Integrating Chronic and Other Care Management Services into Patient Care

Medical Society of Delaware

MSD Hot Topic Education Session

July 21, 2026

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Provider Outreach and Education

NOVITAS SOLUTIONS

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Agenda

1. Novitas Solutions
2. Management of Patient Care
3. Chronic Care Management (CCM)
4. Principal Care Management (PCM)
5. Principal Illness Navigation (PIN)

Acronym List

Acronym	Definition
CCM	Chronic care management
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
DME	Durable Medical Equipment
E/M	Evaluation and management
ESRD	End stage renal disease
HCPCS	Healthcare Common Procedure Coding System
HH+H	Home Health and Hospice
IOM	Internet-Only Manual
MAC	Medicare Administrative Contractor
MDM	Medical decision making
MLN	Medicare Learning Network
NPP	Non-physician practitioner
PCM	Principal care management
PIN	Principal illness navigation

Novitas Solutions

Who We Are and What We Offer

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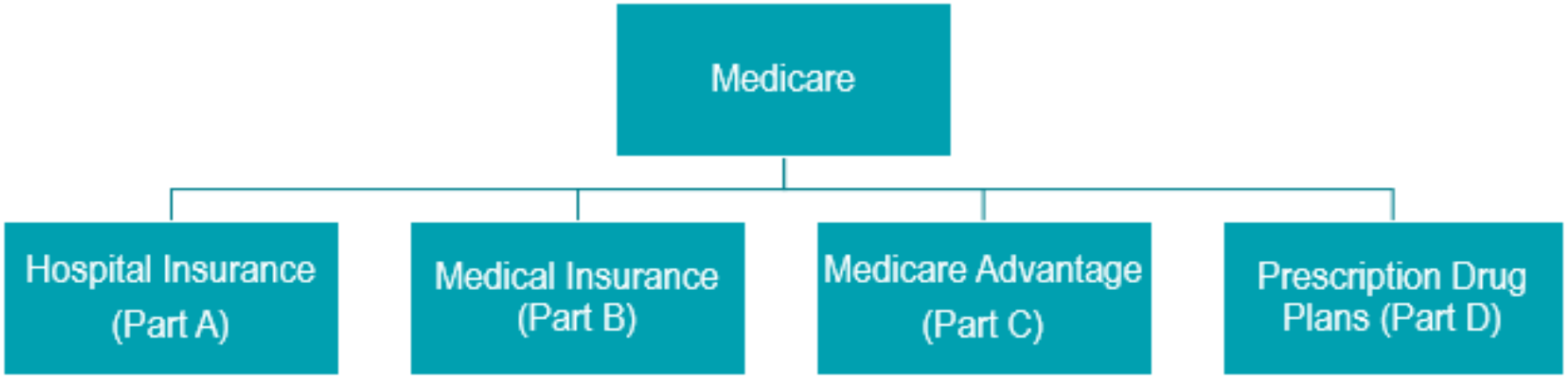
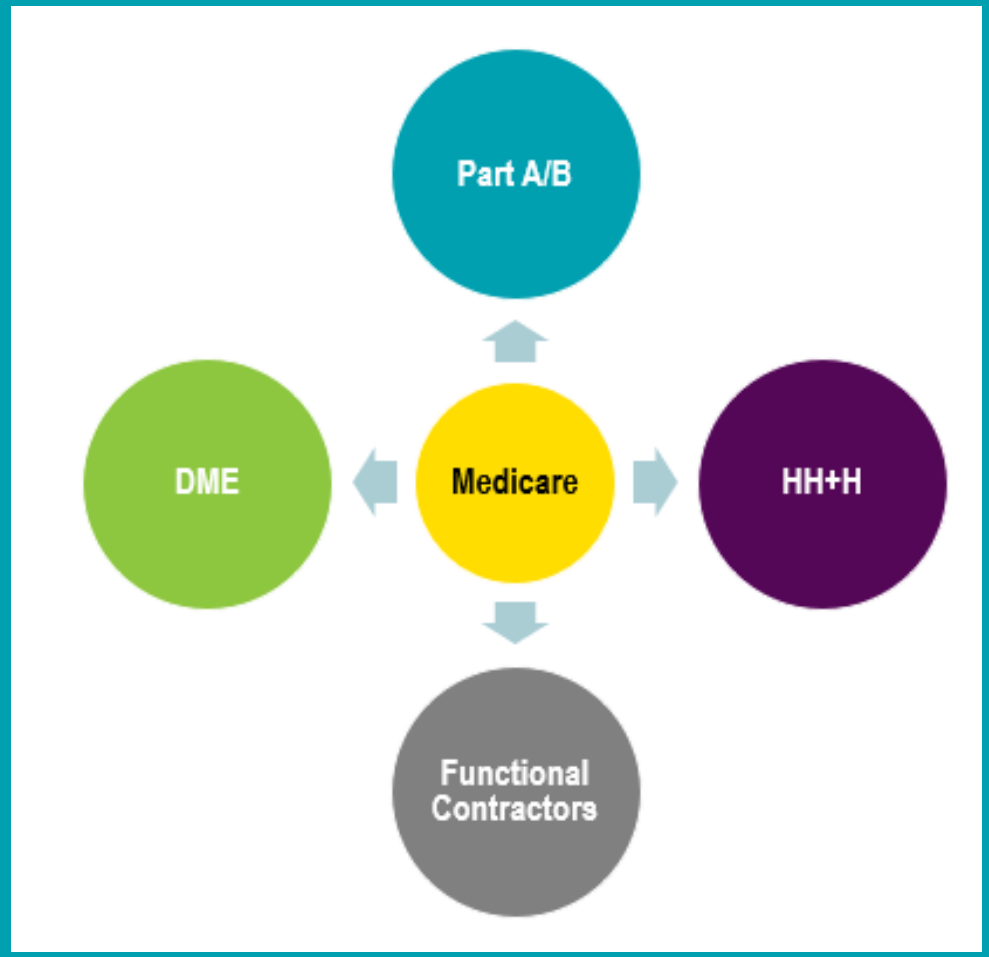
Medicare Program



- Background:
  - CMS is the federal agency responsible for providing health coverage for the Medicare program
  - Medicare program is the largest health insurance program in the United States
- Purpose:
  - Provides insurance coverage to individuals eligible to enroll:
    - Age 65 and older
    - Disabled individuals under the age of 65
    - Individuals with permanent kidney failure (end stage renal disease)
- Note: MACs do not have information or answer questions on Medicare Advantage plans (Part C) or Prescription Drug plan (Part D)
- References:
  - Centers for Medicare & Medicaid Services
  - What Medicare Part A Covers
  - What Medicare Part B Covers
  - Medicare Advantage Plan Directory
  - Prescription Drug Plan Directory

CMS Contractors

- Medicare Administrative Contractor (MAC) definition:
  - MACs are multi-state, regional contractors responsible for processing Medicare claims for a defined geographic area or jurisdiction:
    - Part A: hospital insurance
    - Part B: medical insurance
    - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)
    - Home Health and Hospice (HH+H)
- Functional contractors' definition:
  - Other CMS contractors who assist with:
    - Facilitating program integrity activities
    - Performing administrative functions
    - Promoting equitable access to high quality and affordable health care
- Reference:
  - What's a MAC

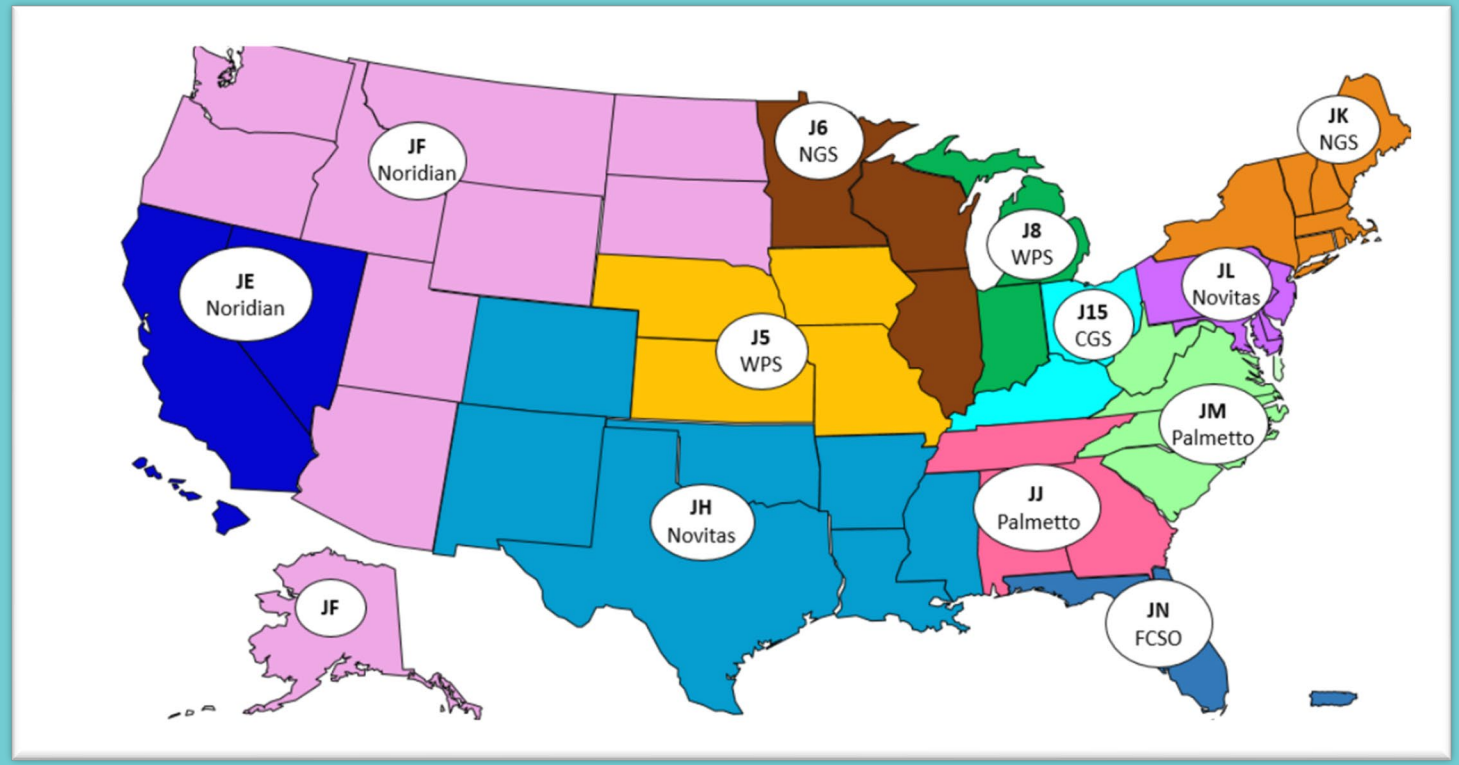


What MACs Do


Enforce program integrity
Enroll providers and suppliers
Coordinate with CMS and other Medicare contractors
Process claims
Issue decisions regarding appeal requests (redeterminations)
Reconcile Medicare reimbursement
Facilitate outreach and education
Respond to provider inquiries

MAC Jurisdictions: Part A/B

- Novitas Solutions:
  - Part A/B Jurisdiction H (JH):
    - Arkansas (AR), Colorado (CO), Louisiana (LA), Mississippi (MS), New Mexico (NM), Oklahoma (OK), and Texas (TX)
  - Indian Health Services (IHS)
  - Veterans Affairs
  - Part A/B Jurisdiction L (JL):
    - District Colombia (DC), Delaware (DE), Maryland (MD), New Jersey (NJ), Pennsylvania (PA)
- Two main office locations:
  - Jacksonville, FL
  - Mechanicsburg, PA



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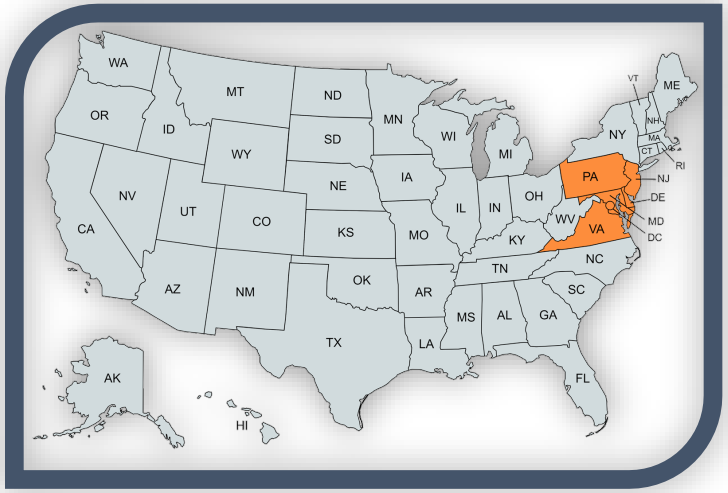
Medicare Administrative Contractor

Jurisdiction L (JL)

Delaware, District of Columbia, Maryland, New Jersey, and Pennsylvania as well as Arlington and Fairfax counties in Virginia, and the cities of Alexandria, Fairfax, and Falls Church in Virginia for Part B services only



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Provider Resources

Assistance is available!

Education

Events and Registration
On-Demand Learning

Provider Enrollment

Enrollment Application Forms
Tutorials
Submission Options

Novitasphere Portal

Portal Enrollment
Features and Functionality

Electronic Billing – EDI

EDI Enrollment
PC-ACE Software
Electronic Remittance Advice

Additional Help

New Provider Roadmap
Self-Service Tools
Fee Schedules

Contact Us

Get connected!

Customer Contact Center

1-877-235-8073
Monday – Friday 8 a.m. - 4 p.m. ET/CT/MT
Phone numbers and mailing addresses

Electronic Mailing List

Latest news and updates

Social Media

Follow us on:
YouTube
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Novitas Portal - Novitasphere

- Novitasphere is a **free** secure internet portal available to providers, billing services, and clearinghouses
- Novitasphere provides numerous tools to help prevent billing errors and other compliance concerns including (not an all-inclusive list):
  - Patient eligibility details
  - MBI lookup tool
  - Claim status
  - Appeals
  - Claim corrections (Part B only)
  - Comparative billing reports (Part B only)
  - Submit/Retrieve documents
- Live Chat feature
- Dedicated Help Desk 1-855-880-8424
- Reference:
  - Novitasphere (JH) (JL)

Educational Opportunities

- Live webinars focused on specialty specific and widespread topics incorporating real-time Medicare requirements, processes, and instructions regarding how to prevent frequent and costly errors:
  - Topics change monthly
  - StayConnected Workshop Series
  - Medicare Navigator Series
  - Educational Event Calendar (JH) (JL)
- Full repository of On-Demand Learning (JH) (JL) educational resources available convenient viewing:
  - Click-and-play videos
  - Webinar recordings
- **Free:**
  - All educational opportunities are free

Management of Patient Care

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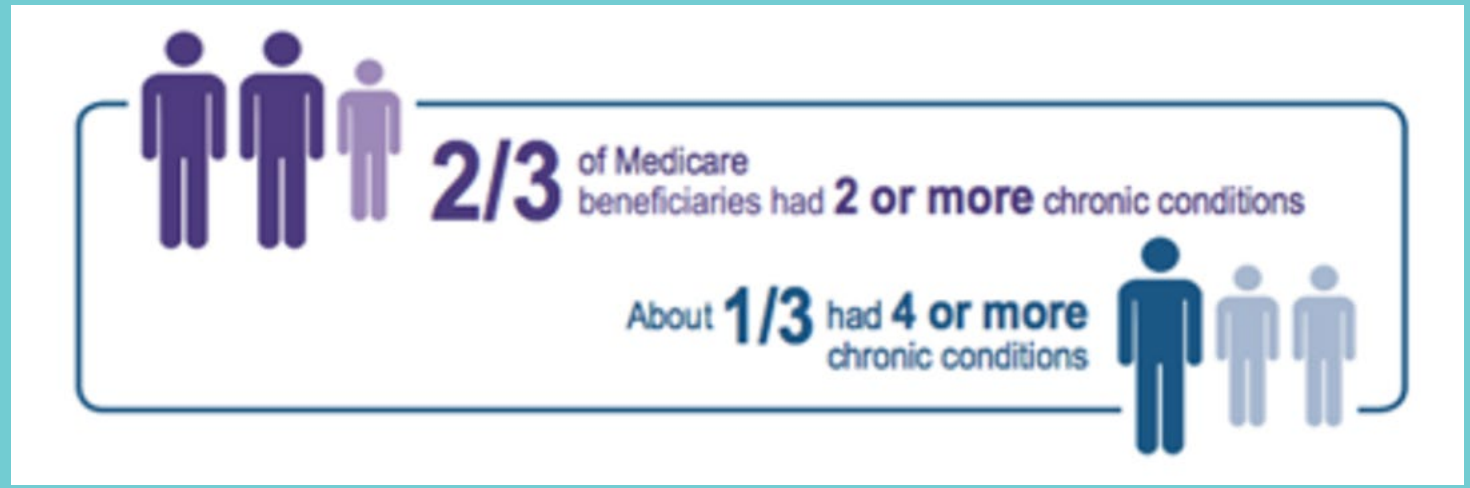
Care Management Services

- Definition:
  - Collaborative approach to healthcare focusing on the patient, rather than just their condition
- Care management services:
  - Provide coordinated services supporting ongoing patient care
  - Focus on the whole patient across conditions
  - Include assessment care planning and coordination
  - Support management of chronic conditions
  - Improve care quality and continuity

Chronic Conditions and Care Management

- Many Medicare patients have 1 or more chronic conditions
- Majority of Medicare expenditures associated with chronic conditions
- Care management services support coordination of complex care
- Services are designed to improve outcomes and reduce avoidable utilization



Chronic Care Management (CCM)

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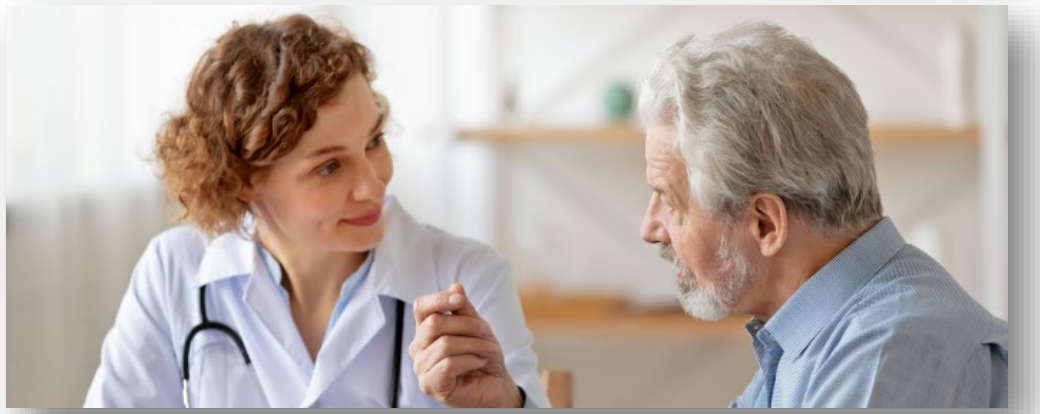
CCM Overview

- CMS recognizes CCM as a critical primary care service that contributes to better Medicare patient health and care
- Non-face-to-face care management services under Medicare Physician Fee Schedule
- Requires 2 or more chronic conditions
- Conditions expected to last at least 12 months or until death
- Conditions place patient at risk of:
  - Hospitalization
  - Acute exacerbation
  - Functional decline

- CCM services include (not all-inclusive list):
  - Ongoing care coordination
  - Development and maintenance of care plan
  - Communication with care team and patient
  - Access to care management support
- Reference:
  - Medicare Learning Network (MLN) Booklet: MLN909188 - Chronic Care Management Services



Chronic Conditions

- Examples of chronic conditions include, but are not limited to:
  - Alcohol abuse
  - Alzheimer's disease and related dementia
  - Arthritis (osteoarthritis and rheumatoid)
  - Asthma
  - Atrial fibrillation
  - Autism spectrum disorders
  - Cancer (breast, colorectal, lung, and prostate)
  - Cardiovascular disease
  - Chronic kidney disease
  - Chronic obstructive pulmonary disease (COPD)
  - Depression
  - Diabetes
  - Heart failure
  - Hepatitis (chronic viral B & C)
  - HIV and AIDS
  - Hyperlipidemia (high cholesterol)
  - Hypertension (high blood pressure)
  - Ischemic heart disease
  - Osteoporosis
  - Schizophrenia and other psychotic disorders
  - Stroke
  - Substance use disorders

CCM Billing Practitioners

- CCM services may be furnished by specific practitioner types:
  - Physicians
  - Certified nurse midwives (CNMs)
  - Clinical nurse specialists (CNSs)
  - Nurse practitioners (NPs)
  - Physician assistants (PAs)
  - Clinical staff services:
    - ➢ Clinical staff may deliver CCM services not provided directly by the billing practitioner, under direction of the billing practitioner on an incident to basis:
      - ❑ To be covered as incident to the physician's service, the service must be:
        - ✓ An integral, although incidental, part of the physician's professional service
        - ✓ Commonly rendered without charge or included in the physician's bill
        - ✓ Commonly furnished in physician's offices or clinics
        - ✓ Furnished by the physician or by auxiliary personnel under the physician's general supervision

CCM Patient Eligibility

- To qualify for CCM, patients must meet the following criteria
  - 2 or more chronic conditions
  - Expected duration at least 12 months or until death
  - Conditions place patient at significant risk of:
    - Exacerbation
    - Functional decline
    - Hospitalization
- Billing requirements:
  - Minimum 20 minutes of non-face-to-face time per month
  - Services based on cumulative monthly time
  - Patient must be a Medicare beneficiary

CCM Billing and Reimbursement

- Billing for CCM services includes initiating visits and monthly time-based reporting
- Initiating visit:
  - Required for new patients or those not seen within previous 12 months
  - May be reported separately
  - Add-on code can cover time spent outside of usual efforts
- Monthly billing codes:
  - Time-based codes per calendar month
  - Non-complex CCM – clinical staff time
  - Complex CCM – requires moderate or high MDM
- Rural health clinics (RHC) / Federally qualified health centers (FQHC) billing:
  - RHCs and FQHCs use specific codes for CCM services
  - Reimbursement includes care management elements
- Reference:
  - Care Management Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Frequently Asked Questions

CCM Patient Consent

- Patients need to provide informed consent only once unless they switch to a different CCM practitioner
- Obtain consent prior to billing
- Written or verbal consent permitted
- Document in the medical record:
  - Available CCM services
  - Possible cost sharing responsibilities
  - Single practitioner billing requirement
  - Right to stop CCM services at any time (effective at the end of the calendar month)
  - Information required was explained by the practitioner and whether the patient accepted or declined services

CCM Service Elements

- CCM service elements apply to both service types:
  - Non-complex CCM:
    - 30 minutes per month
  - Complex CCM:
    - 60 minutes per month
- Non-face-to-face services:
  - Care coordination across providers
  - Management of care transitions
  - Communication with patient and caregivers
- Care plan requirements:
  - Electronic care plan maintained
  - Regular review and updates
  - Accessible to care team
- Access and continuity:
  - 24/7 access to care team
  - Ongoing patient-practitioner relationship

Care Plan Requirements

- A care plan is central to CCM services and must be consistently maintained and accessible
- The comprehensive care plan for all health issues with a focus on managing chronic conditions must be:
  - Person-centered electronic care plan
  - Based on comprehensive assessment and available supports
  - Created revised and monitored per code requirements
  - Shared with patient and caregivers
  - Electronically captured and maintained
  - Available to all providers involved in care across settings

Comprehensive Care Plan for All Health Issues

- Comprehensive care plan for all health issues typically includes, but isn't limited to:
  - Problem list
  - Expected outcome and prognosis
  - Measurable treatment goals
  - Cognitive and functional assessment
  - Symptom management
  - Planned interventions
  - Medication management
  - Environmental evaluation
  - Caregiver assessment
  - Interaction and coordination with outside resources, practitioners, and providers
  - Periodic review requirements
  - Revision of the care plan, when applicable

Care Transition Management

- Coordinate care across providers and settings
- Document referrals and follow-up activities
- Support transitions after:
  - Hospital discharge
  - Skilled nursing facility stay
  - Emergency department visit
- Share continuity of care documentation promptly

CCM Codes

- CCM codes to use for each service based on who is performing the service and how long it is performed each month:

Code	Care type	Staff Type	Time	Add-on code	Add-on code time
99490	Chronic care management	Clinical staff	First 20 minutes	+99439	Each additional 20 minutes (+Billed with primary code 99490)
99491	Chronic care management	Physician or other qualified health care professional	First 30 minutes	+99437	Each additional 30 minutes (+Billed with primary code 99491)
99487	Complex chronic care management	Clinical staff	First 60 minutes	+99489	Each additional 30 minutes (+ Billed with primary code 99487)
G3002	Chronic pain management and treatment	Physician or other qualified health care professional	First 30 minutes (Must meet or exceed 30 minutes)	+G3003	Each additional 15 minutes (Must meet or exceed 15 minutes) (+ Billed with primary code G3002)

Chronic Pain Management Services

- In addition to CCM services Medicare also covers chronic pain management services
- Medicare reimburses for chronic pain management and treatment as a monthly bundle
- Requires initial face-to-face visit at least 30 minutes
- Includes:
  - Assessment and monitoring
  - Use of validated pain scale
  - Development and maintenance of care plan
  - Medication management
  - Care coordination across providers
  - Behavioral health integration as needed

Medical Decision Making (MDM)

- Complex CCM requires moderate or high complexity MDM
- MDM level supports classification of CCM services
- Refer to AMA CPT guidance for MDM criteria:
  - A guide to assist in selecting the level of MDM for reporting an E/M service code
- Reference:
  - Table 2 – CPT E/M Office Revisions Level of Medical Decision Making (MDM)

Table 2 – CPT E/M Office Revisions Level of Medical Decision Making (MDM)

Revisions effective January 1, 2021:

Note: this content will not be included in the CPT 2020 code set release

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making: Number and Complexity of Problems Addressed	Elements of Medical Decision Making: Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Elements of Medical Decision Making: Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	N/A	N/A	N/A	N/A
99202 99212	Straightforward	**Minimal** • **1** self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

99203
99213
	Low	**Low**
		• **2** or more self-limited or minor problems;
		or
		• **1** stable chronic illness;
		or
		• **1** acute, uncomplicated illness or injury
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
			Category 1: Tests and documents
			• **Any combination of 2 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • review of the result(s) of each unique test*;
			  • ordering of each unique test*
			or
			Category 2: Assessment requiring an independent historian(s)
			(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)
				Low risk of morbidity from additional diagnostic testing or treatment

99204
99214
	Moderate	**Moderate**
		• **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment;
		or
		• **2** or more stable chronic illnesses;
		or
		• **1** undiagnosed new problem with uncertain prognosis;
		or
		• **1** acute illness with systemic symptoms;
		or
		• **1** acute complicated injury
			Moderate
			(Must meet the requirements of at least 1 out of 3 categories)
			Category 1: Tests, documents, or independent historian(s)
			• **Any combination of 3 from the following**:
			  • Review of prior external note(s) from each unique source*;
			  • Review of the result(s) of each unique test*;
			  • Ordering of each unique test*;
			  • Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
			or
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported)
				Moderate risk of morbidity from additional diagnostic testing or treatment
				
				Examples only:
				• Prescription drug management
				• Decision regarding minor surgery with identified patient or procedure risk factors
				• Decision regarding elective major surgery without identified patient or procedure risk factors
				• Diagnosis or treatment significantly limited by social determinants of health

99205
99215
	High	**High**
		• **1** or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;
		or
		• **1** acute or chronic illness or injury that poses a threat to life or bodily function
			Extensive
			(Must meet the requirements of at least 2 out of 3 categories)
			Category 1: Tests, documents, or independent historian(s)
			• **Any combination of 3 from the following**:
			  • Review of prior external note(s) from each unique source*;
			  • Review of the result(s) of each unique test*;
			  • Ordering of each unique test*;
			  • Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
			• **Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);**
			or
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
				High risk of morbidity from additional diagnostic testing or treatment
				
				Examples only:
				• Drug therapy requiring intensive monitoring for toxicity
				• Decision regarding elective major surgery with identified patient or procedure risk factors
				• Decision regarding emergency major surgery
				• Decision regarding hospitalization
				• Decision not to resuscitate or to de-escalate care because of poor prognosis

Moderate Level of MDM

- AMA definition of moderate level of MDM:

Number and complexity of problem(s) that are addressed during the encounter	Amount and/or complexity of data to be reviewed and analyzed	Risk of complications and/or morbidity or mortality of patient management
Moderate ❑ 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment: or ❑ **2 or more** stable chronic illnesses; or ❑ **1** undiagnosed new problem with uncertain prognosis ❑ **1** acute illness with systemic symptoms ❑ **1** acute complicated injury	**Moderate** **(Must meet the requirements of at least 1 of the 3 categories)** **Category 1: Tests, documents, or independent historian(s)** ❑ Any combination of **3** from the following: ❑ Review of prior external note(s) from each unique source*; ❑ Review of the result(s) of each unique test*; ❑ Ordering of each unique test* ❑ Assessment requiring an independent historian(s) (*Each unique test, order or document is counted to meet a threshold number) ❑ **Category 2: Independent interpretation of test(s) performed by another physician/other qualified health care professional (not separately reported)** ❑ **Category 3: Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported)**	**Moderate** ❑ Moderate risk of morbidity from additional diagnostic testing or treatment Examples only: ❑ Prescription drug management ❑ Decision regarding minor surgery with identified patient or procedure risk factors ❑ Decision regarding elective major surgery without identified patient or procedure risk factors ❑ Diagnosis or treatment significantly limited by social determinants of health

High Level of MDM

- AMA definition of high level of MDM:

Number and complexity of problem(s) that are addressed during the encounter	Amount and/or complexity of data to be reviewed and analyzed	Risk of complications and/or morbidity or mortality of patient management
High ❑ **1** or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; or ❑ **1** acute or chronic illness or injury that poses a threat to life or bodily function	**Extensive** **(Must meet the requirements of at least 2 of the 3 categories)** **Category 1: Tests, documents or independent historian(s)** ❑ Any combination of **3** from the following: ❑ Review of prior external note(s) from each unique source*; ❑ Review of the result(s) of each unique test*; ❑ Ordering of each unique test* ❑ Assessment requiring an independent historian(s) (*Each unique test, order or document is counted to meet a threshold number) ❑ **Category 2: Independent interpretation of test(s) performed by another physician/other qualified health care professional (not separately reported)** ❑ **Category 3: Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported)**	**High risk of morbidity from additional diagnostic testing or treatment** Examples only: ❑ Drug therapy requiring intensive monitoring for toxicity ❑ Decision regarding elective major surgery with identified patient or procedure risk factors ❑ Decision regarding emergency major surgery ❑ Decision regarding hospitalization ❑ Decision not to resuscitate or to de-escalate care because of poor prognosis

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Concurrent Billing of Care Management Services

- Concurrent billing of care management services is allowed:
  - CCM codes 99487, 99489, 99490, and 99491 by the same practitioner for services provided during the 30-day TCM service period (CPT codes 99495, 99496)
  - RHCs and FQHCs with CCM and TCM services during the same period
  - Remote physiologic monitoring (RPM) and remote therapy monitoring (RTM) with CCM or TCM:
    - Practitioners may bill either RPM and RTM, but not both, concurrently with any CCM or TCM service
- What services cannot be billed concurrently:
  - Complex and non-complex CCM in same month
  - CCM with:
    - G0181 or G0182 (home health care supervision, hospice care supervision)
    - 90951 – 90970 (certain end stage renal disease (ESRD) services)
  - Complex CCM and prolonged E/M services in the same month
  - Same time counted for multiple services

CCM Key Takeaways

- CCM services:
  - Supports patients with multiple chronic conditions:
    - CCM is designed for individuals with 2 or more chronic conditions expected to last at least 12 months or until end of life
  - Improves care coordination and continuity:
    - Services ensure communication among providers and consistent management of the patient's health needs across settings
  - Provides ongoing, non-face-to-face care:
    - Includes care planning, medication management, follow-ups, and patient education conducted outside of office visits
  - Enhances patient outcomes and quality of life:
    - Focuses on proactive management to prevent complications, hospitalizations, and disease progression
  - Requires a comprehensive care plan:
    - A personalized, patient-centered care plan is created, regularly updated, and shared with the care team and patient
  - Encourages patient engagement and self-management:
    - Patients are supported with education and tools to actively participate in managing their conditions
  - Includes 24/7 access to care support:
    - Patients must have the ability to reach a care team member for urgent care needs at any time

Principal Care Management (PCM)

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PCM Services Overview

- PCM differs from CCM by focusing on a single high-risk condition
- Condition expected to last at least 3 months
- Condition places patient at risk of hospitalization or decline
- Service characteristics:
  - Disease-specific care plan required
  - Monthly time-based service
  - Minimum 30 minutes per month
- Disease-specific care plan:
  - Electronic care plan:
    - Periodically reviewed and updated
  - Ensure receipt of preventive services
  - Medication management and reconciliation
  - Coordinate with home- and community-based clinical service providers
- References:
  - Principal Care Management Services

Disease-Specific Care Plan

- Much like chronic care management, the disease-specific care plan typically includes, but is not limited to:
  - Problem addressed
  - Expected outcome and prognosis with measurable treatment goals
  - Cognitive and functional assessment
  - Symptom management
  - Planned interventions
  - Medication management
  - Environmental evaluation
  - Caregiver assessment
  - Coordination with outside resources and providers
  - Requirements for periodic review
  - When applicable, revision of the care plan

PCM Coding and Documentation Requirements

- PCM services are billed using codes - 99424, 99425, 99426, 99427
- Minimum 30 minutes per calendar month
- Time may include practitioner or clinical staff:
  - Non-clinical staff time not counted
- Documentation must include:
  - Time spent
  - Credentials of individual performing service
  - Care plan and patient interaction
- Reference:
  - Medicare Learning Network (MLN) Booklet: MLN909188 – Chronic Care Management Services

PCM Billing Restrictions

- PCM codes cannot be billed during same calendar month as:
  - Chronic care management (CPT codes 99487, 99489, 99490, 99491 and 99439)
  - ESRD (CPT codes 90951-90970)
  - Supervision of home health care or hospice supervision (HCPCS codes G0181 or G0182)
- Time accumulates throughout month:
  - Once threshold requirement fulfilled, claim may be billed
- Use of certified electronic health record (EHR) technology is required to satisfy certain service elements

PCM Services Inclusions and Limitations

- PCM services includes activities not typically or ordinarily furnished face-to-face:
  - Telephone calls
  - Review of medical records or test results
  - Coordination and exchange of health information
  - Patient education or motivational counseling
- Excludes time and effort of any other service:
  - Time and effort cannot count towards any other service or code

Provider Eligibility

- Eligible professionals allowed to bill PCM:
  - Physicians, physician assistants, clinical nurse specialists, nurse practitioners, and certified nurse midwives
  - Hospitals (outpatient only):
    - Includes critical access hospitals (CAHs)
  - RHCs
  - FQHCs
- Typically provided by specialty physicians, but may be provided by primary care practitioners
- Not within the scope of practice of limited license physicians and practitioners, such as clinical psychologists, podiatrists, or dentists
- Only 1 practitioner or facility can report PCM per month

Physician Supervision

- PCM services require general supervision
- General supervision means the billing practitioner doesn't personally furnish the service, it's done under their overall direction and control
- Medicare does not require the physician's physical presence while service is furnished

PCM Patient Eligibility

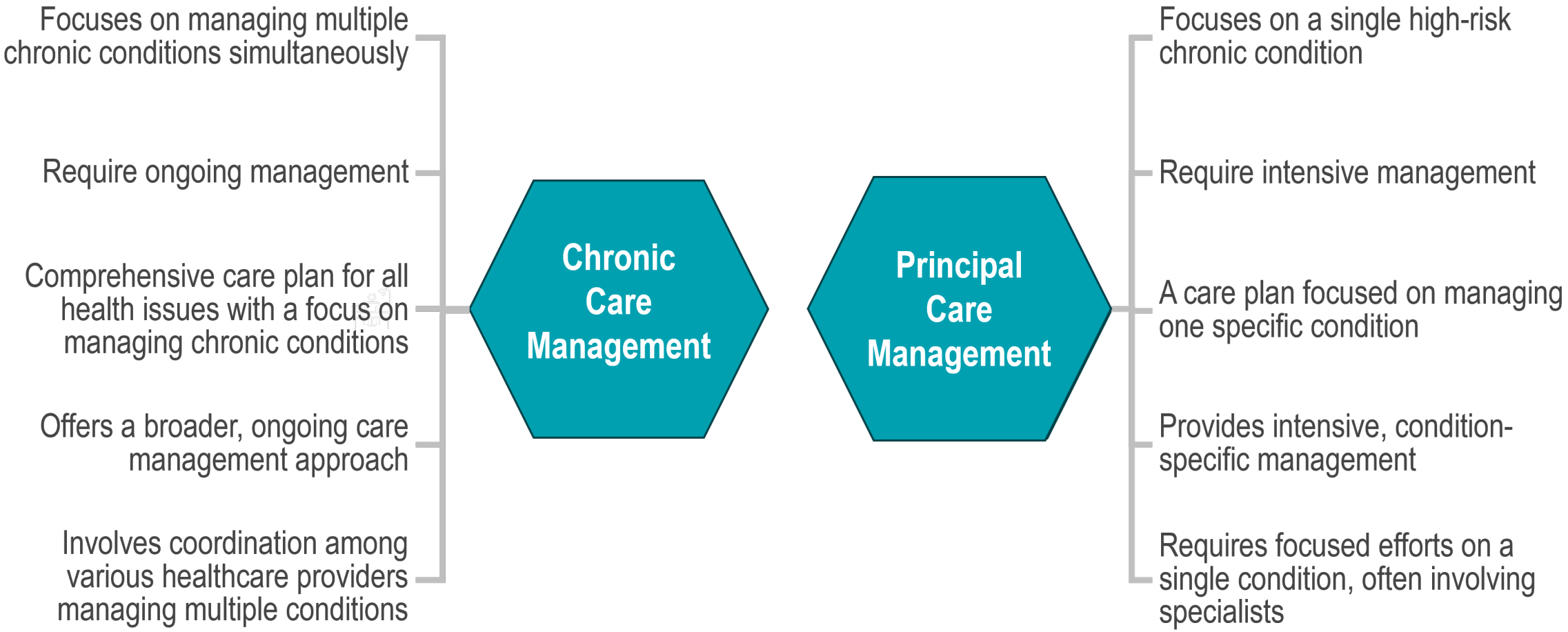
- PCM patient eligibility requirements:
  - Must have a single high-risk disease or complex chronic condition, lasting between 3 months and 1 year or until death:
    - May place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline
    - Problem may have led to a recent hospitalization
  - Patient acceptance and consent **must** be documented
  - Deductible and coinsurance **does** apply

PCM CPT Codes

- The following PCM codes describe time-based services:
  - 99424:
    - First 30 minutes provided personally by a physician or other qualified health care professional (QHP), per calendar month
  - 99425:
    - Each additional 30 minutes provided personally by a physician or QHP (List separately in addition to code for primary procedure)
  - 99426:
    - First 30 minutes of **clinical staff time** directed by physician or other qualified health care professional, per calendar month
  - 99427:
    - Each additional 30 minutes of clinical staff time (List separately in addition to code for primary procedure)
  - **Note: Do not report** 99424 within the same month as 99426

CCM versus PCM

- CCM and PCM services are distinctly different



PCM Key Takeaways

- PCM applies to a single high-risk condition
- Requires at least 30 minutes of qualifying time per month by practitioner or clinical staff
- Requires disease-specific care plan maintenance and periodically reviewed
- Typically furnished by specialty practitioners
- May also be furnished by primary care practitioners
- Transition to CCM when more than 1 chronic condition is present
- PCM and CCM not billed in the same calendar month

Principal Illness Navigation (PIN)

NOVITAS SOLUTIONS

PIN Overview

- PIN services support patients with more than 1 serious condition, expected to last at least 3 months and puts the patient at high risk for 1 or more of the following:
  - Hospitalization
  - Nursing home placement
  - A sudden worsening of preexisting symptoms
  - Physical or mental decline
  - Death
- Principal Illness Navigation (PIN) services:
  - Supports patients with serious high-risk conditions
  - Addresses barriers including social determinants of health
  - Improves access coordination and adherence
- Includes:
  - Care navigation
  - Resource coordination
  - Patient support services
- Reference:
  - Principal Illness Navigation Services
  - Caregiver Training (CTS), Community Health Integration (CHI), Principal Illness Navigation (PIN), and Physical Activity and Nutrition Risk Assessment Services

Who Can Provide PIN Services

- PIN services are provided by trained or certified auxiliary staff, including:
  - Patient navigators
  - Community health workers
  - Certified peer specialists
- PIN-Peer Support services are provided under the direction of a physician or other practitioner:
  - Auxiliary staff providing PIN services must be under the general supervision of a physician or other billing practitioner

When PIN Services Can Be Furnished

- PIN and PIN-Peer Support services require an initiating E/M visit addressing a serious high-risk condition
- Condition requirements:
  - 1 high-risk condition expected to last at least 3 months
  - Places patient at risk of hospitalization, nursing facility placement, exacerbation, functional decline, or death
- Care management requirements:
  - Development, monitoring, or revision of a disease-specific care plan
  - Frequent treatment or medication adjustments or substantial caregiver support

Billing for PIN Services

- PIN services are reported using time based monthly codes
- Provided by trained auxiliary personnel
- Restrictions:
  - 1 practitioner per month
  - PIN and peer support not billed together for same condition
- Reference:
  - Medicare Learning Network (MLN) Booklet: MLN909188: Chronic Care Management Services

Primary code	Description	*Add-on code	Add-on code description
G0023	PIN service, 60 minutes per month	*G0024	PIN service, additional 30 minutes per month (billed with primary code G0023)
G0140	Navigation service, peer support, 60 minutes per month	*G0146	Navigation service, peer support, additional 30 minutes per month (billed with primary code G0140)

PIN Key Takeaways

- PIN supports patients with serious high-risk conditions
- Services address care navigation and social barriers
- Services furnished under the direction of a physician or other practitioner
- Initiation following an E/M visit addressing a serious high-risk condition expected to last at least 3 months
- G0023 and G0024 used for services furnished by certified or trained auxiliary personnel
- G0140 and G0146 used for behavioral health navigation services furnished by auxiliary personnel such as peer support specialists
- PIN services can be provided once per month per practitioner
- PIN and PIN-Peer Support services not billed concurrently for the same condition

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Thank You for Attending!

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