (2.54) 99437: $59.59 (1.79)

Reimbursement reflects national amounts for the non-facility setting. Actual amounts will vary by location. Cost-share applies.

Complex Chronic Care Management Reimbursement

Service	Reimbursement & RVU
Complex Chronic Care Management – Staff Time First 60 minutes per calendar month (99487) Each additional 30 minutes per calendar month (99489)	99487: $134.15 (4.03) 99489: $72.23 (2.17)

Reimbursement reflects national amounts for the non-facility setting. Actual amounts will vary by location. Cost-share applies.

Principal Care Management Reimbursement

Service	Reimbursement & RVU
Principal Care Management – Staff Time First 30 minutes per calendar month (99426) Each additional 30 minutes per calendar month (99427)	99426: $61.92 (1.86) 99427: $47.27 (1.42)

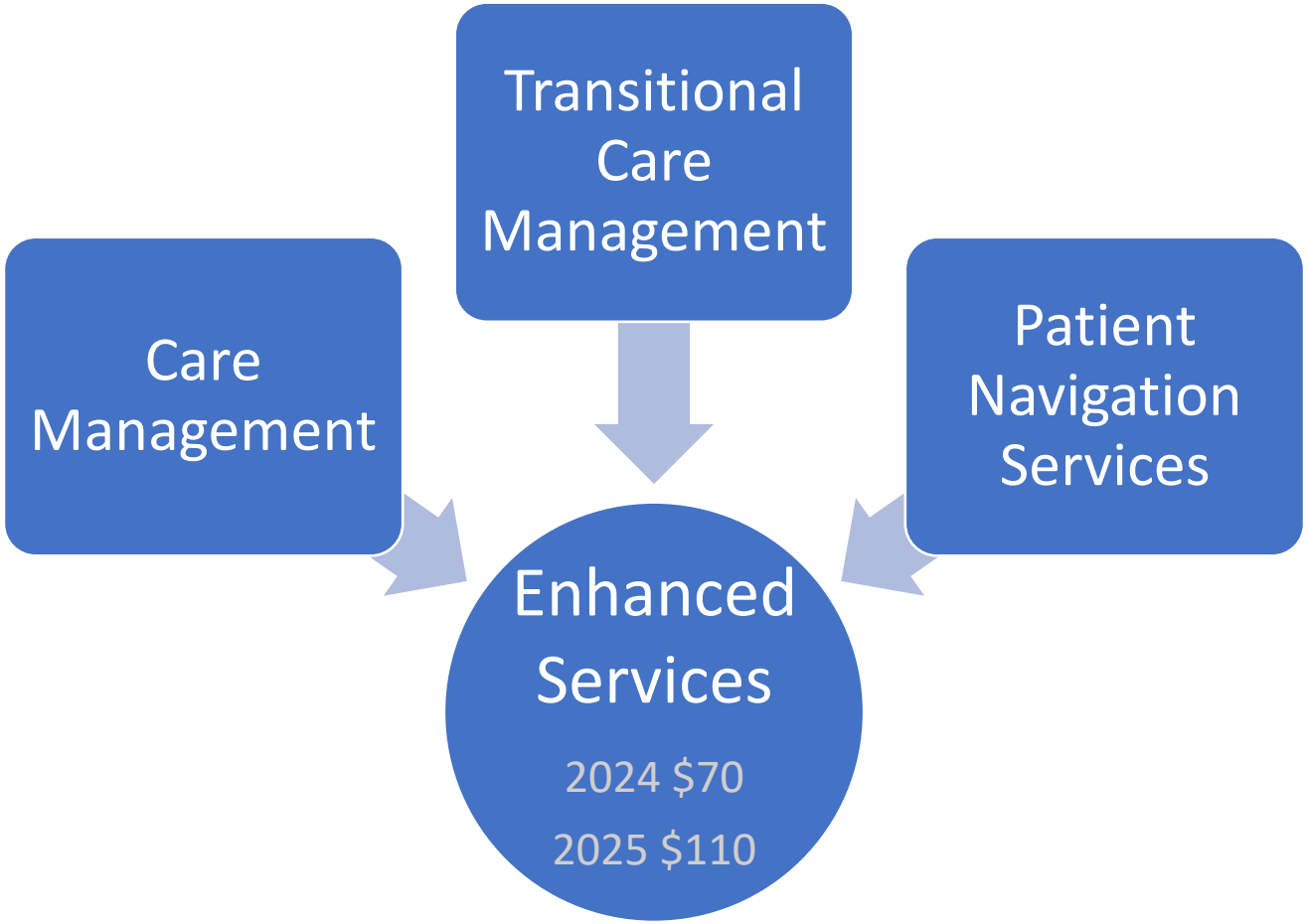
Reimbursement reflects national amounts for the non-facility setting. Actual amounts will vary by location. Cost-share applies.

Principal Care Management Reimbursement

Service	Reimbursement & RVU
Principal Care Management – Practitioner Time First 30 minutes per calendar month (99424) Each additional 30 minutes per calendar month (99425)	99424: $82.55 (2.48) 99425: $59.92 (1.80)

Reimbursement reflects national amounts for the non-facility setting. Actual amounts will vary by location. Cost-share applies.

Enhanced Oncology Model



EOM Second Cohort Fact Sheet | CMS; Update: Enhancing Oncology Model Factsheet | CMS

ASCO®
AMERICAN SOCIETY OF CLINICAL ONCOLOGY
KNOWLEDGE CONQUERS CANCER

Resources

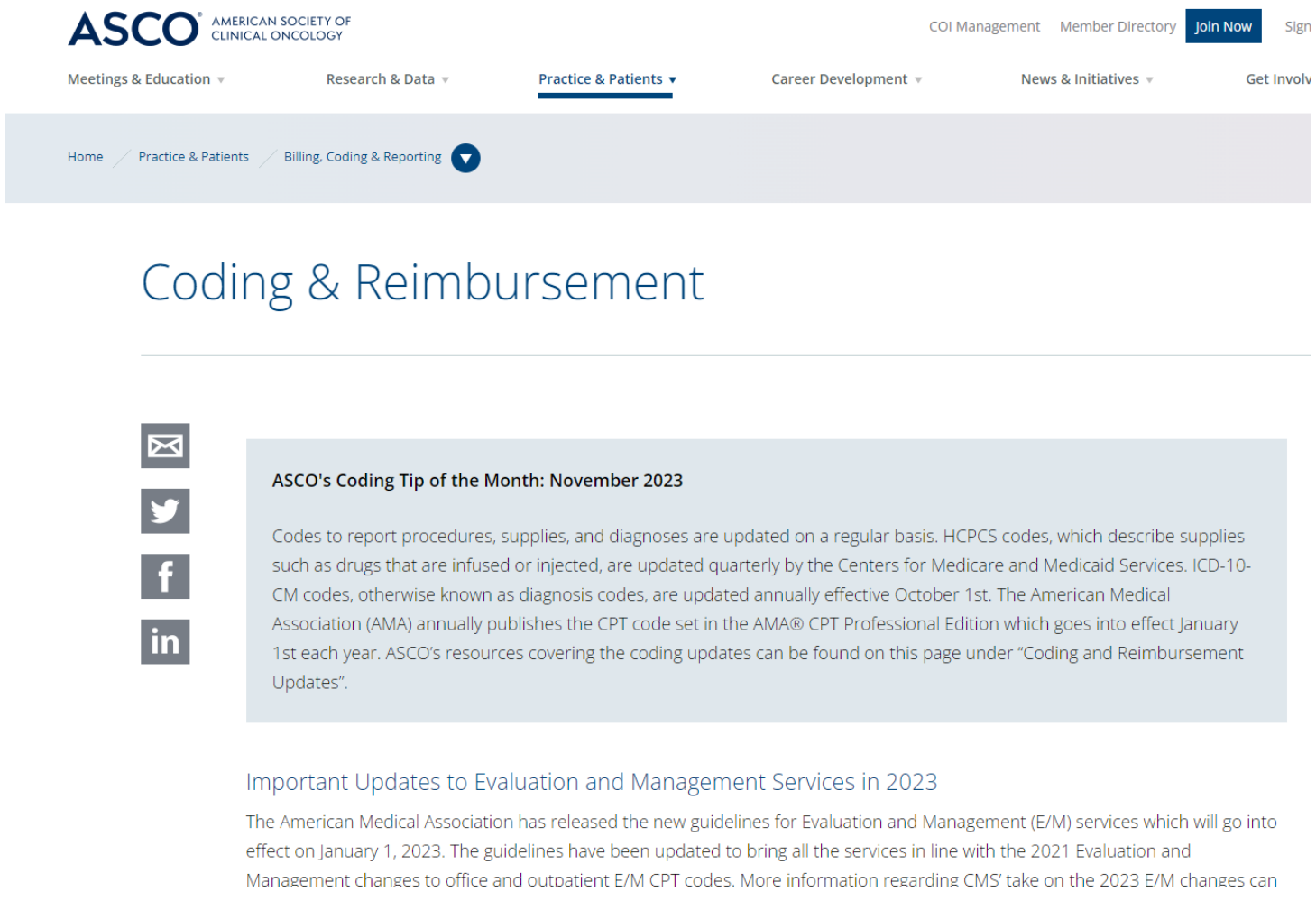
CMS Resources

- CMS Care Management Services
- CMS Health-Related Social Needs FAQ
- Health Equity Services in the 2024 Physician Fee Schedule Final Rule
- Annual Wellness Visit: Social Determinants of Health Risk Assessment
- 2024 Medicare Physician Fee Schedule Final Rule

ASCO Resources

- Care Management Services
- Care Management and Patient Navigation Services Comparison

Coding and Reimbursement Resources



Available Resources

- Tip of the Month
- HCPCS and ICD-10 Updates
- Updates to E/M Services in 2021 and 2023
- Practice Administration Guides

ASCO AMERICAN SOCIETY OF CLINICAL ONCOLOGY
KNOWLEDGE CONQUERS CANCER

- Go to **www.asco.org**
- Select "**Coding & Reimbursement**" under the "**Billing, Coding, and Reporting**" tab.

ASCO®
AMERICAN SOCIETY OF CLINICAL ONCOLOGY
KNOWLEDGE CONQUERS CANCER

Questions about the presentation material or any other coding questions may be sent to practice@asco.org.