SUPPLEMENT 1 EXECUTIVE SUMMARY OF BILLING CODE CATEGORIES

Instructions for Use

- This high-level summary compares the 5 different billing code categories including: 1) Principal Illness Navigation (PIN); 2) Community Health Integration (CHI); 3) Principal Care Management (PCM); 4) Chronic Care Management (CCM); and 5) Cognitive Assessment and Care Planning (CACP).
- This summary can be used with your local healthcare system leadership and key stakeholders when discussing the different billing code options in your local healthcare system. Please confer with your local billing experts for categories most applicable to your healthcare system.
- For a more in-depth guide about billing codes, please see the Billing Code Resource Guide.

	PRINCIPAL ILLNESS NAVIGATION (PIN). G0023, G0024	COMMUNITY HEALTH INTEGRATION (CHI) G0019, G0022	PRINCIPAL CARE MANAGEMENT (PCM) 99426, 99427	CHRONIC CARE MANAGEMENT (CCM) 99490, 99439, 99487, 99489	COGNITIVE ASSESSMENT & CARE PLANNING (CACP) 99483
WHAT IT IS	Monthly supportive service performed by auxiliary staff to help patients and caregivers navigate the healthcare system during the process of diagnosis and treatment. Generally considered non-clinical in nature.	Monthly supportive service performed by auxiliary staff to help patients and caregivers overcome SDOH barriers to achieve their care plan during the process of diagnosis and treatment. Generally considered non-clinical in nature.	Monthly care management service performed by clinical staff to assist patients with clinical and non-clinical aspects of managing one high risk condition.	Monthly care management service performed by clinical staff to assist patients with clinical and non-clinical aspects of managing their overall health.	Visit with a physician or NPP to focus on detailed cognitive assessment, evaluation and diagnosis of cognitive conditions, and development of a cognition-focused care plan.
PATIENT QUALIFYING CONDITIONS	Confirmed or **suspected** serious, high-risk condition expected to last at least 3 months, which places the patient at risk of decompensation or **functional decline**.	At least one unmet social need that is significantly limiting the provider's ability to make a diagnosis or administer treatment for a specified medical problem. No suspected or confirmed medical diagnosis is required.	One or more complex chronic conditions that are expected to last at least 3 months, which places the patient at risk of hospitalization, acute exacerbation or decompensation, or **functional decline**.	Two or more complex chronic conditions that are expected to last at least 12 months or until the death of the patient, which places the patient at risk of death, acute exacerbation or decompensation, or **functional decline**.	Confirmed or suspected condition that requires additional evaluation and development of a cognitive care plan.

QUALIFYING INITIATING VISIT	• Outpatient E/M visit, other than Level 1, including Transitional Care Management visit • Annual Wellness Visits performed by the billing provider • Certain services typically performed by clinical psychologists Patients must have a qualifying visit every 12 months.	• Outpatient E/M visit, other than Level 1, including Transitional Care Management visit • Annual Wellness Visits performed by the billing provider Patients must have a qualifying visit every 12 months.	• Outpatient E/M visit, other than Level 1, including Transitional Care Management visit • Annual Wellness Visits performed by the billing provider Patients must have a qualifying visit every 12 months.	• Outpatient E/M visit, other than Level 1, including Transitional Care Management visit • Annual Wellness Visits performed by the billing provider Patients must have a qualifying visit every 12 months.	CACP can be performed in response to a self- reported cognition concern, a cognitive finding on assessment/exam, or as part of the ongoing care of a patient with a documented cognitive condition.
MEDICALLY REASONABLE AND NECESSARY	During the qualifying initiating visit, the billing provider must establish the treatment plan and specify how PIN services are reasonable and necessary to help accomplish that plan.	During the qualifying initiating visit, the billing provider must establish the treatment plan and specify how CHI services are reasonable and necessary to help accomplish that plan.	During the qualifying initiating visit, the provider must discuss PCM and establish PCM as reasonable and necessary to accomplish the care plan.	During the qualifying initiating visit, the provider must discuss CCM and establish CCM as reasonable and necessary to accomplish the care plan.	Documentation should make clear the reason for the visit. A qualifying diagnosis code should be added to the claim to demonstrate medical necessity.
OVERSIGHT	The provider who performs the qualifying initiating visit provides general supervision to the navigator/navigation team.	The provider who performs the qualifying initiating visit provides general supervision to the navigator/navigation team.	The care team may operate under the general supervision of any qualified provider (any provider who can bill E/M services.)	The care team may operate under the general supervision of any qualified provider (any provider who can bill E/M services.)	Members of the care team may operate under the direct supervision of the billing provider to assist in gathering data in advance of the visit, preparing the patient/caregiver for the visit, documentation, education of the patient/caregiver, and other aspects of care.

CONSENT	Consent can be obtained by any member of the care team but must precede any billable services. Required elements of consent: • The availability of PIN services • The patient's possible cost sharing responsibilities • The patient's right to stop navigation services at any time (effective at the end of the calendar month) • That the care team member explained the required information and whether the patient accepted or declined services	Consent can be obtained by any member of the care team but must precede any billable services. Required elements of consent: • The availability of CHI services • The patient's possible cost sharing responsibilities • That only one provider can furnish CHI services per month • The patient's right to stop navigation services at any time (effective at the end of the calendar month • That the care team member explained the required information and whether the patient accepted or declined services	Consent can be obtained by any member of the care team but must precede any billable services. Required elements of consent: • The availability of PCM services • The patient's possible cost sharing responsibilities • The patient's right to stop navigation services at any time (effective at the end of the calendar month) • That more than one provider may furnish PCM each month, but not for the same condition • That the care team member explained the required information and whether the patient accepted or declined services	Consent can be obtained by any member of the care team but must precede any billable services. Required elements of consent: • The availability of CCM services • The patient's possible cost sharing responsibilities • The patient's right to stop navigation services at any time (effective at the end of the calendar month) • That the care team member explained the required information and whether the patient • accepted or declined services	Separate documented consent is not required.
BILLING	The provider who performs the qualifying initiating visit is the billing provider.	The provider who performs the qualifying initiating visit is the billing provider.	The provider who supervises the clinical staff rendering services to the patient is the billing provider.	The provider who supervises the clinical staff rendering services to the patient is the billing provider.	The provider who performs the visit is the billing provider.

COMMERCIAL COVERAGE	This service is specific to Medicare and may not be paid by commercial plans. Other HCPCS codes may be used to account for this service. Contact the plan directly.	This service is specific to Medicare and may not be paid by commercial plans. Other HCPCS codes may be used to account for care management. Contact the plan directly.	These services may or may not be paid by commercial plans. Other HCPCS codes may be used to account for PCM. Contact the plan directly.	These services may or may not be paid by commercial plans. Other HCPCS codes may be used to account for CCM. Contact the plan directly.	These services are often paid by commercial plans when medically indicated, but alternative codes may be used to account for this care. Contact the plan directly.
CARE PLAN	The treatment plan should generally describe the plan to assist the patient to the point of diagnosis and be updated with the clinical treatment plan if/when a diagnosis is confirmed.	The treatment plan should generally describe the plan to assist the patient in overcoming unmet SDOH needs to achieve the care plan.	The care plan should focus on the qualifying condition(s) and any other needs impacting the patient's ability to effectively manage their condition(s).	The care plan must be comprehensive, addressing not only the qualifying chronic conditions, but the overall health and wellbeing needs of the patient, including needs related to suspected conditions and unmet SDOH needs.	The written care plan should reflect a synthesis of the information acquired during the cognitive assessment and must be written in plain language that is easy to understand by patients and caregivers. The party responsible for carrying out each action step should be listed. The following elements must be included: 1. Neuropsychiatric symptoms, or their absence, with a plan for management. 2. Neurocognitive symptoms, or their absence, with a plan for management. 3. Functional limitations with a plan for management. 4. Any options for needed community services. 5. The initial follow-up schedule. This care plan must be documented as having been discussed and shared with the patient and/or caregiver at the time of initial education and support.