BRAIN HEALTH NAVIGATOR BILLING CODE RESOURCE GUIDE

Guidance Effective January 1, 2026

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DEFINING BASIC TERMS FOR WORKFLOW AND REIMBURSEMENT

Development of the reimbursement strategy for brain health workflows is most effective when clinicians who are developing clinical workflows understand relevant reimbursement terminology. A robust glossary is provided in Appendix A, but these terms are integral to determining the best reimbursement strategy for your preferred workflow.

Billing Provider: A provider who is eligible to submit claims for billable services, has been granted appropriate billing privileges, and is authorized to submit claims for specified services. Billing provider eligibility may vary by payor.

Supervising Provider/Overseeing Provider: A provider who is authorized to provide supervision to auxiliary personnel for specified services. In most cases, the billing provider is the supervising provider.

Qualifying Initiating Visit: A specified face-to-face service with a patient that must occur before initiating certain care management and navigation services. In some cases, the provider who performs the qualifying initiating visit is required to be the supervising/billing provider for the service.

Auxiliary Personnel: Any staff who is acting under the supervision of a physician, regardless of whether the individual is an employee, leased employee, or independent contractor of the physician, or of the legal entity that employs or contracts with the physician. Auxiliary personnel are not required to have a clinical background or hold a clinical license. However, they must be trained and competent to perform assigned services under the supervision of the provider.

Clinical Staff: Any staff who works for, or under the direction of, a physician or qualified health care professional and does not bill services separately. The person may be–but is not required to be–licensed or regulated to help the physician perform specific duties. Clinical staff are qualified by their training, which may be formal (degree or certification program) or organization-based (internal training programs.)

Patient Navigators for Illness vs Insurance

"Navigator" can have many different definitions.

"Patient navigator", "insurance navigator", and "in-person assister" are all terms used for health insurance navigators, defined as "an individual or organization that's trained and able to help consumers, small businesses, and their employees as they look for health coverage options through the Marketplace, including completing eligibility and enrollment forms." Insurance navigators have a distinct set of educational requirements and certifications they must obtain and maintain.

In this toolkit, "navigator" is used to describe an individual who assists patients in understanding and successfully journeying through the complexities of advanced illness or intricate diagnostic or treatment pathways. Terms like "health system navigator" or "brain health navigator" share the same general meaning. In this paradigm, specific tasks and duties, as well as education, training, and/or certification will depend on the employing organization.

Direct Supervision: The practitioner directs the clinical or auxiliary staff in the performance of the service and is immediately available to join the encounter during the performance of the service. Any service approved to be provided via telehealth (except those with a global surgery indicator of 010 or 090) which requires direct supervision may be performed under direct telehealth supervision, where the supervising practitioner is immediately available to join the encounter via real-time audio and video technology.

General Supervision: The practitioner provides overall direction and control to the clinical or auxiliary staff who are performing the service, but the practitioner's presence is not required during the performance of the service.

PRINCIPAL ILLNESS NAVIGATION (PIN)

Medicare makes payment for navigation services for patients who meet qualifications:

- One (confirmed or suspected) serious, high-risk condition expected to last at least 3 months, which places the patient at significant risk of hospitalization or 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

Medicare specifically mentioned dementia as a disease that would meet the definition of "serious, high-risk diseases" where PIN would be reasonable and necessary, but they clarify that ultimately, "serious, high-risk disease" is based on clinical judgement. PIN can be performed to help patients navigate to a diagnosis, or to help patients post-diagnosis as they navigate their treatment plan.

Navigators spend time in the following tasks to benefit patients/caregivers:

- Person-centered assessment
- Identifying or referring patient (and caregiver or family, if applicable) to appropriate supportive services
- Practitioner, home-, and community-based care coordination
- Health education
- Building patient self-advocacy skills
- Health care access/health system navigation
- Facilitating behavioral change as necessary for meeting diagnosis and treatment goals
- Facilitating and providing social and emotional support to help the patient cope with the condition, social determinants of health (SDOH) need(s), and adjust daily routines to better meet diagnosis and treatment goals
- Leveraging knowledge of the serious, high-risk condition and/or lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals

While PIN services focus on benefiting the patient through the elements listed above, the Navigator's scope of practice is not limited to these specific tasks.

Who are "auxiliary personnel"?

Medicare defines auxiliary personnel as: Any staff who is acting under the supervision of a physician, regardless of whether the individual is an employee, leased employee, or independent contractor of the physician, or of the legal entity that employs or contracts with the physician. Auxiliary personnel are not required to have a clinical background or hold a clinical license. However, they must be trained and competent to perform assigned services under the supervision of the provider.

The auxiliary personnel who render PIN services may be external to, and/or under contract with, the overseeing practitioner or their practice. For instance, providers in a health care system may work with a centralized patient navigation office or with navigators embedded in a specialty clinic while remaining the overseeing provider. Providers and organizations may also contract with a community-based

organization that employs navigators, peer support specialists or other auxiliary personnel, if they meet all "incident to" requirements and conditions for payment of PIN services.

PIN services may occur in-person with the patient/caregiver, or may be rendered by telephone or telemedicine technology, without being subject to Medicare telehealth regulations. However, if additional billable services are rendered by the navigator or a member of the care team during the course of navigation, they are subject to all applicable place of service and telehealth requirements.

NAVIGATOR TRAINING/CERTIFICATION

Auxiliary personnel who provide PIN services must meet applicable state requirements, including licensure. In states with no applicable requirements, auxiliary personnel providing PIN services must be trained or certified in specific competencies:

- Patient and family communication
- Interpersonal and relationship-building
- Patient and family capacity building
- Service coordination and systems navigation
- Patient advocacy, facilitation, individual and community assessment
- Professionalism and ethical conduct
- Developing an appropriate knowledge base, including specific certification or training on the serious, high-risk condition, illness, or disease being addressed

Unless required at the state level, the training for personnel providing PIN services may be provided in any format (in person, online synchronous or asynchronous, or other forms of self-study) so long as the training covers all mandatory competencies; best practice is to keep a record of all training. Formal healthcare navigator certifications are available from universities, healthcare organizations, and professional societies.

Medicare clarifies that in the absence of state level requirements, clinical social workers (CSWs), marriage and family therapists (MFTs) and mental health counselors (MHCs) who are performing PIN services under the general supervision of a billing practitioner satisfy all training and certification requirements to perform the service, even when they perform the service for a qualifying condition that is not considered a mental illness.

QUALIFYING INITIATING VISIT

Patients receiving PIN must have a qualifying initiating visit. The visit must address the serious, high-risk condition that requires navigation, even if the condition is a differential rather than confirmed diagnosis. During this initiating visit, the billing practitioner will establish the treatment plan, specify how PIN services are reasonable and necessary to help accomplish that plan, and establish the PIN services as incidental to their professional services. Auxiliary personnel can render the subsequent PIN services under the general supervision of the provider.

Medicare lists specific visits that may be used to establish the PIN treatment plan and used to document medical necessity. They include:

- Outpatient E/M visit (other than Level 1) including the E/M visit that is part of a Transitional Care Management visit: CPT codes 99202-99205, 99212-99215, 99495, 99496
- Psychiatric diagnostic evaluation: CPT 90791

- Health Behavior Assessment and Intervention (HBAI) services: CPT codes 96156, 96158, 96159, 96164, 96165, 96167, and 96168
- Annual Wellness Visits when performed by a practitioner who is qualified to identify and develop a care plan for a high-risk condition that would qualify for PIN services: CPT codes G0402, G0438, G0439

For patients receiving PIN services for more than 12 months, a qualifying initiating visit must be performed at least annually. During the qualifying visit, the provider must again address the high-risk condition, review/update the treatment plan, demonstrate that PIN is medically reasonable and necessary, and specify how PIN services will help the patient accomplish the treatment plan.

BILLING

PIN is rendered by auxiliary staff incident to the billing provider's professional services and under their general supervision. The provider who performs the qualifying initiating visit is the only practitioner eligible to bill PIN services. Physicians, non-physician practitioners, and psychologists may report PIN services and provide supervision of auxiliary personnel.

Eligible mental health practitioners, including clinical social workers (CSWs), marriage and family therapists (MFTs), and mental health counselors (MHCs) who are enrolled with Medicare may act as the billing provider for PIN services they personally perform for the diagnosis or treatment of mental illness. If the mental health practitioner is personally providing PIN services, they may only bill for time they personally spend on the PIN service; these practitioners may not bill for time spent on PIN by other auxiliary personnel as they do not qualify as supervising practitioners.

What about mental health practitioners?

Mental health practitioners, including clinical social workers (CSWs), marriage and family therapists (MFTs), and mental health counselors (MHCs) who are enrolled with Medicare may act as the billing provider for PIN services they personally perform for the diagnosis or treatment of mental illness. If the mental health practitioner is personally providing PIN services, they may only bill for time they personally spend on the PIN service; these practitioners may not bill for time spent on PIN by other auxiliary personnel as they do not qualify as supervising practitioners. When acting as the billing provider, they must use Psychiatric diagnostic evaluation or Health Behavior Assessment and Intervention services for the initiating visit. When acting in the role of the billing provider, mental health practitioners are paid at 75% of the Physician Fee Schedule.

Qualified mental health practitioners may also act as auxiliary staff under the general supervision of the billing provider. In this capacity, they may provide PIN services for patients with any qualifying diagnosis, not just mental health diagnoses.

Whether acting as the billing provider or auxiliary staff, mental health practitioners who are enrolled with Medicare have satisfied all training/certification requirements for the provision of PIN services unless state level requirements are in place.

Two codes are used to report PIN services:

G0023: First 60 minutes of PIN services per calendar month
G0024: Each additional 30 minutes of PIN services per calendar month (list separately in addition to G0023)

There are no frequency limitations for billing PIN services; patients may receive navigation services as long as reasonable and necessary for their condition, and as many units as necessary of G0024 may be utilized to describe the total time spent in PIN for the month.

These codes are not subject to the CPT Time Rule; the full time must be met to bill each service. For instance:

- If 43 minutes of time are spent on PIN services for the month, the service may not be billed because it does not meet the time requirement (60 min)
- If 82 minutes of PIN services are provided for the month, the billing provider would report one unit of G0023
- If 97 minutes of PIN services are provided for the month, the billing provider would report one unit of G0023 and one unit of G0024
- If 210 minutes of PIN services are provided for the month, the billing provider would report one unit of G0023 and five units of G0024

The total time spent on navigation services will vary from month to month based on patient needs. Some months the total time spent will not result in a billable service. If this occurs, it does not mean that the patient is un-enrolled from navigation, or that a new consent or care plan is required. Patients may remain enrolled in PIN services until they elect to end the service, the care plan is satisfied, or the services are no longer reasonable and necessary. Providers should submit claims only for the months when the services rendered meet the required time elements.

PIN services may be furnished in facility and non-facility settings, and patient cost-sharing applies.

COUNTING TIME

Because PIN services are time-based, it's important for all care team members who participate in the provision of PIN to accurately track and report the time spent in navigation services. Examples of time that counts towards PIN for time tracking includes:

- Time spent explaining PIN services and obtaining patient consent for services
- Conversations between the navigator and the caregiver to discuss the schedule of appointments and the patient's transportation needs
- Navigator time spent obtaining medical records from outside providers
- Navigator time spent making a referral to Patient Financial Services
- Conversations between the patient and navigator making a list of questions to ask the specialist at the next office visit
- Time spent documenting services provided to patients and their caregivers
- Navigator time spent escalating and discussing positive screening scores with the appropriate clinician
- Overseeing provider time spent reviewing navigation tasks and documentation
- Care team (e.g., social worker) time spent helping the navigator identify community resources to address a patient's SDOH needs, if the care team is also under the general supervision of the billing provider and meets the requirements to perform PIN services
- Navigator time spent calling the insurance company to follow up on prior authorization paperwork

If time is spent on separately billable services, that time cannot be counted towards PIN time. Examples of time that cannot be "double counted" include:

- Time spent by the navigator in administering the physical activity and nutrition assessment, if the assessment will be separately billed using CPT code G0136

- Time spent by the overseeing provider reviewing the results of assessments or neuropsychological testing, if that time will be billed as part of an E/M visit (CPT codes 99202-99215) or neuropsychological testing evaluation (CPT codes 96132 and 96133)
- Time spent by the navigator discussing the need for advance care planning, educating the patient/caregiver about end-of-life treatments, or helping the patient complete paperwork to appoint a medical power of attorney or advanced directive if that time will be billed as Advance Care Planning (CPT codes 99497 and 99498)
- Time spent by the care team providing care management services, if those services are reported under other care management codes (CPT codes 99426, 99487, 99490, etc.)

CONCURRENT BILLING

Patients may receive PIN services for more than one condition at a time. For example, a patient is seen by the PCP for concerns about cognition. During the exam, the physician notes an irregular heartbeat and performs an EKG which shows new onset atrial fibrillation. The patient may be enrolled in brain health navigation for the cognition concern as well as cardiology navigation for new onset arrythmia.

Patients may also receive PIN services at the same time as they receive other types of care management. For example, if the patient is already enrolled in chronic care management (CCM) for diabetes and chronic kidney disease, but a new cognition concern is noted, the patient may also be enrolled in PIN for brain health. Patients may also receive PIN and care management services for the same condition; for example, a patient may be enrolled in PIN during a workup of a cognition concern and may also be enrolled in principal care management (PCM) when a diagnosis of Lewy Body dementia is made.

REQUIRED DOCUMENTATION

PIN service providers should ensure necessary documentation is maintained in the patient's medical record.

Consent

Medicare requires that patients (or their medical decision-maker) consent to receive PIN services. Informed consent may be written or verbal, and any member of the care team may obtain consent. Documentation of consent should include the following points:

- The availability of navigation 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

Patients need to provide informed consent only once unless they switch to a different navigation program/provider, or if they have received PIN services for more than 12 months. For long-term navigation, patients must be re-consented annually.

Care Plan & Provision of Care

Unlike clinically oriented care management services, Medicare does not require a comprehensive care plan as a service element for PIN. However, the overseeing provider must establish a treatment plan for the serious, high-risk condition that is the focus of navigation services. Because navigation services often occur before a definitive diagnosis is made, 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 when a diagnosis is confirmed.

For instance, the treatment plan for a patient with a cognition concern who is being navigated to a dementia diagnosis may include direction for the navigator to assist the patient with completing screenings, assessment, testing, imaging, and bloodwork to determine a diagnosis and treatment plan, including identifying and addressing unmet SDOH needs and navigating the healthcare system. If a diagnosis is confirmed and the patient's treatment is updated to include disease modifying therapy, the navigation treatment plan can include direction for the navigator to assist the patient in meeting the clinical treatment plan goals, including addressing social, emotional, and financial needs and navigating the healthcare system.

Any care that navigators/care teams provide as part of the navigation service should be documented in the medical record, including assessment for and provision of services related to unmet social needs. If SDOH needs are identified, ICD-10 Z-codes should be, but are not required to be, added to the patient's medical record. Trained auxiliary personnel may diagnose SDOH.

Documentation should make clear the general nature of the navigation services provided as well as the time spent providing navigation. An example of a monthly navigation service log is included in the appendix. To ease the workload for the billing provider, navigators should tally the total time in care at the end of the month.

CMS clarifies that the personnel who furnish PIN services do not personally have to enter their documentation in the medical record, but the documentation must be permanently recorded in the medical record. For instance, if a health system contracts with an outside organization to perform PIN, navigators in the outside organization do not need to enter documentation directly into the electronic medical record. They may maintain confidential records within their own system, then provide the documentation to the health system at the end of the month. The health system can then upload the care record to the patient's chart so that they maintain a record of the provision of care services.

Provider Verification

The billing provider must review and verify the monthly PIN services. While there are multiple EHR-specific workflows to facilitate this, the actual documentation that is required from the billing provider is not explicit. An example of provider "review and verify" language is:

> *I have reviewed the navigation documentation and agree with the services provided. Total time in navigation for this month is 64 minutes.*

COMMUNITY HEALTH INTEGRATION (CHI) SERVICES

Medicare makes payment for services designed to address upstream drivers that are limiting the practitioner's ability to diagnose or treat a medical problem. Patients qualify for Community Health Integration (CHI) based on the presence of one or more upstream drivers; there is no medical diagnosis (confirmed or suspected) required to qualify for services. Patient financial status does not impact eligibility for CHI. These services are appropriate to furnish during the time when patients are receiving a medical workup to diagnose a condition or during the treatment of a condition.

Upstream drivers can include the social, structural, and environmental barriers to patient health historically called the "social determinants/drivers of health" (SDOH) as well as a wide range of root causes of problems, including patient behaviors. The term "upstream drivers" is more broadly defined and comprehensive compared to the term "SDOH."

These upstream drivers can include:

- Inadequate health literacy
- Inadequate housing or utilities
- Food insecurity
- Low income
- Transportation insecurity
- Problems of adjustment to life-cycle transitions
- Problems in relationship with spouse or partner
- Stressful life events affecting family and household
- Smoking or the use of tobacco products
- Physical inactivity
- Inadequate dietary intake or nutrition

What are Social Determinants of Health (SDOH) and "upstream driver(s)?

Medicare defines SDOH as "the economic and social condition(s) that influence the health of people and communities" and include (but are not limited to) examples like food insecurity, transportation insecurity, housing insecurity, and unreliable access to public utilities, when these conditions significantly limit the practitioner's ability to diagnose or treat the problem(s) addressed in the visit.

In the 2026 Medicare Physician Fee Schedule Final Rule, the term SDOH was broadly replaced by the term "upstream driver(s)." This term is considered more comprehensive and includes factors that impact health including patient behaviors (tobacco use, physical inactivity, substance misuse, etc.) as well as dietary, behavioral, medical, and environmental drivers of health.

CHI services are performed by auxiliary personnel, which may include community health workers (CHWs), under the general supervision of the billing provider; however, the services are not limited to CHWs. These personnel provide the following for the benefit of the patient/caregiver:

- Person-centered assessment
- Practitioner, home-, and community-based care coordination
- Health education
- Building patient self-advocacy skills
- Health care access/health system navigation
- Facilitating behavioral change as necessary for meeting diagnosis and treatment goals
- Facilitating and providing social and emotional support to help the patient cope with the problem(s) addressed in the initiating visit, the upstream driver(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

The auxiliary personnel who render CHI services may be external to, and/or under contract with, the overseeing practitioner or their practice, but should be clinically integrated with the billing provider. For instance, providers in a health care system may work with a centralized patient community integration office or with community health workers embedded in a specialty clinic while remaining the overseeing provider; these staff are clinically integrated through shared electronic medical records. Providers and organizations may also contract with a community-based organization that employs CHWs or other auxiliary personnel if they meet all "incident to" requirements and conditions for payment of CHI services.

CHI services may occur in-person with the patient/caregiver in a home or office setting, or may be rendered by telephone or telemedicine technology, without being subject to Medicare telehealth

regulations. However, if additional billable services are rendered by the care team during the course of service, they are subject to all applicable place of service and telehealth requirements.

AUXILIARY PERSONNEL TRAINING/CERTIFICATION

Auxiliary personnel who provide CHI services must meet applicable state requirements, including licensure. In states with no applicable requirements, auxiliary personnel providing CHI services must be trained or certified in specific competencies:

- Patient and family communication
- Interpersonal and relationship-building
- Patient and family capacity building
- Service coordination and systems navigation
- Patient advocacy, facilitation, individual and community assessment
- Professionalism and ethical conduct
- Developing an appropriate knowledge base, including local community-based resources

Unless required at the state level, the training for personnel providing CHI services may be provided in any format (in person, online synchronous or asynchronous, or other forms of self-study) so long as the training covers all mandatory competencies; best practice is to keep a record of all training. Formal CHW certifications are available from universities, healthcare organizations, and professional societies, or may be administered by the state.

Medicare clarifies that in the absence of state level requirements, clinical social workers (CSWs), marriage and family therapists (MFTs) and mental health counselors (MHCs) who are performing CHI services under the general supervision of a billing practitioner satisfy all training and certification requirements to perform the service, even when they perform the service for a qualifying condition that is not considered a mental illness.

QUALIFYING INITIATING VISIT

Patients receiving CHI must have a qualifying initiating visit. The visit must identify at least one upstream driver that is significantly limiting the provider's ability to make a diagnosis or administer treatment for a specified medical problem. During this initiating visit, the billing practitioner will establish the treatment plan, specify how addressing the upstream driver(s) would help accomplish that plan, and establish the CHI services as incidental to their professional services. Auxiliary personnel can perform the subsequent CHI services under the general supervision of the provider.

Medicare lists specific visits that may be used to establish the CHI treatment plan and used to document medical necessity. They include:

- Outpatient E/M visit (other than Level 1) including the E/M visit that is part of a Transitional Care Management visit: CPT codes 99202-99205, 99212-99215, 99495, 99496
- Annual Wellness Visits performed by the billing provider: CPT codes G0402, G0438, G0439
- Psychiatric diagnostic evaluation: CPT 90791
- Health Behavior Assessment and Intervention (HBAI) services: CPT codes 96156, 96158, 96159, 96164, 96165, 96167, and 96168

For patients receiving CHI services for more than 12 months, a qualifying visit must be performed at least annually. During the qualifying visit, the provider must address the upstream driver(s) that is

limiting their ability to diagnose or treat a medical problem and specify how the CHI services will help overcome the upstream driver(s).

BILLING

CHI is rendered by auxiliary staff incident to the billing provider's professional services and under their general supervision. The provider who performs the qualifying initiating visit should bill the CHI services. Physicians and non-physician practitioners may report CHI services and provide supervision of auxiliary personnel.

Eligible mental health practitioners, including clinical social workers (CSWs), marriage and family therapists (MFTs), and mental health counselors (MHCs) who are enrolled with Medicare may act as the billing provider for CHI services they personally perform for the diagnosis or treatment of mental illness. If the mental health practitioner is personally providing CHI services, they may only bill for time they personally spend on the CHI service; these practitioners may not bill for time spent on CHI by other auxiliary personnel as they do not qualify as supervising practitioners.

Two codes are used to report CHI services:

G0019: First 60 minutes of CHI services per calendar month

G0022: Each additional 30 minutes of CHI services per calendar month (list separately in addition to G0019)

There are no frequency limitations for billing CHI services; patients may receive services as long as reasonable and necessary, and as many units as necessary of G0022 may be utilized to describe the total time spent in CHI for the month.

These codes are not subject to the CPT Time Rule; the full time must be met to bill each service. For instance:

- If 43 minutes of time are spent in CHI services for the month, the service may not be billed because it does not meet the time requirement (60 min)
- If 82 minutes of CHI services are provided for the month, the billing provider would report one unit of G0019
- If 97 minutes of CHI services are provided for the month, the billing provider would report one unit of G0019 and one unit of G0022

What about mental health practitioners?

Mental health practitioners, including clinical social workers (CSWs), marriage and family therapists (MFTs), and mental health counselors (MHCs) who are enrolled with Medicare may act as the billing provider for CHI services they personally perform for the diagnosis or treatment of mental illness. If the mental health practitioner is personally providing CHI services, they may only bill for time they personally spend on the service; these practitioners may not bill for time spent on CHI by other auxiliary personnel as they do not qualify as supervising practitioners. When acting as the billing provider, they must use Psychiatric diagnostic evaluation or Health Behavior Assessment and Intervention services for the initiating visit. When acting in the role of the billing provider, mental health practitioners are paid at 75% of the Physician Fee Schedule.

Qualified mental health practitioners may also act as auxiliary staff under the general supervision of the billing provider. In this capacity, they may provide CHI services for patients with any qualifying diagnosis, not just mental health diagnoses.

Whether acting as the billing provider or auxiliary staff, mental health practitioners who are enrolled with Medicare have satisfied all training/certification requirements for the provision of CHI services unless state level requirements are in place.

- If 210 minutes of CHI services are provided for the month, the billing provider would report one unit of G0019 and five units of G0022

The total time spent on CHI services will vary from month to month based on patient needs. Some months the total time spent will not result in a billable service. If this occurs, it does not mean that the patient is un-enrolled from CHI. Patients may remain enrolled in CHI services until they elect to end the service, the care plan is satisfied, or the services are no longer reasonable and necessary. Providers should submit claims only for the months when the services rendered meet the required time elements.

CHI services may be furnished in facility and non-facility settings, and patient cost-sharing applies.

COUNTING TIME

Because CHI services are time-based, it's important for all care team members who participate in the provision of CHI to accurately track and report the time spent on the provision of services. Examples of time that counts towards CHI for time tracking includes the examples provided in the PIN section, as well as:

- Time spent by the CHW visiting the patient in their home to assess home safety
- Time spent by the auxiliary personnel researching local options to help patients address upstream driver(s)
- Time spent by the care team coordinating care with a community non-profit (e.g., Meals on Wheels) on behalf of the patient

If time is spent on separately billable services, that time cannot be counted towards CHI time.

CONCURRENT BILLING

Patients may only receive CHI services from one practitioner at a time. This helps ensure a single point of contact for addressing social needs to avoid a fragmented approach and duplicative services. However, patients may receive other types of care management services at the same time as CHI, including PIN and other care management services. CHI may not be billed for patients who are under a home health plan of care.

REQUIRED DOCUMENTATION

CHI service providers should ensure necessary documentation is maintained in the patient's medical record.

Consent

Medicare requires that patients (or their medical decision-maker) consent to receive CHI services. Informed consent may be written or verbal, and any member of the care team may obtain consent. Documentation of consent should include the following points:

- The availability of CHI services
- The patient's possible cost-sharing responsibilities
- That only one practitioner may provide CHI services each 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

Patients need to provide informed consent only once unless they switch to a different CHI program/provider, or if they have received CHI services for more than 12 months. For long-term services, patients must be re-consented annually.

Care Plan & Provision of Care

Like PIN, Medicare does not require a comprehensive care plan as a service element for CHI. However, the overseeing provider must establish the presence of upstream driver(s) and how CHI services are reasonable and necessary to remove barriers to diagnosing and treating the patient.

For instance, a patient may screen positive for a cognition concern during the AWV. At that visit, they also are identified as having transportation difficulties, because they do not drive and there is no public transportation available. The provider needs to perform a workup for the cognitive concern, and orders CHI services so that the patient can receive support for transportation services to necessary appointments, like blood draws and brain imaging, which are necessary to diagnose/treat the patient's cognitive concern. If additional needs arise during the course of the CHI services, the staff may also address those needs, as well as assisting the patient with health system navigation, patient education, and other elements described by the CHI service.

Any care that staff provide as part of the CHI service should be documented in the medical record, including assessment for, and provision of services related to, unmet social needs. For identified SDOH needs, ICD-10 Z-codes should (but are not required to) be added to the patient's medical record. Trained auxiliary personnel may diagnose SDOH. Documentation should make clear the general nature of the services provided as well as the time spent providing services. An example of monthly CHI service documentation is included in the appendix. To ease the workload for the billing provider, staff should tally the total time in care at the end of the month.

Per CMS regulations, the personnel who furnish CHI services do not personally have to enter their documentation in the medical record, but the documentation must be permanently recorded in the medical record. For instance, if a health system contracts with an outside organization to perform CHI, the care team from the outside organization does not need to enter documentation directly into the electronic medical record. They may maintain confidential records within their own system, then provide the documentation to the health system at the end of the month. The health system can then upload the care record to the patient's chart so that they maintain a record of the provision of care services.

Provider Verification

The billing provider must review and verify the monthly CHI services. While there are multiple EHR-specific workflows to facilitate this, the actual documentation that is required from the billing provider is not explicit. An example of provider "review and verify" language is:

> *I have reviewed the CHI documentation and agree with the services provided. Total time in CHI for this month is 64 minutes.*

CLINICALLY ORIENTED CARE MANAGEMENT SERVICES

Medicare makes payment for clinically oriented care management services that can include time spent on navigation and addressing social needs. These services include Chronic Care Management (CCM), Principal Care Management (PCM) and Behavioral Health Integration (BHI). Qualification for these services requires a confirmed diagnosis, so these services are not always appropriate for patients who are being navigated to a dementia diagnosis. However, for patients who qualify for or are already enrolled in these services for non-dementia diagnoses, navigation for cognition concerns can

appropriately be included in these services because a cognition problem would be a complicating/interfering factor in the care management of the existing qualifying diagnoses.

For example, a patient with diabetes and chronic kidney disease is enrolled in chronic care management (CCM). The patient frequently forgets to take important medications and has missed scheduled bloodwork and office visits. The provider recognizes that the patient may have a cognitive problem and needs to be worked up for dementia. Time spent helping the patient navigate through the workup is appropriately included in the care management services being provided for diabetes and CKD.

The specific elements of these services are detailed in the appendix, but in general, the purpose of clinically oriented care management services is to assist patients in managing their overall health, with a specific focus on:

- Assessing the patient's medical, functional, and psychosocial needs
- Ensuring the patient gets timely recommended preventive services
- Reviewing medications and any potential interactions
- Overseeing the patient's medication self-management
- Coordinating care with home- and community-based clinical service providers
- Communicating with home- and community-based providers about the patient's psychosocial needs and functional decline
- Managing transitions of care
- Providing continuity of care
- Improving patient/caregiver access to care and communication with providers

Like PIN and CHI, care management services may occur in-person with the patient/caregiver, or may be rendered by telephone or telemedicine technology, without being subject to Medicare telehealth regulations. However, if additional billable services are rendered in the course of care management, the services are subject to all applicable place of service and telehealth requirements.

PATIENT ELIGIBILITY

Patients qualify for clinically oriented care management based on their medical condition.

Chronic Care Management (CCM)

Patients are eligible for CCM if they have two or more chronic conditions that:

- Are expected to last at least 12 months or until the patient's death
  and
- That place them at significant risk of death, acute exacerbation/decompensation, or functional decline

Principal Care Management (PCM)

Patients are eligible for PCM if they have one or more complex chronic conditions that:

- Are expected to last at least 3 months or until the patient's death
  and
- That place them at significant risk of hospitalization, acute exacerbation/decompensation, or functional decline or death

General Behavioral Health Integration (BHI)

Patients are eligible for BHI if they have any mental, behavioral health, or psychiatric condition that the billing practitioner treats—including substance use disorders—that in the clinical judgment of the billing practitioner, would benefit from BHI services.

Examples of Chronic Conditions

Examples of chronic conditions that would qualify a patient for care management include, but aren't limited to:

- Alcohol abuse
- Alzheimer's disease and related dementias
- Arthritis (osteoarthritis and rheumatoid)
- Asthma
- Atrial fibrillation and other arrythmias
- 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
- Hypertension
- Ischemic heart disease
- Osteoporosis
- Schizophrenia and other psychotic disorders
- Stroke
- Substance use disorders

It's estimated that more than two thirds of Medicare beneficiaries are eligible for chronic care management based on having a diagnosis of two or more chronic conditions.

CARE MANAGEMENT TEAM

Care management services are rendered by clinical staff under the general supervision of the billing provider. "Clinical staff" is a broad term that encompasses those staff who are qualified by training to perform or assist in performing a service, but do not independently report (bill) professional services. These staff may be employed, leased, or contracted to work under the supervision of professionals who bill for services, like physicians and non-physician practitioners. Clinical staff includes medical assistants, licensed practical nurses, registered nurses, health educators, navigators, community health workers, pharmacists, and others. There are no specific training, certification, or licensure requirements for clinical staff according to Medicare and CPT regulations. Rather, these individuals are qualified based on their training and relationship with the billing provider.

Who are Clinical Staff?

A clinical staff member is a person who works under the supervision of a physician or other qualified health care professional and who is allowed by law, regulation, and facility policy to perform or assist in the performance of a specified professional service, but who does not individually report that professional service. Clinical staff are not required to hold a license or certification. They are qualified by training, and it is their relationship to the overseeing provider that defines them as clinical staff.

Like PIN and CHI services, clinical staff who render care management services may be external to, and/or under contract with, the overseeing practitioner or their practice. For instance, providers in a health care system may work with a centralized care management office or with care managers embedded in a specialty clinic while remaining the overseeing provider. Providers and organizations may also contract with community-based organizations that employ clinical staff if they meet all "incident to" requirements and conditions for payment of care management services. Note that when they are employed to provide services in hospitals, physicians and non-physician practitioners (NPPs)—like nurse practitioners and physician assistants—may not report "incident to" services. If they are in outpatient practice, they may report "incident to" services. Providers who are qualified to oversee care management services and report care management services include physicians and NPPs.

QUALIFYING VISIT

Patients receiving care management services must have a qualifying initiating visit, including:

- Outpatient E/M visit (other than Level 1) including the E/M visit that is part of a Transitional Care Management visit: CPT codes 99202-99205, 99212-99215, 99495, 99496
- Annual Wellness Visits: CPT codes G0402, G0438, G0439

The billing provider must discuss care management at the visit for the encounter to fulfill the requirements of a qualifying visit. For patients receiving care management services for more than 12 months, a qualifying visit must be performed at least annually.

BILLING

Care management is rendered by clinical staff incident to the billing provider's professional services and under their general supervision. Physicians and non-physician practitioners may report care

management services and provide general supervision of clinical staff. A full guide to billing care management services is included in the appendix.

Like PIN, there are no frequency limitations for billing care management services; patients may receive care management services as long as reasonable and necessary for their condition. CCM, PCM, and BHI codes are not subject to the CPT Time Rule; the full time must be met to bill each service.

The total time spent on care management services will vary from month to month based on patient needs. Some months the total time spent will not result in a billable service. If this occurs, it does not mean that the patient is un-enrolled from care management, or that a new consent or care plan is required. Patients may remain enrolled in care management services until they elect to end the service, the care plan is satisfied, or the services are no longer reasonable and necessary. Providers should submit claims only for the months when the services rendered meet the required time elements.

Care management services may be furnished in facility and non-facility settings, and patient cost-sharing applies.

COUNTING TIME

Because care management services are time-based, it's important for all care team members who participate in the provision of care to accurately track and report the time spent in navigation services. Examples of time that counts towards care management for time tracking includes examples provided in the PIN section of this guide when they are performed by clinical staff, but may also include:

- Time spent by the clinical staff creating, revising, or monitoring a person-centered, electronic care plan based on physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment and an inventory of resources and supports
- Care team time spent reviewing discharge paperwork from the hospital, skilled nursing facility, or sub-acute facility to understand the patient's ongoing care needs
- Clinical staff time spent in discussion with the retail pharmacist to clarify medication orders
- Clinical staff time spent submitting prior authorization paperwork

If time is spent on separately billable services, that time cannot be counted towards care management time.

CONCURRENT BILLING

Patients may receive care management services concurrent with PIN services, and during the period of time they are receiving Transitional Care Management services. A full guide to concurrent billing for care management is in the appendix.

REQUIRED DOCUMENTATION

Care management providers should ensure required documentation is maintained in the patient's medical record.

Consent

Medicare requires that patients (or their medical decision-maker) consent to receive care management services. Informed consent may be written or verbal, and any member of the care team may obtain consent. Documentation of consent should include the following points:

- The availability of care management services
- The patient's possible cost-sharing responsibilities

- That the patient may only receive chronic care management services from one provider per month, and more than one provider may provide PCM/BHI services per month, but never for the same condition
- The patient's right to stop care management 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

Patients need to provide informed consent only once unless they switch to a different care management program/provider. Patients must be re-consented annually.

Care Plan & Provision of Care

A full description of the required care plan for each type of care management is provided in the appendix, but for care management services, patients must be offered a written care plan, and the care plan must also be electronically available within the medical record. The care plan must also be made available to other health care providers who are participating in the patient's care.

For CCM, 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 upstream driver(s). For PCM and BHI, 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), such as the medical workup for cognition concern.

Any care that clinical staff provide as part of the care management service should be documented in the medical record. Documentation should make clear the general nature of the services provided as well as the time spent providing care management. To ease the workload for the billing provider, a member of the care team should tally the total time in care at the end of the month.

Provider Verification

The billing provider must review and verify the monthly care management services. While there are multiple EHR-specific workflows to facilitate this, the actual documentation that is required from the billing provider is not explicit. An example of provider "review and verify" language is:

> *I have reviewed the care management documentation and agree with the continued services. Total time in care management for this month is 64 minutes.*

SERVICES PERSONALLY PERFORMED BY THE BILLING PROVIDER

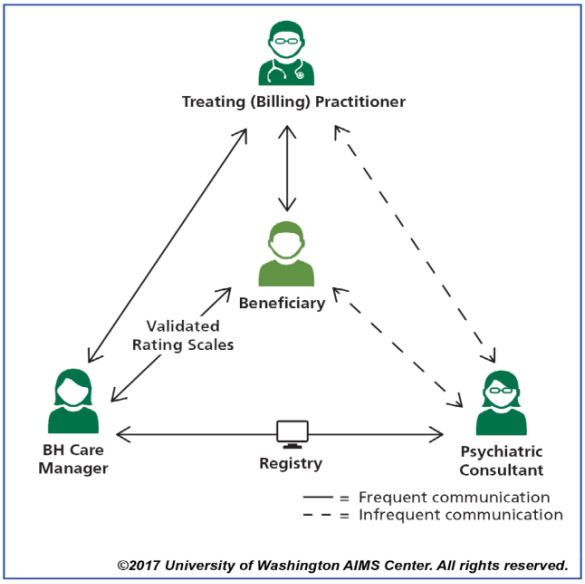
Billing codes describing care management (PCM or CCM) that is personally performed by the billing provider are available for use. These codes are described in greater detail in Appendix D. When billing care management personally rendered by the billing provider, staff time spent on care management services is not billable in the same month. However, staff efforts for navigation and care management may be represented by other service codes, such as PIN, and should be evaluated to determine if they may appropriately be billed as such.

When the billing provider spends significant time developing the comprehensive care plan for CCM (beyond the time typically associated with the initiating visit), they may be able to bill additional care plan development time. This service is only able to be billed as an add-on code to the CCM service during the first month of an episode of CCM. See Appendix D for more details.

PSYCHIATRIC COLLABORATIVE CARE MODEL (COCM)

The Psychiatric Collaborative Care Model (CoCM) is an approach to behavioral health services that allows the treating (billing provider) to retain the care of the patient who has a suspected or confirmed psychiatric, behavioral, or mental health diagnosis by working with a psychiatric consultant and behavioral health care manager (BHCM).

The treating practitioner is usually a primary care physician or non-physician practitioner but may be a specialist; for the purpose of this guide, the treating provider will be referred to as the primary care provider or PCP. The psychiatric consultant is a medical professional trained in psychiatry and qualified to prescribe the full range of medications. The BHMC is a member of the care team who has formal education or specialized training in behavioral health (including social work, nursing, or psychology) working under the direction of the billing provider.



While rare, this type of care management may be used to assist qualifying patients in navigating the care plan for diagnosis and treatment of dementia. Note that this type of care management is only available to patients with a suspected or confirmed qualifying diagnosis.

The service requires multiple elements:

- The PCP must complete an initiating visit, and the BHCM must administer validated rating scales
- The primary care team, together with the patient, creates a care plan which may include pharmacotherapy, psychotherapy and/or other treatments
- The BHCM proactively and systematically follows up with the patient, using validated scales and maintaining records in a registry which the psychiatric consultant can access
- The BHCM may also provide brief evidence-based psychosocial interventions, such as motivational interviewing. The primary care team (usually the BHCM) reviews the treatment plan and status ***at least weekly*** with the psychiatric consultant, who advises the primary care team on treatment and maintenance/modification of the care plan, including referring to behavioral health specialty care as needed
- The primary care team (usually the BHCM but also the PCP as needed) carries out the care plan with the patient

CARE TEAM MEMBERS AND ROLES

Each member of the care team has defined roles and responsibilities in the CoCM model.

Primary Care Provider

The PCP is the billing practitioner who:

- Provides direction and supervision to the BHCM
- Oversees the patient's care, including prescribing medications, providing treatment for medical conditions, and making referrals to specialty care when needed

- Engages in the ongoing oversight, management, collaboration, and reassessment of the patient and their care plan
- Performs the qualifying initiating visit

Behavioral Health Care Manager (BHCM)

The BHCM is an employee of, or under contract with, the billing practitioner. The BHCM may or may not be an individual who meets requirements to independently deliver and bill services. The BHMC is required to have formal education or training in behavioral health. Regardless of their licensure, the BHCM:

- Delivers care management services, including administering validated rating scales and participating in behavioral health care planning for the behavioral or psychiatric health problem; makes revisions to the care plan for patients who are not progressing or whose status changes; provides brief psychosocial interventions; maintains the patient registry; engages in consultation with the psychiatric consultant; and maintains ongoing collaboration with the billing provider
- Has a continuous relationship with the patient, is able to deliver services face-to-face with the patient, and has a collaborative, integrated relationship with the rest of the care team
- **Must have availability to work with patients outside of regular clinic hours as needed to complete care management duties**
- **Must be able to meet with patients face-to-face (although face-to-face meetings are not a requirement for billing the service.)**

Clerical and administrative staff time, and time spent by the BHCM in clerical or administrative duties ***do not*** count towards the CoCM time tracking.

Psychiatric Consultant

The psychiatric consultant is an employee of, or under contract with, the billing practitioner. The psychiatric consultant is commonly located remotely from the primary care practice and does not separately bill for services that are part of the CoCM service, including:

- At least weekly, reviewing the clinical status of patients receiving CoCM
- Informing the PCP and BHCM of any diagnosis made
- Making recommendations to improve patient adherence and tolerance of behavioral health treatment
- Adjusting behavioral health treatment for patients who aren't progressing
- Managing any negative interactions between the patient's behavioral health and medical treatments
- Making referrals for direct provision of psychiatric care when clinically indicated

Generally, the Psychiatric Consultant does not have ongoing direct contact with the patient, prescribe medications, or deliver treatment directly to the patient. However, they may interact with the patient and bill for services such as E/M visits during the diagnostic process.

The Psychiatric Consultant does not have to be contracted with Medicare to provide consultative services in the CoCM model because the PC does not separately bill Medicare for their services provided as part of the CoCM service.

QUALIFYING INITIATING VISIT

Patients who receive CoCM must have a qualifying initiating visit with the primary care provider, during which time the provider will identify and address the medical necessity for CoCM and discuss the service with the patient, even if a psychiatric, behavioral, or mental health diagnosis has not yet been

confirmed. If the PCP does not discuss CoCM with the patient at the initiating visit, the visit does not count as a qualifying initiating visit.

Medicare lists specific visits that may be used to establish the relationship between the PCP and the patient for the purpose of establishing the medical necessity of CoCM. They include:

- Outpatient E/M visit performed by the billing practitioner, including the E/M visit that is part of a Transitional Care Management visit: CPT codes 99202-99205, 99212-99215, 99495, 99496
- Annual Wellness Visits when performed by the billing practitioner: CPT codes G0402, G0438, G0439

If patients fail to meet treatment goals and are referred for direct psychiatric care, or if there is a break in CoCM for six consecutive months, a new initiating visit will be required to reestablish CoCM.

BILLING

The primary care provider is the billing provider for CoCM services. **Services rendered by the BHCM and psychiatric consultant as part of CoCM are *not* billed separately.**

Unlike other care management codes, CoCM is subject to the CPT Time Rule which states that a unit of time is met when the midway point is reached. For CoCM services, a 60-minute service may be billed when 31 minutes of service have been provided. However, to bill an add-on 30-minute service, the total time will not be met until the initial 60 minutes plus at least 16 additional minutes of service has been provided (i.e., to bill a 60-minute service with a 30-minute add-on time, at least 76 minutes of service must be rendered.)

CoCM is rendered by the care team, including the BHCM under the general supervision of the billing provider. The provider who performs the qualifying initiating visit should bill the CoCM services. Physicians and non-physician practitioners may report CoCM services and provide supervision of the BHCM.

Four codes are used to report CoCM services:

99492: First Month CoCM, 70 minutes of services in the calendar month (first month of the current CoCM episode)
99493: Subsequent Month CoCM, 60 minutes of services in the calendar month (any month after the first month of the current CoCM episode)
99494: CoCM Time Add-On (any month), 30 additional minutes of service in the calendar month (bill in addition to 99492 or 99493)
G2214: Initial or Subsequent CoCM, 30 minutes of service in the initial or subsequent calendar month

To bill 99492, it must be the first month in an episode of CoCM. The care team must document at least 36 minutes of care in the month. If the care team exceeds 86 minutes of care in the first month, 99494 may be added on to account for additional time.

In subsequent months, 99493 may be billed when the care team provides 31 or more minutes of care. If the care team exceeds 76 minutes of care, 99494 may be added to account for additional time.

If the care team provides 16-35 minutes of care in the first month, or 16-30 minutes of care in subsequent months, bill G2214.

There are no frequency limitations for billing CoCM services; patients may receive services as long as reasonable and necessary, and as many units as necessary of 99494 may be utilized to describe the total time spent in CoCM for the month. Patients may remain enrolled in CoCM until they elect to end the service, the care plan is satisfied, or the services are no longer reasonable and necessary. Providers should submit claims only for the months when the services rendered meet the required time elements.

The total time spent on CoCM will vary from month to month based on patient needs. Some months the total time spent will not reach the threshold necessary for billing services. If this occurs, the patient is not un-enrolled from services. However, if this occurs consistently, it may be appropriate to "graduate" the patient from CoCM, either by ending their care management enrollment, or by discussing if another form of care management is more appropriate for their current care needs. If 6 months elapse without a billable service, the patient's eligibility for CoCM ends, and the patient cannot be re-enrolled until they have a qualifying initiating visit and provide consent.

CoCM services may be furnished in facility and non-facility settings, and patient cost-sharing applies. The place of service listed on the claim should reflect the location where the PCP would ordinarily see the patient for face-to-face visits.

COUNTING TIME

CoCM services are time-based. Unlike other care management services where multiple members of the clinical team can contribute to the time counted for the service, in CoCM, **only the time spent by the BHCM** will count towards the total time spent on the service. The BHCM may engage in the following activities that count towards the total time:

- Outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional
- Initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan
- Entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation
- Participation in weekly caseload consultation with the psychiatric consultant
- Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies
- Tracking patient follow-up and progress using the registry, with appropriate documentation
- Ongoing coordination of the patient's mental health care and collaboration with the treating physician or other qualified health care professional and any other treating mental health providers
- Additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant
- Monitoring patient outcomes using validated rating scales
- Relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.

All time spent should be documented and totaled at the end of the calendar month to determine billing.

CONCURRENT BILLING

Patients may receive other navigation and care management services while receiving CoCM except Behavioral Health Integration (BHI). If the patient receives more than one navigation/care management service, the time spent should be clearly documented. Only time spent by the BHCM on appropriate CoCM tasks may count towards CoCM time. Time spent on other tasks, by the BHCM or other members of the care team (e.g., time spent by the navigator on scheduling appointments or by a member of the clinical team responding to a question about a comorbid medical condition) should only be counted towards other services.

REQUIRED DOCUMENTATION

CoCM service providers should ensure required documentation is maintained in the patient's medical record.

Consent

Medicare requires that patients (or their medical decision-maker) consent to receive CoCM services. Informed consent may be written or verbal, and any member of the care team may obtain consent. Documentation of consent should include the following points:

- The availability of collaborative care management services
- The patient's possible cost sharing responsibilities for both in-person and non face-to-face care
- The patient's right to stop CoCM services at any time (effective at the end of the calendar month)
- That CoCM will involve the PCP and care team collaborating with other providers, including the Psychiatric Consultant
- That the care team member explained the required information and whether the patient accepted or declined services

Patients need to provide informed consent only once unless they switch to a different CoCM provider, their episode of care has ended and a new episode of care is beginning, or if CoCM services have lasted for more than 12 months.

Care Plan & Provision of Care

Unlike chronic care management, Medicare does not require a comprehensive care plan as a service element for CoCM. However, the care team is responsible for developing an individualized treatment plan for the patient, and the BHCM must develop a care plan to enact that treatment plan. Administration and scores of validated rating scales and brief interventions should be documented. Documentation should make clear the general nature of the care provided and the time spent providing that care.

Psychiatric Consultant Documentation

The Psychiatric Consultant is responsible for reviewing the registry weekly and making recommendations to assist patients in meeting their treatment goals. Documentation should make clear that the registry was reviewed. If recommendations are made, this should be clear in the documentation. However, it's not a requirement that the PC personally enters this documentation into the electronic medical record.

Provider Verification

The billing provider must review and verify the monthly CoCM services. While there are multiple EHR-specific workflows to facilitate this, the actual documentation that is required from the billing provider is not explicit. An example of provider "review and verify" language is:

I have reviewed the treatment plan documentation and agree with the services provided. Total time in CoCM for this month is 64 minutes.

COGNITIVE ASSESSMENT AND CARE PLANNING (CACP)

Cognitive Assessment and Care Planning (CACP) is a specific billable visit to perform an in-depth assessment of cognition and make a detailed cognitive care plan. The CPT code details several elements of the visit, but Medicare Local Coverage Determinations (LCD) along with the associated Billing and Coding documents provide additional guidance on the required documentation and visit elements. The following guidance incorporates CPT and LCD requirements. Note that LCD requirements are not applicable in all Medicare Administrative Contractor regions.

NATURE OF THE VISIT

The CACP visit is intended to be a prolonged visit with the provider to perform a detailed assessment of the patient's neurocognitive ability and function and develop a comprehensive written care plan for the patient's cognitive health. This visit is scheduled in response to known or suspected cognitive impairment, typically noted in one of four ways:

- During the Medicare Annual Wellness Visit
- As part of a routine patient visit based on direct observation or via brief cognitive test
- Upon consideration of information from the patient, family, friends, caregivers, and others
- An existing cognitive diagnosis like MCI or dementia

Some elements of the visit must be performed by the billing provider, but the care team may contribute to the necessary elements of the visit. For example, a number of standardized instruments for assessing cognition and function are required; care team members may administer and score these instruments, while the billing provider utilizes these data to make a diagnosis and treatment plan.

CACP is approved to be performed in office/outpatient settings, care facilities, private home, rest homes, or via telehealth, subject to Medicare telehealth regulations.

QUALIFIED BILLING PROVIDERS

Physicians and non-physician practitioners (NPs, PA, CNSs) are qualified to perform the cognitive exam and medical decision making that is required as part of the visit, and to provide supervision to members of the care team who participate in gathering data for the visit.

This visit is not restricted by medical specialty. Primary care and neurology are the most frequent providers of this service.

MEDICAL NECESSITY

Like all healthcare services, CACP must be medically necessary. Medical necessity is demonstrated through ICD-10 codes. It's important to attach a qualifying ICD-10 code to the claim when billing this service, even if the diagnosis is differential rather than confirmed. A list of qualifying diagnoses from the Palmetto GBA LCD is available in Appendix F. Generally, these diagnoses will also be accepted in other MACs.

Common diagnoses that demonstrate medical necessity for the service include:

- Mild cognitive impairment (G31.84)
- Age-related cognitive decline (R42.81)
- Vascular and other dementias (F01 & F02)

- Alzheimer's disease (G30)
- Deficits following stroke or cerebrovascular disease (I69)

If the patient receives the service in the absence of a confirmed diagnosis, medical necessity of the service must be clear in the documentation.

REQUIRED ELEMENTS AND DOCUMENTATION

The CPT code description, the Medicare LCD, and LCD billing and coding guidance each establish elements of care and documentation that are required for the CACP service. The following guidance condenses those requirements to streamline the clinical workflow.

Assessments may be performed and data elements may be gathered over multiple visits prior to the CACP encounter but must be clinically accurate for the patient's current presentation. Generally, that means the data must be collected within the past three months; if the patient's clinical presentation has changed, any past assessments should be updated to reflect the current condition for the purpose of creating the cognitive care plan.

Note that the full instrument raw scoring and results from each tool must be available for MAC review, if requested. Therefore, while the score from an instrument may be available from another provider (e.g., the PCP may complete a Mini-Cog) if the raw scoring is not available in the record, the assessment must be repeated.

Elements of Care

1. An independent historian must be present to provide history which the patient may not be able to completely or reliably provide.
2. The provider must perform a cognition-focused evaluation, including:
    a. Pertinent history
    b. Factors that could contribute to cognitive impairment (e.g., psychoactive medications, chronic pain syndromes, infection, depression, and other brain diseases)
    c. The patient's decision-making capacity
    d. Evaluation of safety, at home and otherwise
    e. Evaluation of motor vehicle operation safety, if applicable
3. The following assessments must be completed using standardized instruments; in some cases, specific instruments are required:
    a. Assessment of cognition using one or more of the following:
        i. Mini-Cog©
        ii. GPCOG
        iii. Short Montreal Cognitive Assessment (s-MoCA)
    b. Functional assessment (i.e., Basic and Instrumental Activities of Daily Living) using at least one of the following:
        i. Katz Index of Independence in Activities of Daily Living
        ii. Lawton-Brody Instrumental Activities of Daily Living Scale (IADL)
    c. Evaluation for neuropsychiatric and behavioral symptoms, including depression, via standardized instruments, which must include at least one of the following:
        i. Neuropsychiatric Inventory Questionnaire (NPI-Q)
        ii. BEHAV5+©

iii. Patient Health Questionnaire-2 (PHQ-2)

d. Dementia staging using one of the following:
   i. Functional Assessment Staging Test (FAST scale)
   ii. Clinical Dementia Rating (CDR® Dementia Staging Instrument)
   iii. Dementia Severity Rating Scale (DSRS)
   iv. Global Deterioration Score (GDS)

4. Medication reconciliation and review for high-risk medications
5. Caregiver(s), caregiver(s) knowledge, caregiver(s) needs, social supports and willingness of caregiver(s) to take on caregiving tasks must be identified
6. The provider must perform moderate or high complexity medical decision making
7. Advance Care Planning must be discussed, updated, revised, or reviewed

Documentation

1. Record the presence of the independent historian and what information they provided.
2. Document the pertinent history and cognition-focused evaluation performed by the provider, including:
   a. Evaluation of home and motor vehicle safety
   b. Determination whether the patient is or is not able to make their own decisions or that decision making capacity is uncertain and will require further evaluation.
3. Raw scoring and results from each assessment/standardized instrument must be retained in the medical record:
   a. Assessment of cognition using the Mini-Cog©, GPCOG, or Short Montreal Cognitive Assessment (s-MoCA)
   b. Functional assessment using the Katz Index of Independence in Activities of Daily Living or the Lawton-Brody Instrumental Activities of Daily Living Scale (IADL)
   c. Dementia staging using the Functional Assessment Staging Test (FAST scale), Clinical Dementia Rating (CDR® Dementia Staging Instrument), Dementia Severity Rating Scale (DSRS), or Global Deterioration Score (GDS)
   d. Neuropsychiatric evaluation using the Neuropsychiatric Inventory Questionnaire (NPI-Q), BEHAV5+©, or Patient Health Questionnaire-2 (PHQ-2)
4. Document that medication reconciliation and review for high-risk medications was completed
5. Identify social supports and caregivers by name in the medical record, including evaluation of their needs (i.e., Zarit Caregiver Interview), how much they know about the patient's condition, and their willingness to assist in the patient's care
6. Evidence of the provider's medical decision making of moderate or high complexity, including:
   a. The patient's current status, likely progression of the disease, and need for referrals.
   b. The medical necessity of the service, accurate diagnosis, time invested, and comprehensive work towards the patient's well-being
   c. If a cognitive diagnosis has not been confirmed, documentation must make clear the presence of cognitive impairment and the narrative history that spurred suspicion for a potential cognitive impairment diagnosis
7. Creation of written Advance Care Plan or documentation of its review/revision/update, and assessment of the patient's palliative care needs
8. A written care plan detailed in the next section.

COGNITIVE CARE PLAN

The written care plan must be completed by the billing provider. It 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, must be addressed with a plan for management.
2. Neurocognitive symptoms, or their absence, must be addressed with a plan for management.
3. Functional limitations must be addressed with a plan for management.
4. Any options for needed community services must be documented.
5. The initial follow-up schedule should be specified.
6. 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.

BILLING CACP & REIMBURSEMENT

CACP should be billed on the date of the visit with the patient and caregiver/independent historian, even if data is collected for the visit across other billable visits.

CACP is billed using **99483**. There are a number of services that may not be billed by the same provider on the same day as CACP (see appendix F).

When the billing provider personally spends more than 60 minutes on the date of service, time add-on code **G2212** may be billed for each additional 15 minutes of provider time.

Billing Example

On the date of the service, the provider reviews standardized instruments and test results, labs, and imaging results prior to the patient's arrival. During the visit, the provider conducts the cognitive exam, interviews the caregivers, discusses the patient's home safety and driving safety, reviews the patient's medications, and spends time educating the patient and caregiver about the diagnosis, prognosis, and treatment plan. The provider discusses advance care planning.

The provider develops and documents the care plan, including: placing orders; making referrals; starting, stopping, or changing medications; developing a follow-up schedule; providing information for community resources; identifying a responsible party for each task on the care plan. Before the patient leaves, the written care plan is provided to the patient.

After the patient leaves, the provider spends time documenting the CACP discussion. The total time the provider personally spends on the date of the encounter is 137 minutes. The provider documents the total time spent on the date of the encounter and bills 99483 (60 minutes) plus 5 units of G2212 (75 minutes).

CONSIDERATIONS FOR COMMERCIAL AND MEDICAID COVERAGE

The services and requirements included in this guide are based off Traditional Medicare guidelines. Medicare Advantage (Part C) also covers these services, but patient cost-sharing may vary by plan. For dually eligible Medicare beneficiaries, Medicaid plans will cover all cost-sharing associated with care management and navigation services.

Commercial insurance plan coverage of care management and navigation services varies; some insurance plans provide these services through internal resources and do not reimburse providers for these services. Others may cover some, but not all, services. Similarly, Medicaid coverage of these services varies. Medicaid Managed Care Organizations are responsible for coordinating care for enrollees and may not separately reimburse providers for these services or may require providers to participate in specific programs to receive reimbursement for services.

For organizations with a large population of patients in need of navigation who do not have Medicare as the primary payer, consider partnering with high-volume payers to develop a condition management code for navigation services. Negotiations with payers will be most effective when data demonstrates the value of navigation services. Value can include deferred or avoided costs (e.g., decreased emergency room visits or unnecessary utilization), improved patient safety (e.g., deprescribing high risk medications, identifying and treating substance use), or better documentation and management of patient health status and needs (e.g., improved capture of clinical conditions/HCCs, improved identification of upstream driver(s) and referral to interventions.)

DETERMINING YOUR APPROACH TO NAVIGATION REIMBURSEMENT

The primary mechanisms of payment for navigation services—PIN, CHI, and clinical care management—each have benefits and barriers for care teams based on the clinical/care pathway and diagnostic journey in the health system. Most patients would likely benefit from a variety of services as they navigate their brain health journey. The best approach will vary from program to program and patient to patient. Ultimately, navigation reimbursement will depend on the staff who participate in the navigation, the tasks they perform, the overseeing provider, and the services covered by the patient's insurance.

For the greatest reimbursement success, programs should consider consenting patients into all services they are eligible to receive at the time of navigation initiation, then billing for the services that are actually performed. This allows care teams to provide the right care at the right time by the right member of the care team, without being limited by billing and reimbursement considerations.

For instance, a patient with diabetes and hypertension who has a new cognitive concern may be consented into Principal Illness Navigation (PIN) and Chronic Care Management (CCM). Initially, a navigator may provide the patient/family with significant health system navigation support, including scheduling appointments, helping to understand and address insurance issues, obtaining records from outside providers, and working with a community organization to address transportation needs. As the patient progresses through the care journey, a clinical care coordinator may spend time answering questions about diagnostic imaging and bloodwork, explaining the role of various specialists in the care journey, and helping the patient better manage their chronic conditions as part of their overall brain health plan. When a new diagnosis is made, the CCM care plan can be updated to help the patient meet their new treatment goals. In this scenario, the patient benefits from PIN and CCM and the healthcare organization improves the patient's care in a financially sustainable manner.

COMPREHENSIVE CONSENT

Obtaining consent is important for all billable services in the navigation reimbursement pathway. Whether a program offers one or more reimbursable services, consent for all services can be obtained and documented at the same time. To enable efficient and compliant documentation, a "smart phrase" can be built into the EHR or navigation order set. Example phrasing:

The patient was informed of the availability of <PIN, CHI, CCM, PCM> services. The purpose of these services was explained, and all questions were answered. The patient is aware that they may have cost-sharing responsibilities depending on their insurance coverage, and that they may stop services at any time (effective at the end of the month of notification). They are also aware that for CHI, only one practitioner may provide services at a time, and for PCM, no other practitioners may bill for PCM for <qualifying diagnosis>. They consented to receive <fill in the blank> services.

COMPREHENSIVE ORDER

Whether a navigation program offers one or more navigation/care management services, enrolling patients in navigation or care management should be simple for providers while fulfilling all regulatory requirements. This can be built into the navigation pathway as an order set or may be an individual order from the overseeing provider. To ensure all required documentation is captured, the order for navigation can be written for the provider to "fill in the blank." An example order that would be used when PIN, CHI, and PCM/CCM are offered as part of the navigation pathway is:

Initiate care navigation for <suspected><condition, such as dementia or AD>; the patient will benefit from assistance navigating the health care system and a single point of contact in the diagnostic pathway to coordinate care. The patient's ability to meet treatment goals, including workup for suspected conditions, is complicated by < upstream driver(s)>; initiate CHI services to overcome this and any other identified upstream driver(s) so the patient can fully and effectively participate in their treatment plan. The patient's medical condition is complicated by <chronic condition(s)> which would benefit from care management to help the patient meet their treatment goals.

ESTABLISHING THE TREATMENT/CARE PLAN

Terminology around establishing a treatment plan or care plan for navigation and care management services can be confusing, but it doesn't have to be. A care plan does not require special documentation from the provider, although many EHRs have specific care plan modules that help the staff track the care they provide and the patient's progress towards meeting those goals. However, even if using these modules to track patient navigation services, the overseeing provider does not need to complete this documentation.

For PIN and CHI services, the provider must establish a "treatment plan" for the suspected or confirmed medical condition that would benefit from navigation, or the upstream driver(s) that would benefit from CHI services. For organizations with an established brain health navigation program, the treatment plan can be as simple as "refer to brain health navigation program." The program itself is the treatment plan because the program encompasses the medical workup, referrals to specialists, imaging, and other care that patients with a suspected cognitive condition may require. Establishing an order set for this referral process simplifies the documentation and meets regulatory requirements for the provider performing the qualifying visit. Clinical or auxiliary staff who are rendering the navigation services can transcribe this documentation into the EHR care plan module as needed, and some EHRs can automatically populate the care plan from the order, subject to personalization by the navigator.

Principal Care Management (PCM) and Behavioral Health Integration (BHI) require a disease-specific care plan. This is typically the medical management of the qualifying condition, along with the plan to identify/address other patient needs. In the case of a patient who is receiving PCM or BHI for a condition like diabetes or depression, the referral to the brain health navigation program is part of the treatment

plan, but medication, exercise, diet, or other interventions used to manage the qualifying condition must also be included in the care plan.

Chronic Care Management requires a "comprehensive care plan for all health issues." The care plan is based on a physical, mental, cognitive, psychosocial, functional and environmental assessment, and an inventory of resources and supports. However, the complete care plan does not have to be immediately established; it can be developed over time as the clinical staff help perform more assessments to identify patient needs. At minimum, it should address treatment for the qualifying conditions (medications, imaging, referrals) as well as other suspected or confirmed conditions impacting the patient's overall health.

BILLLING NAVIGATION AND CARE MANAGEMENT IN HOSPITAL OUTPATIENT DEPARTMENTS

The place of service for any care management code should be the setting where the provider normally sees the patient. If that place of service is 19 or 22 (hospital outpatient departments), the service will be paid at the facility rate per the Physician Fee Schedule. CMS originally clarified this in their FAQ document for CCM from 2016 which also clarifies that hospital outpatient departments may bill care management services incident to the provider. Additionally, the CMS FAQ document specific to PIN/CHI also states:

> The CHI and PIN codes are priced in both the facility and non-facility settings. The billing physician or practitioner should report the place of service (POS code) for the location where they would ordinarily provide in person, face-to-face care to the beneficiary. For instance, a billing practitioner who ordinarily furnishes in-person, face-to-face care to a beneficiary in a hospital outpatient department should bill for CHI or PIN services using the place of service for hospital outpatient departments for the professional work associated with the service, which will be paid at the facility rate.

To better grasp this, it is important to understand the CPT place of service definitions and the "incident to" regulation at § 410.26. In the AMA CPT definitions of place of service codes, hospitals, on/off campus hospitals, skilled nursing facilities, and others are considered "facilities." Place of service determines if providers are paid at facility or non-facility rates per the Physician Fee Schedule. However, the "incident to" regulations do not use facility and non-facility to determine where "incident to" services may be provided. Rather, they use the term institutional and noninstitutional setting, where "noninstitutional setting means all settings other than a hospital or skilled nursing facility." Medicare Part B pays for services incident to the service of a physician or other practitioner when furnished in "a noninstitutional setting to noninstitutional patients."

Additionally, when navigation/care management services are rendered with a POS of 19 or 22, professional fee will be paid under the Physician Fee Schedule while hospital/facility fees will be paid via the Outpatient Prospective Payment System.

ADDITIONAL CONSIDERATIONS

Care teams will be limited in the services they may bill based on clinical workflow considerations, such as:

- Who performed the qualifying initiating visit?
- Who established the treatment plan/care plan for the qualifying condition or upstream driver(s)?
- Who is the overseeing/billing provider and what services are they eligible to oversee/bill?

- What services are clinical and auxiliary staff organizationally permitted to provide for patients receiving navigation or care management?
- What, if any, state regulations impact the provision of navigation or care management?
- Who is part of the care team providing navigation or care management?

SELECTING REIMBURSEMENT CODES

When staff are performing navigation and care management services, the billing provider, care team, or revenue cycle professionals may need assistance in determining the correct codes to bill. This is a general workflow to help make that determination.

Initiating Visit and Consent

Before determining which services may be billed, first confirm that the patient has had a qualifying initiating visit and the patient/caregiver provided consent for the service.

Counting Time

In most circumstances, time from **all** qualified members of the care team can be counted towards the total time spent on navigation or care management in the month; this can include billing provider time with some potential exceptions in hospital-based outpatient departments. If the billing/overseeing provider is consulted during the navigation/care management, their time can be recorded as part of the monthly time.

If the billing provider personally provides 30 minutes or more care management service during the month, consider selecting a provider-specific code for billing.

Any time spent on navigation or care management may only be counted once when determining the service to bill; if any time spent is paid under another service (i.e., test administration billed under 96138), that time may not be counted in navigation or care management time.

Refer to the concurrent billing guidelines if opting to bill more than one service per calendar month.

Billing Code Selection

In general, care management services reimburse at higher rates for comparable time compared to navigation services. If appropriate, time spent by the care team should be evaluated to determine if the services rendered meet the definition of care management services, and if so, care management services should be selected first.

The billing code selection process assumes that the care team providing services meets the criteria for the billable services (e.g., if billing CHI, any state-level requirements for Community Health Workers are met by the staff performing the service.)

Time for all navigation and care management codes is based on time spent in the calendar month.

Step 1: Does the patient have a qualifying medical diagnosis?
If **yes**, a medical diagnosis has been made, proceed to **Step 2**.
If **no**, a medical diagnosis has not yet been made, the patient is only eligible for PIN or CHI. To bill CHI, the patient must have a documented upstream driver(s). If 60 minutes have been spent in navigation services, select PIN (G0023/G0024) or CHI (G0019/G0022) based on the care rendered. Bill the baseline

service (60 min) for 60-89 minutes of service. The time add-on codes begin when service reaches at least 90 minutes in the calendar month. **Stop**. There are no additional billable services.

Step 2: Does the care plan address more than one medical condition?
If **yes**, the care plan addresses 2 or more medical conditions, proceed to **Step 3**.
If **no**, the care plan addresses only 1 medical condition, it may be an option to bill PCM. Proceed to **Step 2a**.

2a. Did the provider personally render at least 30 minutes of care management in the calendar month?
If **no**, Staff PCM may be an option – proceed to **Step 2b**.
If **yes**, the provider did personally render services, bill provider PCM (99424/99425) based on the total time spent by the provider in the month. If staff rendered at least 60 additional minutes of service in the month, proceed to **Step 4**. If additional services rendered by the care team did not reach at least 60 minutes, **Stop**. There are no additional billable services.

2b. Did the staff perform at least 30 minutes of care management during the calendar month?
If **no**, there are no billable services performed. **Stop**.
If **yes**, bill Staff PCM (99426/99427) based on total time spent by the staff in the month. Remember that even time spent by a navigator can count towards PCM, however, if at least 60 additional minutes of time have been spent in navigation services, you may also bill PIN. Proceed to **Step 4**.

Step 3: **Does the comprehensive care plan address two or more chronic conditions?**
If **yes**, the comprehensive care plan addresses two or more chronic health conditions, it may be an option to bill CCM. Proceed to **Step 3a**.
If **no**, return to Step 2 and evaluate appropriateness of billing PCM services.

3a. Did the provider personally render at least 30 minutes of care management in the calendar month?
If **no**, Staff CCM may be an option – proceed to **Step 3b**.
If **yes**, the provider did personally render services, bill provider CCM (99491/99437) based on the total time spent by the provider in the month. If staff rendered at least 60 additional minutes of service in the month, proceed to **Step 4**. If additional services rendered by the care team did not reach at least 60 minutes, **Stop**. There are no additional billable services.

3b. Did the provider perform moderate or high medical decision making while overseeing the staff in the calendar month?
If **no**, proceed to **Step 3c**.
If **yes**, proceed to **Step 3d.**

3c. Did the staff perform at least 20 minutes of care management during the calendar month?
If **no**, there are no billable services performed. **Stop**.
If **yes**, bill Staff CCM (99490/99439) based on total time spent by the staff in the month. Remember that even time spent by a navigator can count towards CCM, however, if at least 60 additional minutes of time have been spent in navigation services, you may also bill PIN. Proceed to **Step 4**.

3d. Did the staff perform at least 60 minutes of care management during the calendar month?
If **no**, proceed to **Step 3c.**

If **yes**, bill Complex CCM (99487/99489) based on total time spent by the staff in the month. Remember that even time spent by a navigator can count towards Complex CCM, however, if at least 60 additional minutes of time have been spent in navigation services, you may also bill PIN. Proceed to **Step 4**.

Step 4: Is there evidence of at least 60 minutes of time spent by the staff in navigation services that has not been counted in any other care management services billed during the calendar month?
If **no, Stop**. There are no additional billable services.
If **yes**, bill PIN (G0023/G0024) or CHI (G0019/G0022) based on the care rendered and the total amount of time not counted in other services. **Stop**. There are no additional billable services.

FREQUENTLY ASKED QUESTIONS (FAQ)

GENERAL STAFFING, WORKFLOW, AND COST-SHARING

I am employed by the physician group but the staff who will provide navigation/care management services to my patients are employed by the health system and operate at a centralized navigation office or in a specialty clinic. Can they still perform services for my patients? Am I still the billing provider?

Medicare regulations allow all PIN, CHI, and care management services to be performed "incident to" the professional services of the provider, and under the general supervision of the billing provider, which means the billing practitioner provides overall direction and control to the clinical or auxiliary staff who are performing the service, but the practitioner's physical presence is not required during the performance of the service. The staff who perform these services need not be located in the same physical location as the billing provider.

Medicare provides a definition of auxiliary personnel who may perform services "incident to" the billing provider at regulation at § 410.26:

> **Auxiliary personnel** means any individual who is acting under the supervision of a physician (or other practitioner), regardless of whether the individual is an employee, leased employee, or independent contractor of the physician (or other practitioner) or of the same entity that employs or contracts with the physician (or other practitioner), has not been excluded from the Medicare, Medicaid and all other federally funded health care programs by the Office of Inspector General or had his or her Medicare enrollment revoked, and meets any applicable requirements to provide incident to services, including licensure, imposed by the State in which the services are being furnished.

Medicare further defines a "leased employee" at that same regulation:

> **Leased employment** means an employment relationship that is recognized by applicable State law and that is established by two employers by a contract such that one employer hires the services of an employee of the other employer.

When the staff who are performing navigation or care management services are part of the same health system but not physically located in the same office suite or employed by the same employer, they typically will be considered "leased" employees. The two employers must have a formal agreement in place that clarifies the nature of the relationship between the two entities, although the lease is not required to have a monetary exchange. It is likely that this agreement already exists if physicians are tasking centralized employees with work. Check with your administration team.

Medicare Claims Processing Manual Chapter 12 Section 30.6.4 explains "A physician is not precluded from billing under the "incident to" provision for services provided by employees whose services cannot be paid for directly under the Medicare program. Employees of the physician may provide services incident to the physician's service, but the physician alone is permitted to bill Medicare. Services

provided by employees as “incident to” are covered when they meet all the requirements for incident to and are medically necessary for the individual needs of the patient.”

Who is best positioned to get patient consent for navigation and care management services?
Consent may be obtained and documented by any member of the care team for PIN, CHI, and care management services. No billable navigation/care management services may occur until the patient/caregiver consents to the service. Verbal consent that is documented in the medical record satisfies consent requirements.

The initial care plan or treatment plan, along with the medical necessity of services, must be documented at the initiating visit (although the care/treatment plan can undergo revision at a later date.) To avoid unnecessary work, many workflows include the provider capturing consent during the initiating visit. To ease provider burden, a documentation short-cut (such as a “smart phrase”) can be developed to document the required elements of consent.

If the billing provider does not personally obtain consent, they should make a strong recommendation and obtain buy-in from the patient/caregiver for the service, even if the formal elements of consent are explained and documented by someone else, such as the navigator at the first navigation touchpoint.

How often are patients billed for the co-pay required to access the services?
PIN, CHI, and care management services are billed at the end of the calendar month, when the care provided to the patient satisfies the billing requirements. Patients generally will then pay a co-pay for each month that they receive a billable service. For services provided in March, the claim would likely be submitted in April, and depending on how quickly insurance processes it, the patient might receive a bill for their co-pay in May. If the patient has Traditional Medicare (Part B) with supplemental insurance (including Medicaid), they will likely not pay anything out of pocket. Some Medicare Advantage (Part C) plans may also waive cost-sharing for care management or navigation services.

For patients with Traditional Medicare (Part B), all navigation and care management services are subject to a 20% coinsurance (co-pay) once the deductible has been satisfied.

How should we “sell” navigation and/or care management services to patients to justify the required co-pay?
A strong provider recommendation is the best way to overcome any potential resistance to services, although most patients who are in the process of navigating to a dementia diagnosis or navigating early dementia care generally do not oppose additional help in the journey.

Example of a strong provider recommendation: *I am concerned about your brain health and want to get additional testing/ bloodwork/ imaging to better understand what’s happening and how we can help your cognition. We have a dedicated brain health nurse I would like to connect you to. He/She will be able to provide you with more information about this process, help you set up appointments, and answer questions you have about next steps or any results we get along the way. There may be a co-pay for this service, but I believe it’s in your best interest to get assistance during this time. Is that something you are interested in?*

If cost-sharing remains a significant barrier, there are other options you may discuss with your administration team that can help overcome this, including:

- Use of nominal gifts
- Policy-based waivers of cost-sharing for navigation and care management services
- Grant funding for patient cost-sharing portions of these services

PRINCIPAL ILLNESS NAVIGATION (PIN)

I saw a patient four months ago and now feel that PIN would be helpful for them. Do I need to see them again for a qualifying initiating visit, or can the previous visit fulfill the initiating visit requirement?

There is not a requirement that the qualifying initiating visit happen within a specific time frame, with the exception of a qualifying initiating visit being performed at least every twelve months. It would not be unusual for a patient to have one or more months elapse between the initiating visit and a month when they receive billable PIN services.

However, during the qualifying initiating visit, the billing practitioner ***must*** have documented:

- the treatment plan
- how PIN services are reasonable and necessary to help accomplish that plan, and
- established the PIN services as incidental to their professional services

If these elements were not performed and documented during the visit, the patient must have another qualifying initiating visit with a qualified billing practitioner.

Who is qualified to perform PIN services?

Auxiliary staff may perform PIN services subject to training and state licensure, if applicable. Medicare defines auxiliary personnel as "any staff who is acting under the supervision of a physician, regardless of whether the individual is an employee, leased employee, or independent contractor of the physician, or of the legal entity that employs or contracts with the physician. ***Auxiliary personnel are not required to have a clinical background or hold a clinical license. However, they must be trained and competent to perform assigned services under the supervision of the provider***."

At the time of publication, there are no state requirements for licensure of PIN navigators. Therefore, any auxiliary personnel who are under the general supervision of a qualified provider and who have been trained and are competent in the domains required by Medicare may perform PIN services. The domains are:

- Patient and family communication
- Interpersonal and relationship-building
- Patient and family capacity building
- Service coordination and systems navigation
- Patient advocacy, facilitation, individual and community assessment
- Professionalism and ethical conduct
- Developing an appropriate knowledge base, including specific certification or training on the serious, high-risk condition, illness, or disease being addressed

Can in-house or "home grown" training satisfy training requirements for navigators?

There are no limitations or requirements for the training in the required domains as long as the staff is deemed competent in the domain.

Is the PIN billing period a rolling 30 days or per calendar month?

PIN is billed per calendar month.

Can the provider bill PIN on the same date as an E/M visit, or on the same date as another care management service?

Yes. PIN can be billed on the same date as other care management services as long as the services are allowed to be billed by the same provider in the same month and all requirements for each service are met/documented. See Appendix G for details about concurrent billing of navigation and care management services. Navigation and care management services can also be billed on the same date as an E/M visit.

For billing purposes, CPT codes for care management services are considered E/M services. If billing two care management services, or a care management service with an E/M visit, amend the code with modifier -25 to indicate a separate and distinct E/M service. Consult revenue cycle staff for detailed guidance.

The overseeing provider for PIN typically sees patients in an On/Off Campus outpatient Hospital, billed with place of service (POS) code 19 or 22. The 2024 Physician Fee Schedule Final Rules states that "There is no benefit under the PFS for facility settings in accordance with the "incident to" regulation at § 410.26." What POS can be used to bill PIN services?

The place of service for any PIN/CHI or care management code should be the setting where the provider normally sees the patient. If that POS is 19 or 22, the service will be paid at the facility rate per the Physician Fee Schedule. CMS clarified this in their FAQ document for CCM from 2016. The CMS FAQ document specific to PIN/CHI also states:

> The CHI and PIN codes are priced in both the facility and non-facility settings. The billing physician or practitioner should report the place of service (POS code) for the location where they would ordinarily provide in person, face-to-face care to the beneficiary. For instance, a billing practitioner who ordinarily furnishes in-person, face-to-face care to a beneficiary in a hospital outpatient department should bill for CHI or PIN services using the place of service for hospital outpatient departments for the professional work associated with the service, which will be paid at the facility rate.

The 2024 Physician Fee Schedule Rule states:

> There is no benefit under the PFS for facility settings in accordance with the "incident to" regulation at § 410.26. Since PIN services are provided under incident to regulations, inpatient/observation E/M visits and ED visits cannot serve as initiating visits for the purpose of PIN. We also continue to believe that the furnishing practitioner should have continuity from initiating visit through the supervision of PIN services, given the medical necessity of PIN services, and the formation of the appropriate treatment plan specific to that patient. This framework is similar to the current requirements for billing care management services, and the requirements for billing CHI services that we are finalizing in this rule. PIN services are furnished over the course of a month, and we note that patients do not stay in inpatient, observation, or ED settings for one month, making practitioners in this setting unable to furnish PIN services for the duration of the month, as required under incident to requirements.

To contextualize this statement, it is important to understand the CPT place of service definitions and the "incident to" regulation at § 410.26. In the AMA CPT definitions of POS codes, hospitals, on/off campus hospitals, skilled nursing facilities, and others are considered "facilities." Place of service determines if providers are paid at facility or non-facility rates per the Physician Fee Schedule. However,

the “incident to” regulations do not use facility and non-facility to determine where “incident to” services may be provided. Rather, they use the term institutional and noninstitutional setting, where “noninstitutional setting means all settings other than a hospital or skilled nursing facility.” Medicare Part B pays for services incident to the service of a physician or other practitioner when furnished in “a noninstitutional setting to noninstitutional patients.”

Is verbal consent for PIN sufficient to meet requirements, and who may obtain that verbal consent?

Any member of the care team may obtain consent from the patient/caregiver for navigation or care management services. The consent must be documented in the chart, and all required elements of the informed consent must be documented as having been addressed. The required elements of consent for PIN are:

- The availability of navigation 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

If the patient does not consent to receiving navigation/care management services, you may still provide some or all of the elements of navigation/care management. However, you may not bill for these services.

Who can create the care plan and bill for PIN services?

PIN does not require a comprehensive care plan like CCM or a disease-specific care plan like PCM/BHI. PIN requires a “treatment plan” that establishes the medical necessity of navigation for the patient relevant to the suspected or confirmed diagnosis. **The treatment plan must be developed by the provider during the qualifying initiating visit.** The treatment plan can be simple and incorporated into the medical treatment plan. For instance, when ordering labs, imaging, or referrals, adding a smart phrase like “*navigation to assist the patient with completing medical care plan, including identifying and addressing upstream driver(s) and navigating the healthcare system, during process of diagnosis*.”

If/After a diagnosis is confirmed and the patient’s treatment plan is updated—for instance, to include disease modifying therapy—the navigation treatment plan can include direction for the navigator to assist the patient in meeting the clinical treatment plan goals, including addressing social, emotional, and financial needs and navigating the healthcare system.

Can Social Workers bill for PIN?

Only providers who are authorized to bill for a qualifying initiating visit may bill for navigation services. The qualifying initiating visits for PIN are:

- Outpatient E/M visit (other than Level 1) including the E/M visit that is part of a Transitional Care Management visit: CPT codes 99202-99205, 99212-99215, 99495, 99496
- Psychiatric diagnostic evaluation: CPT 90791
- Health Behavior Assessment and Intervention (HBAI) services: CPT codes 96156, 96158, 96159, 96164, 96165, 96167, and 96168
- Annual Wellness Visits when performed by a practitioner who is qualified to identify a high-risk condition that would qualify for PIN services: CPT codes G0402, G0438, G0439

The provider who performs the qualifying initiating visit is the provider who bills the PIN service. Clinical social workers (CSWs) may perform a qualifying visit (if they perform a BHAI service) and bill PIN. If the eligible social worker performs the qualifying visit and bills for PIN services, only the time they personally spend on PIN may be counted towards the service as CSWs are not qualified supervising providers.

However, social workers—including CSWs—may also act as part of the navigation team under the supervision of the billing provider who has performed the qualifying initiating visit (such as an office E/M visit.)

When the billing provider is an MD or DO, PIN is paid at the full rate of the Physician Fee Schedule. When the billing provider is a non-physician practitioner like a nurse practitioner or physician assistant, PIN is paid at 85% of the Physician Fee Schedule. When the billing provider is a CSW, PIN is paid at 75% of the Physician Fee Schedule.

Where can I go to find out the licenses required for navigators and billing providers in my state?

The billing provider would be the physician/non-physician practitioner or other qualified healthcare professional who performs the initiating visit and who provides general supervision to the staff rendering services to patients. Generally billing provider licensure is regulated by the appropriate state board, such as the State Board of Medicine (MDs, DOs, Physician Assistants) or the State Board of Nursing (Nurse Practitioners, Certified Nurse Specialists).

The auxiliary staff who perform PIN services have training and competency requirements; at the time of publication, no states require licensure or state-regulated certification for PIN navigators. Up-to-date information can be found on the appropriate state website in Appendix H.

COMMUNITY HEALTH INTEGRATION (CHI)

Who is qualified to perform CHI services?

Auxiliary staff may perform CHI services subject to training and state licensure, if applicable. Medicare defines auxiliary personnel as "any staff who is acting under the supervision of a physician, regardless of whether the individual is an employee, leased employee, or independent contractor of the physician, or of the legal entity that employs or contracts with the physician. ***Auxiliary personnel are not required to have a clinical background or hold a clinical license. However, they must be trained and competent to perform assigned services under the supervision of the provider***."

At the time of publication, there are no state requirements for licensure of community health workers or other staff who may render CHI services. Therefore, any auxiliary personnel who are under the general supervision of a qualified provider and who have been trained and are competent in the domains required by Medicare may perform CHI services. The required domains are:

- Patient and family communication
- Interpersonal and relationship-building
- Patient and family capacity-building
- Service coordination and system navigation
- Patient advocacy, facilitation, individual and community assessment
- Professionalism and ethical conduct
- Development of an appropriate knowledge base, including local community-based resources.

CHI is intended for people with unaddressed upstream drivers. We don't currently screen for these in our workflow. Is it okay to bill for CHI for patients who were screened by someone else and have SDOH documented in their EMR? Does a SDOH screening need to be documented before billing for CHI, or is the general knowledge of the provider that a patient is struggling with food security sufficient?
The requirement for CHI is that **during the initiating visit**, the billing practitioner documents the upstream driver(s), establishes the treatment plan, specifies how addressing the upstream driver(s) would accomplish the treatment plan, and establishes CHI as incidental to their professional services.

Screening for unmet SDOH needs and upstream driver(s) is not a required element of the CHI initiating visit, but because the billing practitioner must justify the CHI services by specifying how addressing the upstream driver(s) helps the patient accomplish the care plan, it is clinically appropriate to include SDOH screening in the initiating visit workflow. However, if the upstream driver(s) is already identified and documented by another member of the care team, or if the patient self-reports the upstream driver(s), the billing provider need only confirm that the need exists and document accordingly in their note, and ideally (although not required) by adding an appropriate ICD-10 code to the visit claim.

Any member of the patient's care team can collect data about SDOH during any encounter. This includes providers, social workers, community health workers, case managers, patient navigators, and nurses. Patients may also self-report these data. SDOH ICD-10 Z-codes may be added to a claim based on patient self-reported data or documentation from any member of the care team.

Where can I go to find out the licenses required for community health workers/CHI providers and billing providers in my state?
The billing provider would be the physician/non-physician practitioner who performs the initiating visit and who provides general supervision to the staff rendering services to patients. Generally billing provider licensure is regulated by the appropriate state board, such as the State Board of Medicine (MDs, DOs, Physician Assistants) or the State Board of Nursing (Nurse Practitioners, Certified Nurse Specialists).

The staff who perform CHI services have training/competency requirements, but at the time of publication, no states require licensure or state-regulated certification for CHWs or other staff rendering CHI services. Many states offer voluntary training, certification, and registration for CHWs. Up-to-date information can be found on the appropriate state website in Appendix H.

COGNITIVE ASSESSMENT AND CARE PLANNING (CACP) (99483)

Can assessments performed by the BHN be used in Cognitive Assessment and Care Planning (CACP) visits?
CACP requires documentation of several assessments, many of which have specific tools that must be used. For example, the following are required elements of the CACP service:

- Assessment of cognition using the Mini-Cog©, GPCOG, or Short Montreal Cognitive Assessment (s-MoCA)
- Functional assessment of basic and independent activities of daily living with either the Katz Index of Independence in Activities of Daily Living or the Lawton-Brody Instrumental Activities of Daily Living Scale (IADL)
- Dementia staging using Functional Assessment Staging Test (FAST scale), Clinical Dementia Rating (CDR® Dementia Staging Instrument), Dementia Severity Rating Scale (DSRS), or Global Deterioration Score (GDS)

- Neuropsychiatric evaluation using the Neuropsychiatric Inventory Questionnaire (NPI-Q), BEHAV5+©, or Patient Health Questionnaire-2 (PHQ-2)

CMS recommends taking a team-based approach to completing these assessments; they do not have to be completed by the billing provider, and they do not have to be completed the day of the CACP visit; generally, data collected within the 90 days preceding the CACP visit may be used to meet the requirements of the visit.

Note that the raw data (original instruments) must be available in the chart in order to utilize the data to fulfill the CACP requirements. It's not sufficient to state "Mini-Cog completed 3/1/25 with PCP was 2 out of 5." The original clock drawing and delayed recall scores must be available in the chart.

If documentation from the BHN meets these requirements, it may be used to fulfill the elements of the CACP visit.

Can Social Workers perform and bill Cognitive Assessment and Care Planning (CACP) visits?

Only providers who are qualified to perform evaluation and management (E/M) visits are eligible to bill CACP visits. This limits the billing provider to MD/DOs, NPs, CNSs, and PAs. However, social workers may be part of the team involved in performing elements of the CACP visit, such as discussion of advance care planning or identifying social supports and assessing how much caregivers know and are willing to contribute to the care of the patient.

Can G2211 and G2212 be billed with CACP?

G2211 is Medicare's complexity add-on code and may only be billed with office/outpatient E/M visits (99202-99215).

G2212 is Medicare's time add-on code and may be billed with 99483 when time personally spent by the provider ***on the date of service*** exceeds 60 minutes by at least 15 minutes (must meet or exceed 75 minutes). Multiple units of G2212 may be added to the 99483 claim. However, *only* the billing provider's time on the date of the visit may be counted for the time spent on the visit, and the provider's time should be documented in the visit note. For example:

> *I personally spent 90 minutes on the date of the encounter in the review of medical records, examination of the patient, interviewing the caregivers, discussion with and education of the patient and caregivers, and documentation.*

Can CACP be rendered via telehealth?

CACP is an approved Medicare telehealth service. However, if required elements of the visit (e.g., specific assessments/tests) necessitate in-person patient contact, they must be conducted face-to-face. Whether assessments are administered remotely or in person, the raw instrument results must be retained in the medical record.

Must the billing provider perform all required elements of the CACP visit?

Medicare has made clear that they expect CACP to be performed as a team-based service.

Some required elements of the CACP visit may only be performed by the billing provider, including determination of the patient's decision-making capacity and the provider's moderate to high medical decision making.

Except provider-specific tasks, all other elements of the visit may be performed by members of the care team under the supervision of the billing provider or gathered from past patient encounters. For instance, the Mini-Cog© performed by the nurse as part of the Annual Wellness Visit may be used to satisfy the cognition assessment element of CACP as long as the raw instrument is available in the medical record and the results are recent and relevant to the patient's current presentation. A driver safety evaluation performed by OT may be used to satisfy part of the evaluation of motor vehicle safety as long as the results are recent and still relevant to the patient's current presentation. The care team may perform assessments, administer standardized instruments, discuss Advance Care Planning, identify social supports and community resources, assist in the development of the care plan, et cetera; these tasks may be performed on the day of the patient's visit with the provider, or in other patient encounters before the patient's visit with the provider.

PSYCHIATRIC COLLABORATIVE CARE MODEL (COCM)

What is the Psychiatric Collaborative Care Model (CoCM) and how is it different from navigation and other care management services?

CoCM is a model of collaborative care designed to help primary care and other treating providers manage mental, behavioral and psychiatric conditions in the course of their overall treatment of the patient. In this model, the treating provider oversees a behavioral health care manager (BHCM) to provide evidence-based assessments and interventions. A psychiatric consulting provider works with the treating provider and BHCM to develop the psychiatric care plan, meeting with the BHCM weekly to ensure progress is made against the care plan.

CoCM is similar to other care management services in some ways:

- the BHCM provides most of the interventions under the general supervision of the treating provider
- care the BHCM renders may be telephonic, via telehealth technology (without being subject to Medicare telehealth regulations), or in person
- time that the BHCM spends on tasks that do not directly involve the patient (such as creating/maintaining a registry of patients enrolled in CoCM and meeting with the psychiatric consultant weekly) can be counted toward the monthly service time

However, CoCM is different from navigation and care management services in some ways:

- the service is restricted to patients who have a mental, behavioral or psychiatric diagnosis
- the BHCM is qualified by formal education or specialized training in behavioral health (including social work, nursing, or psychology) and may be a provider able to independently report some billable services, but in their capacity as the BHCM, works under the direction of the treating provider
- the tasks the BHCM must complete is more prescriptive than navigation or care management, including time spent delivering evidence-based brief interventions such as motivational interviewing
- the BHCM must be able to see patients face-to-face and outside of clinic hours as needed

Detailed service elements and additional resources for CoCM are located in Appendix E.

Can providers who are not primary care bill CoCM?

Yes, providers who are not primary care may bill CoCM, but only providers who are eligible to bill for E/M visits may submit claims for these services. Psychiatrists are not expected to bill CoCM codes as this is considered part of their psychiatric care.

Does the consulting psychiatrist bill for CoCM?

No, the consulting psychiatrist does not submit any claims for the time spent on the weekly review and update to the psychiatric care plan. Renumeration for services rendered by the consulting psychiatrist is arranged between the treating/billing provider and the consulting psychiatrist.

Does the treating provider's time count for CoCM?

The time spent by the treating provider in the supervision of the BHCM or updating the care plan may be counted in the monthly BHCM time. However, if the treating provider renders a service that they bill for (e.g., a brief telephonic communication with the patient billed using G2012), that time may not be counted in the BHCM time.

APPENDIX A: RELEVANT CMS & CPT DEFINITIONS

The following terms are used in descriptions of services billable under CPT or HCPCS codes maintained by the AMA or CMS. Note that in some cases, CMS definitions may vary from the definition provided by the AMA at the CPT code level or in the prefatory language.

Auxiliary Personnel: Any staff who is acting under the supervision of a physician, regardless of whether the individual is an employee, leased employee, or independent contractor of the physician, or of the legal entity that employs or contracts with the physician. Auxiliary personnel are not required to have a clinical background or hold a clinical license. However, they must be trained and competent to perform assigned services under the supervision of the provider.

Billing Provider: A provider who is eligible to submit claims for billable services, has been granted appropriate billing privileges, and is authorized to submit claims for specified services. Billing provider eligibility may vary by payor.

Caregiver: A family member, friend, or neighbor who provides unpaid assistance to a person with a chronic illness or disabling condition. For PIN and CHI services, CMS is also adopted the definition of family caregiver used in the RAISE Family Caregivers Act, "an adult family member or other individual who has a significant relationship with, and who provides a broad range of assistance to, an individual with a chronic or other health condition, disability, or functional limitation."

Clinical Staff: Any staff who works for, or under the direction of, a physician or qualified health care professional and does not bill services separately. The person may be—but is not required to be—licensed or regulated to help the physician perform specific duties. Clinical staff are qualified by their training, which may be formal (degree or certification program) or organization-based (internal training programs.)

Community-Based Organization: Public or private not-for-profit entities that provide specific services to the community or targeted populations in the community to address the health and social needs of those populations. They may include community-action agencies, housing agencies, area agencies on aging, centers for independent living, aging and disability resource centers or other non-profits that apply for grants or contract with healthcare entities to perform social services. They may receive grants from other agencies in the U.S. Department of Health and Human Services, including Federal grants administered by the Administration for Children and Families (ACF), Administration for Community Living (ACL), the Centers for Disease Control and Prevention (CDC), the Substance Abuse and Mental Health Services Administration (SAMHSA), or State-funded grants to provide social services.

Direct Supervision: The practitioner directs the clinical or auxiliary staff in the performance of the service and is immediately available to join the encounter during the performance of the service. Beginning January 1, 2026, the supervising practitioner may be "immediately available" using real-time audio/video technology (not audio-only) for all approved telehealth services except those with a global surgery indicator of 010 or 090.

General Supervision: The practitioner provides overall direction and control to the clinical or auxiliary staff who are performing the service, but the practitioner's presence is not required during the performance of the service.

Incident to: "Incident to" is a term used to describe services provided to patients by non-physician staff, incident to the professional services of the provider. Only select services may be provided incident to, and only physicians and non-physician practitioners are qualified to bill for incident to services. Every service provided incident to is rendered under the direct or general supervision of the provider, but not every service rendered under the supervision of the provider is considered incident to. For a service to

be considered incident to, it must meet several inclusion/exclusion requirements, such as not belonging to another benefit category, and being part of an established care plan.

Non-Physician Practitioner (NPP): A healthcare provider who is not a physician but who practices in collaboration with or under the supervision of a physician. NPPs may bill payers directly, rather than billing under a physician, in certain circumstances. NPPs also may be known as mid-level practitioners, physician extenders, and advanced practice providers (APPs). NPPs include physician assistants (PAs) and advanced practice registered nurses (APRNs), including nurse practitioners (NPs), clinical nurse specialists (CNSs), certified nurse midwives (CNMs), and certified registered nurse anesthetists (CRNAs). Medicare pays NPPs at 85% of the Physician Fee Schedule rate.

Problem: A disease, condition, illness, injury, symptom, finding, complaint, or other matter addressed at the encounter, with or without a diagnosis being established at the time of the encounter.

Problem Addressed: A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or other qualified healthcare professional reporting the service. This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/ parent/ guardian/ surrogate choice. Notation in patient's medical record that another professional is managing the problem without additional assessment or care coordination documented does not qualify as being addressed or managed by the physician or other qualified healthcare professional reporting the service. Referral without evaluation (by history, examination, or diagnostic study[ies]) or consideration of treatment does not qualify as being addressed or managed by the physician or other qualified healthcare professional reporting the service.

Qualified Health Care Professional (QHP): Educated, licensed or certified, and regulate professional operating under a specified scope of practice to provide patient services that are separate and distinct from other clinical staff. Services may be billed independently or under the facility's services.

Qualifying Initiating Visit: A specified face-to-face service with a patient that must occur before initiating certain care management and navigation services. In some cases, the provider who performs the qualifying initiating visit is required to be the supervising/billing provider for the service

Social Determinants of Health (SDOH): The economic and social condition(s) that influence the health of people and communities and include (but are not limited to) examples like food insecurity, transportation insecurity, housing insecurity, and unreliable access to public utilities.

Supervising Provider: A provider who is authorized to provide supervision to auxiliary personnel for specified services. In most cases, the billing provider is the supervising provider.

Telehealth: Patient visits using an interactive audio and video telecommunications system that enables real-time communication between the patient (located in their home or at an "originating site") and practitioner (located at the "distant site.") Telehealth is distinct from care management services, which are designed to be performed using audio-only communication.

Upstream Drivers: Introduced in the 2026 Physician Fee Schedule, CMS uses this term to refer to the conditions that impact health and health choices "that affect patient behaviors (such as smoking, poor nutrition, low physical activity, substance misuse, etc.) or potential dietary, behavioral, medical, and environmental drivers" of health choices and outcomes.

APPENDIX B: DETAILED SERVICE ELEMENTS FOR PRINCIPAL ILLNESS NAVIGATION SERVICES

G0023: Principal Illness Navigation services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator; 60 minutes per calendar month, in the following activities:

- Person-centered assessment, performed to better understand the individual context of
- the serious, high-risk condition.
    - Conducting a person-centered assessment to understand the patient's life story, strengths, needs, goals, preferences, and desired outcomes, including understanding cultural and linguistic factors, and including unmet SDOH needs (that are not separately billed).
    - Facilitating patient-driven goal setting and establishing an action plan.
    - Providing tailored support as needed to accomplish the practitioner's treatment plan.
- Identifying or referring patient (and caregiver or family, if applicable) to appropriate supportive services.
- Practitioner, Home, and Community-Based Care Coordination
    - Coordinating receipt of needed services from healthcare practitioners, providers, and facilities; home- and community-based service providers; and 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.

APPENDIX C: DETAILED SERVICE ELEMENTS FOR COMMUNITY HEALTH INTEGRATION SERVICES

G0019: Community health integration (CHI) 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, in the following activities to address upstream driver(s) that are significantly limiting ability to diagnose or treat problem(s) addressed in an initiating visit:

- Person-centered assessment, performed to better understand the individualized context of the intersection between the upstream driver(s) and 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.
    - Facilitating patient-driven goal setting 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 referrals 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 upstream driver(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 upstream driver(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 upstream driver(s), in ways that are more likely to promote personalized and effective diagnosis and treatment.
- Health care access / health system navigation:
    - Helping the patient access care, 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 upstream driver(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.

APPENDIX D: DETAILED SERVICE ELEMENTS FOR CLINICALLY ORIENTED CARE MANAGEMENT SERVICES

Extensive guidance on clinical care management services paid under the Medicare Physician Fee Schedule is available through the Medicare Learning Network: https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/chroniccaremanagement.pdf

CARE MANAGEMENT SERVICES RENDERED BY CLINICAL STAFF

CPT/ HCPCS	Short Description	Long Description
99426	PCM (Staff), first 30 minutes per month	Principal care management services, for a single high-risk disease, with the following required elements: one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/ decompensation, functional decline, or death, the condition requires development, monitoring, or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities, ongoing communication and care coordination between relevant practitioners furnishing care; first 30 minutes of clinical staff time directed by physician or other qualified health care professional, per calendar month
99427	PCM (Staff), time add on, 30 min	PCM, each additional 30 minutes personally provided clinical staff
99439	CCM (Staff), time add on, 20 min	CCM, each additional 20 minutes personally provided clinical staff
99490	CCM (Staff), first 20 minutes per month	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month
99487	Complex CCM, first 60 minutes per month	Complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, establishment, or substantial revision of comprehensive care plan, moderate or high complexity medical decision making; first 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month
99489	Complex CCM, time add on (30 min)	Complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, establishment or significant revision of comprehensive care plan, moderate or high complexity medical decision making; each

		additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)
99484	General BHI	Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional time, per calendar month, with the following required elements: • Initial assessment or follow-up monitoring, including using applicable validated rating scales • Behavioral health care planning about behavioral or psychiatric health problems, including revision for patients not progressing or whose status changes • Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling, or psychiatric consultation • Continuity of care with an appointed member of the care team

CARE MANAGEMENT SERVICES PERSONALLY RENDERED BY THE BILLING PROVIDER

CPT/ HCPCS	Short Description	Long Description
99424	PCM (Provider), first 30 minutes per month	Principal care management services, for a single high-risk disease, with the following required elements: one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/ decompensation, functional decline, or death, the condition requires development, monitoring, or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities, ongoing communication and care coordination between relevant practitioners furnishing care; first 30 minutes of service personally performed by the billing provider, per calendar month
99425	PCM (Provider), time add on, 30 min	PCM, each additional 30 minutes personally performed by the billing provider
99491	CCM (Provider), first 30 minutes per month	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 30 minutes of service personally performed by the billing provider, per calendar month
99437	CCM (Provider), time add on, 30 min	CCM, each additional 30 minutes personally performed by the billing provider
G0506	CCM Care Planning	Comprehensive assessment of and care planning for patients requiring chronic care management services, beyond the time typically described by the initiating visit.

APPENDIX E: DETAILED SERVICE ELEMENTS FOR COLLABORATIVE CARE MANAGEMENT (COCM)

CPT/ HCPCS	Short Description	Long Description
99492	First Month CoCM, 70 minutes	Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: • Outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional, • Initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan, • Review by the psychiatric consultant with modifications of the plan if recommended, • Entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant, and • Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.
99493	Subsequent Month CoCM, 60 minutes	Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: • Tracking patient follow-up and progress using the registry, with appropriate documentation, • Participation in weekly caseload consultation with the psychiatric consultant, • Ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers, • Additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant, • Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies, • Monitoring of patient outcomes using validated rating scales, and • Relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.
99494	CoCM Time Add-On (any month), 30 minutes	Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the

		treating physician or other qualified health care professional (List separately in addition to code for primary procedure)
G2214	Initial or Subsequent CoCM, 30 minutes per calendar month	Initial or subsequent psychiatric collaborative care management, first 30 minutes in a month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional

APPENDIX F: COGNITIVE ASSESSMENT AND CARE PLANNING DETAILS

ICD-10 CODES THAT DEMONSTRATE MEDICAL NECESSITY FOR CACP

One or more of the following diagnoses should be addressed in the medical record and the diagnostic code should be added to the claim to support the medical necessity of the CACP service.

Code	Descriptor
F01.50	Vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
F01.A0	Vascular dementia, mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
F01.A11	Vascular dementia, mild, with agitation
F01.A18	Vascular dementia, mild, with other behavioral disturbance
F01.A2	Vascular dementia, mild, with psychotic disturbance
F01.A3	Vascular dementia, mild, with mood disturbance
F01.A4	Vascular dementia, mild, with anxiety
F01.B0	Vascular dementia, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
F01.B11	Vascular dementia, moderate, with agitation
F01.B18	Vascular dementia, moderate, with other behavioral disturbance
F01.B2	Vascular dementia, moderate, with psychotic disturbance
F01.B3	Vascular dementia, moderate, with mood disturbance
F01.B4	Vascular dementia, moderate, with anxiety
F01.C0	Vascular dementia, severe, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
F01.C11	Vascular dementia, severe, with agitation
F01.C18	Vascular dementia, severe, with other behavioral disturbance
F01.C2	Vascular dementia, severe, with psychotic disturbance
F01.C3	Vascular dementia, severe, with mood disturbance
F01.C4	Vascular dementia, severe, with anxiety
F02.80	Dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
F02.A0	Dementia in other diseases classified elsewhere, mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
F02.A11	Dementia in other diseases classified elsewhere, mild, with agitation
F02.A18	Dementia in other diseases classified elsewhere, mild, with other behavioral disturbance
F02.A2	Dementia in other diseases classified elsewhere, mild, with psychotic disturbance
F02.A3	Dementia in other diseases classified elsewhere, mild, with mood disturbance
F02.A4	Dementia in other diseases classified elsewhere, mild, with anxiety

F02.B0	Dementia in other diseases classified elsewhere, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
F02.B11	Dementia in other diseases classified elsewhere, moderate, with agitation
F02.B18	Dementia in other diseases classified elsewhere, moderate, with other behavioral disturbance
F02.B2	Dementia in other diseases classified elsewhere, moderate, with psychotic disturbance
F02.B3	Dementia in other diseases classified elsewhere, moderate, with mood disturbance
F02.B4	Dementia in other diseases classified elsewhere, moderate, with anxiety
F02.C0	Dementia in other diseases classified elsewhere, severe, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
F02.C11	Dementia in other diseases classified elsewhere, severe, with agitation
F02.C18	Dementia in other diseases classified elsewhere, severe, with other behavioral disturbance
F02.C2	Dementia in other diseases classified elsewhere, severe, with psychotic disturbance
F02.C3	Dementia in other diseases classified elsewhere, severe, with mood disturbance
F02.C4	Dementia in other diseases classified elsewhere, severe, with anxiety
F06.70	Mild neurocognitive disorder due to known physiological condition without behavioral disturbance
F06.71	Mild neurocognitive disorder due to known physiological condition with behavioral disturbance
F10.27	Alcohol dependence with alcohol-induced persisting dementia
F10.97	Alcohol use, unspecified with alcohol-induced persisting dementia
F13.27	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced persisting dementia
F13.288	Sedative, hypnotic or anxiolytic dependence with other sedative, hypnotic or anxiolytic-induced disorder
F13.97	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced persisting dementia
F18.17	Inhalant abuse with inhalant-induced dementia
F18.188	Inhalant abuse with other inhalant-induced disorder
F18.27	Inhalant dependence with inhalant-induced dementia
F18.288	Inhalant dependence with other inhalant-induced disorder
F18.97	Inhalant use, unspecified with inhalant-induced persisting dementia
F18.988	Inhalant use, unspecified with other inhalant-induced disorder
F19.17	Other psychoactive substance abuse with psychoactive substance-induced persisting dementia
F19.188	Other psychoactive substance abuse with other psychoactive substance-induced disorder
F19.27	Other psychoactive substance dependence with psychoactive substance-induced persisting dementia
F19.288	Other psychoactive substance dependence with other psychoactive substance-induced disorder
F19.97	Other psychoactive substance use, unspecified with psychoactive substance-induced persisting dementia
F19.988	Other psychoactive substance use, unspecified with other psychoactive substance-induced disorder
G10	Huntington's disease
G30.0	Alzheimer's disease with early onset
G30.1	Alzheimer's disease with late onset

G30.8	Other Alzheimer's disease
G31.01	Pick's disease
G31.09	Other frontotemporal neurocognitive disorder
G31.2	Degeneration of nervous system due to alcohol
G31.83	Neurocognitive disorder with Lewy bodies
G31.84	Mild cognitive impairment of uncertain or unknown etiology
G31.85	Corticobasal degeneration
I69.010	Attention and concentration deficit following nontraumatic subarachnoid hemorrhage
I69.011	Memory deficit following nontraumatic subarachnoid hemorrhage
I69.014	Frontal lobe and executive function deficit following nontraumatic subarachnoid hemorrhage
I69.015	Cognitive social or emotional deficit following nontraumatic subarachnoid hemorrhage
I69.210	Attention and concentration deficit following other nontraumatic intracranial hemorrhage
I69.211	Memory deficit following other nontraumatic intracranial hemorrhage
I69.214	Frontal lobe and executive function deficit following other nontraumatic intracranial hemorrhage
I69.215	Cognitive social or emotional deficit following other nontraumatic intracranial hemorrhage
I69.310	Attention and concentration deficit following cerebral infarction
I69.311	Memory deficit following cerebral infarction
I69.314	Frontal lobe and executive function deficit following cerebral infarction
I69.315	Cognitive social or emotional deficit following cerebral infarction
I69.810	Attention and concentration deficit following other cerebrovascular disease
I69.811	Memory deficit following other cerebrovascular disease
I69.814	Frontal lobe and executive function deficit following other cerebrovascular disease
I69.815	Cognitive social or emotional deficit following other cerebrovascular disease
R41.81	Age-related cognitive decline

CPT CODES THAT MAY NOT BE REPORTED WITH 99483

The following services may not be billed by the same provider on the same date of service unless it is for a separate and medically necessary reason.

90785	INTERACTIVE COMPLEXITY (LIST SEPARATELY IN ADDITION TO THE CODE FOR PRIMARY PROCEDURE)
90791	PSYCHIATRIC DIAGNOSTIC EVALUATION
90792	PSYCHIATRIC DIAGNOSTIC EVALUATION WITH MEDICAL SERVICES
96127	BRIEF EMOTIONAL/BEHAVIORAL ASSESSMENT (EG, DEPRESSION INVENTORY, ATTENTION-DEFICIT/HYPERACTIVITY DISORDER [ADHD] SCALE), WITH SCORING AND DOCUMENTATION, PER STANDARDIZED INSTRUMENT
96146	PSYCHOLOGICAL OR NEUROPSYCHOLOGICAL TEST ADMINISTRATION, WITH SINGLE AUTOMATED, STANDARDIZED INSTRUMENT VIA ELECTRONIC PLATFORM, WITH AUTOMATED RESULT ONLY
96160	ADMINISTRATION OF PATIENT-FOCUSED HEALTH RISK ASSESSMENT INSTRUMENT (EG, HEALTH HAZARD APPRAISAL) WITH SCORING AND DOCUMENTATION, PER STANDARDIZED INSTRUMENT

96161	ADMINISTRATION OF CAREGIVER-FOCUSED HEALTH RISK ASSESSMENT INSTRUMENT (EG, DEPRESSION INVENTORY) FOR THE BENEFIT OF THE PATIENT, WITH SCORING AND DOCUMENTATION, PER STANDARDIZED INSTRUMENT
99202	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES A MEDICALLY APPROPRIATE HISTORY AND/OR EXAMINATION AND STRAIGHTFORWARD MEDICAL DECISION MAKING. WHEN USING TIME FOR CODE SELECTION, 15-29 MINUTES OF TOTAL TIME IS SPENT ON THE DATE OF THE ENCOUNTER.
99203	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES A MEDICALLY APPROPRIATE HISTORY AND/OR EXAMINATION AND LOW LEVEL OF MEDICAL DECISION MAKING. WHEN USING TIME FOR CODE SELECTION, 30-44 MINUTES OF TOTAL TIME IS SPENT ON THE DATE OF THE ENCOUNTER.
99204	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES A MEDICALLY APPROPRIATE HISTORY AND/OR EXAMINATION AND MODERATE LEVEL OF MEDICAL DECISION MAKING. WHEN USING TIME FOR CODE SELECTION, 45-59 MINUTES OF TOTAL TIME IS SPENT ON THE DATE OF THE ENCOUNTER.
99205	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES A MEDICALLY APPROPRIATE HISTORY AND/OR EXAMINATION AND HIGH LEVEL OF MEDICAL DECISION MAKING. WHEN USING TIME FOR CODE SELECTION, 60-74 MINUTES OF TOTAL TIME IS SPENT ON THE DATE OF THE ENCOUNTER.
99211	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT THAT MAY NOT REQUIRE THE PRESENCE OF A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL
99212	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES A MEDICALLY APPROPRIATE HISTORY AND/OR EXAMINATION AND STRAIGHTFORWARD MEDICAL DECISION MAKING. WHEN USING TIME FOR CODE SELECTION, 10-19 MINUTES OF TOTAL TIME IS SPENT ON THE DATE OF THE ENCOUNTER.
99213	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES A MEDICALLY APPROPRIATE HISTORY AND/OR EXAMINATION AND LOW LEVEL OF MEDICAL DECISION MAKING. WHEN USING TIME FOR CODE SELECTION, 20-29 MINUTES OF TOTAL TIME IS SPENT ON THE DATE OF THE ENCOUNTER.
99214	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES A MEDICALLY APPROPRIATE HISTORY AND/OR EXAMINATION AND MODERATE LEVEL OF MEDICAL DECISION MAKING. WHEN USING TIME FOR CODE SELECTION, 30-39 MINUTES OF TOTAL TIME IS SPENT ON THE DATE OF THE ENCOUNTER.
99215	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES A MEDICALLY APPROPRIATE HISTORY AND/OR EXAMINATION AND HIGH LEVEL OF MEDICAL DECISION MAKING. WHEN USING TIME FOR CODE SELECTION, 40-54 MINUTES OF TOTAL TIME IS SPENT ON THE DATE OF THE ENCOUNTER.

99242	OFFICE OR OTHER OUTPATIENT CONSULTATION FOR A NEW OR ESTABLISHED PATIENT, WHICH REQUIRES A MEDICALLY APPROPRIATE HISTORY AND/OR EXAMINATION AND STRAIGHTFORWARD MEDICAL DECISION MAKING. WHEN USING TOTAL TIME ON THE DATE OF THE ENCOUNTER FOR CODE SELECTION, 20 MINUTES MUST BE MET OR EXCEEDED.
99243	OFFICE OR OTHER OUTPATIENT CONSULTATION FOR A NEW OR ESTABLISHED PATIENT, WHICH REQUIRES A MEDICALLY APPROPRIATE HISTORY AND/OR EXAMINATION AND LOW LEVEL OF MEDICAL DECISION MAKING. WHEN USING TOTAL TIME ON THE DATE OF THE ENCOUNTER FOR CODE SELECTION, 30 MINUTES MUST BE MET OR EXCEEDED.
99244	OFFICE OR OTHER OUTPATIENT CONSULTATION FOR A NEW OR ESTABLISHED PATIENT, WHICH REQUIRES A MEDICALLY APPROPRIATE HISTORY AND/OR EXAMINATION AND MODERATE LEVEL OF MEDICAL DECISION MAKING. WHEN USING TOTAL TIME ON THE DATE OF THE ENCOUNTER FOR CODE SELECTION, 40 MINUTES MUST BE MET OR EXCEEDED.
99245	OFFICE OR OTHER OUTPATIENT CONSULTATION FOR A NEW OR ESTABLISHED PATIENT, WHICH REQUIRES A MEDICALLY APPROPRIATE HISTORY AND/OR EXAMINATION AND HIGH LEVEL OF MEDICAL DECISION MAKING. WHEN USING TOTAL TIME ON THE DATE OF THE ENCOUNTER FOR CODE SELECTION, 55 MINUTES MUST BE MET OR EXCEEDED.
99341	HOME OR RESIDENCE VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES A MEDICALLY APPROPRIATE HISTORY AND/OR EXAMINATION AND STRAIGHTFORWARD MEDICAL DECISION MAKING. WHEN USING TOTAL TIME ON THE DATE OF THE ENCOUNTER FOR CODE SELECTION, 15 MINUTES MUST BE MET OR EXCEEDED.
99342	HOME OR RESIDENCE VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES A MEDICALLY APPROPRIATE HISTORY AND/OR EXAMINATION AND LOW LEVEL OF MEDICAL DECISION MAKING. WHEN USING TOTAL TIME ON THE DATE OF THE ENCOUNTER FOR CODE SELECTION, 30 MINUTES MUST BE MET OR EXCEEDED.
99344	HOME OR RESIDENCE VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES A MEDICALLY APPROPRIATE HISTORY AND/OR EXAMINATION AND MODERATE LEVEL OF MEDICAL DECISION MAKING. WHEN USING TOTAL TIME ON THE DATE OF THE ENCOUNTER FOR CODE SELECTION, 60 MINUTES MUST BE MET OR EXCEEDED.
99345	HOME OR RESIDENCE VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES A MEDICALLY APPROPRIATE HISTORY AND/OR EXAMINATION AND HIGH LEVEL OF MEDICAL DECISION MAKING. WHEN USING TOTAL TIME ON THE DATE OF THE ENCOUNTER FOR CODE SELECTION, 75 MINUTES MUST BE MET OR EXCEEDED.
99347	HOME OR RESIDENCE VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES A MEDICALLY APPROPRIATE HISTORY AND/OR EXAMINATION AND STRAIGHTFORWARD MEDICAL DECISION MAKING. WHEN USING TOTAL TIME ON THE DATE OF THE ENCOUNTER FOR CODE SELECTION, 20 MINUTES MUST BE MET OR EXCEEDED.
99348	HOME OR RESIDENCE VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES A MEDICALLY APPROPRIATE HISTORY AND/OR EXAMINATION AND LOW LEVEL OF MEDICAL DECISION MAKING. WHEN USING TOTAL

	TIME ON THE DATE OF THE ENCOUNTER FOR CODE SELECTION, 30 MINUTES MUST BE MET OR EXCEEDED.
99349	HOME OR RESIDENCE VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES A MEDICALLY APPROPRIATE HISTORY AND/OR EXAMINATION AND MODERATE LEVEL OF MEDICAL DECISION MAKING. WHEN USING TOTAL TIME ON THE DATE OF THE ENCOUNTER FOR CODE SELECTION, 40 MINUTES MUST BE MET OR EXCEEDED.
99350	HOME OR RESIDENCE VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES A MEDICALLY APPROPRIATE HISTORY AND/OR EXAMINATION AND HIGH LEVEL OF MEDICAL DECISION MAKING. WHEN USING TOTAL TIME ON THE DATE OF THE ENCOUNTER FOR CODE SELECTION, 60 MINUTES MUST BE MET OR EXCEEDED.
99366	MEDICAL TEAM CONFERENCE WITH INTERDISCIPLINARY TEAM OF HEALTH CARE PROFESSIONALS, FACE-TO-FACE WITH PATIENT AND/OR FAMILY, 30 MINUTES OR MORE, PARTICIPATION BY NONPHYSICIAN QUALIFIED HEALTH CARE PROFESSIONAL
99367	MEDICAL TEAM CONFERENCE WITH INTERDISCIPLINARY TEAM OF HEALTH CARE PROFESSIONALS, PATIENT AND/OR FAMILY NOT PRESENT, 30 MINUTES OR MORE; PARTICIPATION BY PHYSICIAN
99368	MEDICAL TEAM CONFERENCE WITH INTERDISCIPLINARY TEAM OF HEALTH CARE PROFESSIONALS, PATIENT AND/OR FAMILY NOT PRESENT, 30 MINUTES OR MORE; PARTICIPATION BY NONPHYSICIAN QUALIFIED HEALTH CARE PROFESSIONAL
99497	ADVANCE CARE PLANNING INCLUDING THE EXPLANATION AND DISCUSSION OF ADVANCE DIRECTIVES SUCH AS STANDARD FORMS (WITH COMPLETION OF SUCH FORMS, WHEN PERFORMED), BY THE PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL; FIRST 30 MINUTES, FACE-TO-FACE WITH THE PATIENT, FAMILY MEMBER(S), AND/OR SURROGATE
99498	ADVANCE CARE PLANNING INCLUDING THE EXPLANATION AND DISCUSSION OF ADVANCE DIRECTIVES SUCH AS STANDARD FORMS (WITH COMPLETION OF SUCH FORMS, WHEN PERFORMED), BY THE PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL; EACH ADDITIONAL 30 MINUTES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
99605	MEDICATION THERAPY MANAGEMENT SERVICE(S) PROVIDED BY A PHARMACIST, INDIVIDUAL, FACE-TO-FACE WITH PATIENT, WITH ASSESSMENT AND INTERVENTION IF PROVIDED; INITIAL 15 MINUTES, NEW PATIENT
99606	MEDICATION THERAPY MANAGEMENT SERVICE(S) PROVIDED BY A PHARMACIST, INDIVIDUAL, FACE-TO-FACE WITH PATIENT, WITH ASSESSMENT AND INTERVENTION IF PROVIDED; INITIAL 15 MINUTES, ESTABLISHED PATIENT
99607	MEDICATION THERAPY MANAGEMENT SERVICE(S) PROVIDED BY A PHARMACIST, INDIVIDUAL, FACE-TO-FACE WITH PATIENT, WITH ASSESSMENT AND INTERVENTION IF PROVIDED; EACH ADDITIONAL 15 MINUTES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY SERVICE)

APPENDIX G: CONCURRENT BILLING GUIDANCE

CONCURRENT BILLING FOR PIN, CHI, PCM, CCM, AND BHI

General rules of concurrent billing for care management and navigation services:

- A provider may bill either CCM *or* Complex CCM, but never both services in the same month

- A provider may bill multiple navigation/care management services, but each service element must be met for each service billed; each minute spent in care management/navigation may only be counted towards one service
- PCM and CCM services may be personally performed by clinical staff or may be personally performed by the billing provider. Providers may not submit claims for clinical care management personally performed by the billing provider in the same month as clinical care management performed by clinical staff. In the event that the billing provider personally performs care management services, clinical and auxiliary staff time spent on care management for the month should be evaluated to determine if it may be appropriately billed using another billable service, such as PIN.
- CCM/Complex CCM may not be billed during the same service period as home health care supervision (CPT 99374, 99375; HCPCS G0181), hospice care supervision (CPT 99377, 99378; HCPCS G0182), or certain ESRD services (CPT 90951-90970)
- G0506, Medicare's code for Comprehensive Assessment and Care Planning for CCM, is billable only as an add-on code to 9490, 99491, or 99487. It may not be billed in the same month as home health or hospice supervision. It may only be billed once, at the start of a CCM episode
- Navigation and care management services may be billed in the same service period as Transitional Care Management (TCM) (99495, 99496)
- Generally, remote monitoring and telehealth/audio/digital E/M visits may be billed during the same time period as navigation and clinical care management services, as long as all service elements are satisfied, and time is not "double counted." Medical decision making (MDM) during E/M visits – whether in-person, via telehealth/digital, or as audio-only services – cannot count towards MDM for the purpose of determining if Complex CCM service elements have been met for the service period.
- Consult the NCCI edits for the most up-to-date guidance about concurrent billing.

CONCURRENT BILLING FOR COCM

General rules of concurrent billing for Collaborative Care Management:

- A provider may bill either Initial CoCM (99492) *or* Subsequent CoCM (99493), but never both services in the same month
- A provider may bill either CoCM or BHI, but never both services in the same month
- A provider may bill CoCM with other navigation/care management services, but each service element must be met for each service billed; each minute spent in CoCM, care management, or navigation may only be counted towards one service
- CoCM may not be billed during the same service period as home health care supervision (CPT 99374, 99375; HCPCS G0181), hospice care supervision (CPT 99377, 99378; HCPCS G0182), and certain other services. Consult the NCCI edits for the most up-to-date guidance about concurrent billing

CONCURRENT BILLING GUIDELINES FOR NAVIGATION/CARE MANAGEMENT TABLE

	PIN	**CHI**	**CCM/Complex CCM**	**PCM**	**BHI**
PIN	More than one provider can bill PIN services each month, but not for the same qualifying condition	May bill in the same month, by the same or different provider	May bill in the same month, by the same or different provider	May bill in the same month, by the same or different provider	May bill in the same month, by the same or different provider
CHI	May bill in the same month, by the same or different provider	Only one provider can bill CHI services per month	May bill in the same month, by the same or different provider	May bill in the same month, by the same or different provider	May bill in the same month, by the same or different provider
CCM/Complex CCM	May bill in the same month, by the same or different provider	May bill in the same month, by the same or different provider	Only one provider may bill chronic care management services per month, as the service is comprehensive in nature	May bill in the same month, by different providers for different conditions	May bill in the same month, by the same or different provider, but only if managing different conditions
PCM	May bill in the same month, by the same or different provider	May bill in the same month, by the same or different provider	May bill in the same month, by different providers for different conditions	May bill in the same month, by different providers for different conditions	May bill in the same month, by the same or different provider, but only if managing different conditions
BHI	May bill in the same month, by the same or different provider	May bill in the same month, by the same or different provider	May bill in the same month, by different providers for different conditions	May bill in the same month, by the same or different provider, but only if managing different conditions	May bill in the same month by different providers, but only if managing different conditions

APPENDIX H: DETAILED TRAINING/CERTIFICATION REQUIREMENTS AND STATE-SPECIFIC CONSIDERATIONS FOR PIN AND CHI

Some states may have specific requirements for personnel performing PIN and CHI services, or acting as a navigator, community health worker, or care manager. In the absence of state-specific requirements, organizations should maintain clear documentation that staff performing PIN or CHI services have received the appropriate training as outlined in the Medicare requirements (detailed below).

If licensed or certified personnel (e.g., licensed clinical social workers, certified medical assistants, or registered nurses) are retained to perform navigator duties, they should maintain their original license/certification; if they perform duties outside the scope of their license/certification, the organization must maintain clear documentation of appropriate training and organizational scope of practice supporting the performance of these activities.

PRINCIPAL ILLNESS NAVIGATION

At the time of publication, no states require or offer licensure or certification for patient navigators. Medicare requires auxiliary staff who provide PIN services be trained or certified in specific competencies:

- Patient and family communication
- Interpersonal and relationship-building
- Patient and family capacity building
- Service coordination and systems navigation
- Patient advocacy, facilitation, individual and community assessment
- Professionalism and ethical conduct
- Developing an appropriate knowledge base, including specific certification or training on the serious, high-risk condition, illness, or disease being addressed

Many navigator and community health worker training programs include modules addressing these competencies.

COMMUNITY HEALTH INTEGRATION

Per CMS regulation, all auxiliary staff who provide CHI services must be trained in the following competencies, unless they are licensed, certified, or otherwise regulated by the state to provide community health services:

- Patient and family communication
- Interpersonal and relationship-building skills
- Patient and family capacity-building
- Service coordination and system navigation
- Patient advocacy
- Facilitation
- Individual and community assessment
- Professionalism and ethical conduct
- Development of an appropriate knowledge base, including of local community-based resources

These competencies are consistent with the core competencies for Community Health Workers as established by the National Council on CHW Core Consensus Standards (C3 Council). Training should be competency-based; there are no established required hours of training. Most CHW and navigator training programs include curriculum for these competencies.

State-specific Guidance for CHWs

Unless listed below, states do not have formal certification or licensing requirements for CHWs. However, many states do offer CHW training through their department/division of public health, or through partnerships with educational institutions, community-based organizations, or professional associations.

Arizona

Arizona offers voluntary CHW certification. Certification is not required to practice as a CHW in Arizona. https://www.azdhs.gov/licensing/blpo/index.php#community-health-workers

Arkansas

Arkansas offers voluntary CHW certification and a registry of CHWs overseen by the Arkansas Community Health Worker Association. Certification is not required to practice as a CHW in Arkansas. https://www.archwa.org/

California

The California Department of Health Care Access and Information is in the process of developing formal certification for CHWs to meet the state statutes established in 2022. At the time of publication, the certification process had not been finalized. Once finalized, certification will be required; there will be at least two pathways for certification. Currently, CHWs who provide services billable under MediCal have existing certification/experience requirements. https://hcai.ca.gov/workforce/initiatives/community-health-workers-promotores-chw-p/

Colorado

Colorado is in the process of implementing a voluntary CHW certification program, expected to be fully implemented in 2025. Certification is not currently required to practice as a CHW. The program is administered by the Colorado Department of Public Health and Environment. https://cdphe.colorado.gov/community-health-worker-workforce-development

Connecticut

Connecticut has a voluntary CHW certification program, but certification is not required to practice as a CHW. The certification is overseen by the Connecticut State Department of Public Health. https://portal.ct.gov/dph/practitioner-licensing--investigations/community-health-worker/certification-requirements

Florida

The Florida Certification Board (a private certification program) offers a voluntary CHW certification, but it is not required to practice as a CHW. https://flcertificationboard.org/certifications/certified-community-health-worker/

Illinois

The Illinois Department of Public Health oversees a voluntary CHW certification, but it is not required to practice as a CHW in the state. https://dph.illinois.gov/topics-services/prevention-wellness/community-health-workers.html

Indiana

Indiana requires CHW to be certified if they provide services to Medicaid recipients; certification requirements were updated in December 2024. Certification is not a requirement to practice as a CHW in the state. https://www.in.gov/medicaid/providers/files/bulletins/BT2024198.pdf

Kansas

Kansas requires certification of CHWs to pay for services they provide to Medicaid recipients in a fee-for-service model. Certification is not required to practice as a CHW in the state. The certification process is overseen by the Kansas Department of Health and Environment Division of Public Health, who also maintains a certified CHW registry. https://www.kdhe.ks.gov/1870/Certification

Kentucky

Kentucky requires that anyone representing themselves as a CHW is certified by the Department for Public Health, Office of Community Health Workers, who also maintain a certified CHW registry. https://www.chfs.ky.gov/agencies/dph/dpqi/cdpb/Pages/chwp.aspx

Maryland

Maryland requires individuals representing themselves as Community Health Workers to be certified by the state. The certification is overseen by the Maryland Department of Health. https://health.maryland.gov/pophealth/Community-Health-Workers/Pages/Home.aspx

Massachusetts

Massachusetts offers voluntary certification for CHWs. The process is overseen by the Department of Public Health, Board of Community Health Worker Certification. https://www.mass.gov/community-health-worker-certification

Michigan

CHWs who provide reimbursable services to Medicaid recipients must meet Michigan Medicaid certification requirements and register with the Michigan Medicaid CHW Registry. Michigan is considering paths for formal state certification programs. https://www.michigan.gov/mdhhs/inside-mdhhs/legislationpolicy/2022-2024-social-determinants-of-health-strategy/community-health-workers

Minnesota

Minnesota requires certification for CHWs who provide reimbursable services to Medicaid recipients, but certification is not required to work as a CHW in the state. Minnesota Department of Human Services identifies qualifying certifying organizations/programs. https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=ENROLL-55

Missouri

Missouri offers voluntary certification for CHWs through the Missouri Certification Board (a private certification program), but it is not required for practice in the state. https://missouricb.com/chw-c-app/

Nevada

Nevada requires certification and a collaborative practice agreement for CHWs who wish to enroll in Medicaid for reimbursement, but certification is not required to practice as a CHW in the state.

Certification is overseen by the Nevada Certification Board. https://nevadacertboard.org/cchw/chw-requirements/

New Mexico

The New Mexico Division of Public Health administers voluntary CHW certification. Certification is required to utilize the "Certified Community Health Worker" or CCHW title. https://www.nmhealth.org/about/phd/pchb/ochw/cert/

North Dakota

North Dakota is in the process of developing CHW certification to comply with HB 1028, but the process is not finalized as of publication. https://ndlegis.gov/assembly/68-2023/regular/documents/23-0069-06000.pdf

Ohio

Ohio offers voluntary certification for CHWs, administered by the Board of Nursing. https://nursing.ohio.gov/licensing-and-certification/types-of-applications/community-health-workers

Oregon

The Oregon Health Authority oversees voluntary CHW certification. CHWs who provide services as part of Health Homes/the Patient-Centered Primary Care Home program must be certified. https://www.oregon.gov/oha/ei/pages/thw-chw.aspx

Pennsylvania

Pennsylvania offers voluntary certification through the Pennsylvania Certification Board (a private certification program), but it is not required to practice in the commonwealth. https://www.pacertboard.org/cchw

Rhode Island

Rhode Island offers voluntary certification through the Rhode Island Certification Board (a private certification program), but it is not required to practice in the commonwealth. https://www.ricertboard.org/certifications

South Dakota

Certification of CHWs in South Dakota is voluntary but required for CHWs who provide billable services to Medicaid beneficiaries. Certification is overseen by the Community Health Worker Collaborative of South Dakota. https://chwsd.org/chw-and-chr-certification/

Texas

Texas requires any CHW who receives compensation to be certified. Certification is overseen by Texas Health and Human Services, Department of State Health Services. https://www.dshs.texas.gov/community-health-worker

Utah

Certification of CHWs in Utah is voluntary, but CHWs may not use the term "state certified" unless they have received certification through the Utah Department of Health and Human Services. https://healthequity.utah.gov/chw-state-certification/

Virginia

Virginia offers voluntary CHW certification through the Virginia Certification Board (a private certification program), but it is not required to practice as a CHW in the commonwealth. https://www.vacertboard.org/cchw

APPENDIX I: EXAMPLE DOCUMENTATION FOR NAVIGATION, CARE MANAGEMENT, AND COGNITIVE ASSESSMENT SERVICES

These are example logs that demonstrate the documentation that may be recorded for various services. In these examples, the patient is identified as having a cognitive concern and referred to the brain health navigator. One patient is receiving PIN and PCM services concurrently. Another patient is receiving CHI services only.

PRINCIPAL ILLNESS NAVIGATION MONTHLY DOCUMENTAITON LOG

1/3/25 – Contacted patient to initiate intake for brain health navigation. Reviewed program and expectations of care journey. Assisted patient to make appointments for MRI and bloodwork. Screened for SDOH, no identified needs at this time. Completed patient HRA. Total time in navigation: 35 minutes – C. Journey, Patient Navigator

1/6/25 – Contacted Main Health to request MRI and neurology records from hospitalization in 2018. Completed precertification paperwork for MRI. Updated patient on progress. Total time in navigation: 28 minutes – C. Journey, Patient Navigator

1/21/25 – Contacted patient to follow up on missed bloodwork appointment yesterday (1/20/25). Patient forgot about appointment. Rescheduled and set patient up to receive reminder text messages for appointments. Total time in navigation: 22 minutes – C. Journey, Patient Navigator

1/29/25 – Patient called concerned about results of bloodwork. Placed message to nurse navigator, N. Cherish, RN to contact patient to discuss. Confirmed Sleep Medicine appointment has been scheduled for 2/4/25. Total time in navigation: 7 minutes. – C. Journey, Patient Navigator

1/31/25 – Total time in navigation services this month: 92 minutes – C. Journey, Patient Navigator

2/1/25 - I have reviewed the navigation documentation and agree with the services provided. Total time in navigation for this month is 92 minutes. – P. Sherman, MD

Billing & Reimbursement

In this example, P. Sherman MD would submit a claim for G0023 (1 unit) and G0024 (1 unit). Total reimbursement in Traditional Medicare is approximately $130.80 (national payment amount, actual payment varies by locality.)

PRINCIPAL CARE MANAGEMENT MONTHLY DOCUMENTATION LOG

1/7/25 – Contacted patient to establish PCM for diabetes. Care currently impacted by forgetfulness and suspected cognitive condition, currently receiving navigation during brain health workup. Conducted medication reconciliation. Beers Criteria: ASA, ibuprofen (PRN, usually multiple times a week for arthritis pain), diphenhydramine nightly for sleep, oxybutynin for urinary incontinence. ACB score 6 (diphenhydramine, oxybutynin.)

Care plan for diabetes focuses on consistently taking medication, exercise, and improving diet. Discussed barriers to care plan. Patient reports forgetfulness and inconsistent daily routine make it difficult to take medications routinely and manage balanced meals. Discussed option of changing medication from long acting + sliding scale insulin to weekly injection like semaglutide or tirzepatide. Patient is amenable.

Completed STOP-BANG, referral to sleep medicine per protocol for score of 4.

Sent note to P. Sherman MD with medication findings, possibility of changing or deprescribing to reduce Beers/ACB burden and change to diabetes management with weekly injectable medication. Total time in care management: 57 minutes – N. Cherish, RN

1/10/25 – Called patient to discuss orders from P. Sherman MD. Stop diphenhydramine and use 110mg magnesium and 2mg melatonin for sleep, awaiting sleep medicine appointment. Stop or reduce ASA/ibuprofen for pain; use acetaminophen, topical treatments (Bengay, capcaisin), and comfort measures like heating pads. If this does not effectively relieve pain, instructed to contact me. Explained protocol to stop sliding scale insulin and start semaglutide 0.5mg. Instructions sent via patient portal. Patient not amenable to plan to change oxybutrin to mirabegron at this time, will consider it at a later date when stable on new medication regimen. Educated patient on the importance of exercise for managing diabetes/weight and for brain health. Patient reports two recent falls and joint pain with exercise. Placed referral to PT for balance evaluation, strength training and development of a home exercise program. Updated P. Sherman MD on above. Total time in care management: 73 minutes – N. Cherish, RN

1/17/25 – Called patient to check in after medication changes. Just picked up semaglutide from pharmacy yesterday and took first dose. No side effects noted at this time. Reports no changes in sleep after stopping diphenhydramine and using magnesium/melatonin. Reports arthritis pain is responding well to changes in treatment. Reviewed patient's current socialization and discussed importance of social connections for brain health. Patient visits senior center 3-4 days per week, attends church twice a week, and visits with children/grandchildren every weekend. Total time in care management: 21 minutes – N. Cherish, RN

1/24/25 – Contacted patient to check in on medication changes. No concerns at this time. Reports daily blood sugar in the 250-300 range, slightly elevated compared to before staring the semaglutide. Explained this can be normal and should level out within a few weeks. Encouraged patient to eat Mediterranean/MIND diet and reviewed best foods for diabetes management and brain health. Provided materials via patient portal. Answered questions about the bloodwork ordered. Total time in care management: 34 minutes – N. Cherish, RN

1/29/25 – Replied to patient to discuss concerns about abnormal bloodwork results. Vit D level low, P. Sherman MD recommended OTC supplement of 5000iu D3 daily. Discussed p-tau 217 result slightly above reference range and explained meaning in terms of amyloid plaques/AD. Further discussion with neurologist after results of MRI obtained. Total time in care management: 17 minutes – N. Cherish, RN

1/31/25 – Total time in care management for the month is 206 minutes – N. Cherish, RN
2/1/25 - I have reviewed the care management documentation and agree with the continued care plan. Total time in care management for this month is 202 minutes. – P. Sherman, MD

Billing & Reimbursement

In this example, P. Sherman MD would submit a claim for 99426 (1 unit) and 99427 (6 units). Total reimbursement in Traditional Medicare is approximately $345.53 (national payment amount, actual payment varies by locality.)

COMMUNITY HEALTH INTEGRATION MONTHLY DOCUMENTATION LOG

2/4/25 – Contacted patient after receiving referral for navigation which is impacted by SDOH needs. Patient reports lack of access to transportation after vehicle broke down and funds are not available to make repairs. (Z59.82 – Transportation Insecurity). Denies problems with access to food, stable housing, paying for utilities, and ability to afford medical care and medication. Completed qualification process for health system transportation voucher program. Assisted patient to download app on phone and set up account for Health Ride app. Discussed best times to receive care, and that care will be bundled so that several services can be provided on the same day. Total time in CHI services: 38 minutes – C. Journey, Patient Navigator

2/5/25 – Scheduled care appointments for 2/28/25: MRI at 0630 and bloodwork at 0900 at the main hospital, sleep medicine appointment at 1400 at Main Street Clinic. Notified patient of appointments, and scheduled Health Ride for 0545 pickup at patient home on 2/28/25, pickup at main hospital at 1300, and pickup from Main Street Clinic at 1600. Instructed patient to contact the care management office if any problems or scheduling issues happen before or on the day of appointment. Notified patient that a voucher for lunch at the main hospital cafeteria will be available for pickup at the cafeteria office on 2/28/25. Total time in CHI services: 44 minutes – C. Journey, Patient Navigator

2/18/25 – Researched charitable vehicle repair at local church. Obtained paperwork to qualify patient to receive free services. Contacted patient to explain service and complete/return paperwork. Followed up fax with phone call to ensure application was received. Total time in CHI services: 28 minutes – C. Journey, Patient Navigator

2/27/25 – Called patient to confirm all appointments and transportation for tomorrow. Patient informed me that local church approved application for charitable vehicle repair services, and vehicle has been towed to church garage. Anticipate repairs to be completed next week. Total time in CHI services: 8 minutes – C. Journey, Patient Navigator

2/28/25 – Total time in CHI for the month is 98 minutes – C. Journey, Patient Navigator
3/1/25 - I have reviewed the documentation and agree with CHI services to meet SDOH needs. Total time in care management for this month is 98 minutes. – P. Sherman, MD

Billing & Reimbursement

In this example, P. Sherman MD would submit a claim for G0019 (1 unit) and G0022 (1 unit). Total reimbursement in Traditional Medicare is approximately $130.80 (national payment amount, actual payment varies by locality.)

COGNITIVE ASSESSMENT AND CARE PLANNING (CACP) EXAMPLE DOCUMENTATION

Many EHRs will have templates that ease the documentation burden for CACP visits and the development of the cognitive care plan. The following documentation does not rely on a template and is more narrative in nature than is required. An EHR template that pulls together existing discrete data and allows providers to select from checkboxes to fulfill documentation requirements is possible in most certified EHRs.

CACP Visit Note

Patient presents to clinic for Cognitive Assessment and Care Planning. Maria was recently diagnosed with mild cognitive impairment due to Alzheimer's Disease, currently FAST stage 3. She has a significant amnestic deficit and low - but not impaired - executive function and fluency.

Present in the care planning meeting today are: Maria, daughter KellyAnn, son Trevor, daughter Lori, son-in-law Joe, John Smith MD, and Susan Brown RN.

Complete medication reconciliation was performed. ACB score today is 0. No Beers medications.

Hearing screener administered 11/16/24 indicated a high likelihood of hearing impairment and referral to audiology was made. Atrial fibrillation and hyperlipidemia contribute to dementia risks. At this time, there are no other identified conditions that may be contributing to symptoms of MCI. No significant neuropsychiatric symptoms.

Reviewed current testing results. Maria is at high risk of progressing to dementia in the next 5 years. Discussed the evidence that patients who make lifestyle changes may be able to slow or stop the progression of their MCI/dementia.

Scores & Data

- GAD-7 score is 3 (11/16/24)
- GDS score is 7 (11/16/24)
- Mini-Cog is 2/5 (12/19/24)
- Lawton-Brody iADL score is 7/8 (11/16/24)
- Katz ADL is 6/6 (11/16/24)
- PHQ-2 is 1, indicating nominal to no depression symptoms (12/19/24)
- NPI-Q is 1, mild aggression (not significantly worse than "how she's always been" (12/19/24)
- FAST stage 3 (12/19/24)
- Dimensional Apathy Scale total score is 6/72 on 12/12/24. Subscale scores: executive - 2, emotional - 2, behavior/cognitive initiation - 2
- Zarit Caregiver Burden Assessment (Short-12) is 22 (12/19/24) indicating high caregiver burden (daughter, Lori)
- See full neurological exam performed 11/16/24
- See full neuropsychological evaluation performed 11/16/24

Decision-Making Capacity discussed. Maria is able to voice her desires and make decisions independently. Maria should involve her family in complex decision making. The risks associated with decision making for legal/financial matters were reviewed. At this time, Maria is at risk of making impactful financial decisions that may not be aligned with her overall goals. Discussed and provided resources for addressing financial safety and advised to work with banks to put safeguards in place. Also discussed legal safeguards and involving appropriate elder care legal counsel to help plan for the future.

At this time, concerns about home safety are limited to gas stove; recommended auto-shutoff option. Reviewed general home safety for aging adults. Discussed that if symptoms worsen, over time there

may been need to implement home safety measures. General home safety checklist from Alzheimer's Association and elder home safety checklist provided.

Firearm safety discussed and education materials provided.

Motor Vehicle Operation safety discussed. Maria is currently driving, and family does not have concerns about safety at this time, however they are concerned that Maria does not always turn on her phone when she is out. Explained that as her condition progresses, Maria may not be able to self-assess or remember changes in her driving safety. Also discussed the possibility of getting lost while driving and utilizing technology in smart phone, smart watch, or air tag in glove box to assist. Completed driving safety contract between Maria and her children, and general driving safety information provided. Discussed formal driving evaluation in the future if need arises.

Maria names children (KellyAnn, Trevor and Lori) and their spouses as primary support people. Maria is close to neighbors and has friends and family she visits with weekly. Educated on the need to continue to expand the circle of support and to have multiple people able to help care for Maria if/when disease progresses. Lori is a nurse practitioner and understands Maria's medical condition and treatment well; she is the primary point person for medical questions. KellyAnn and Trevor verbalize understanding and stay in communication with Lori as questions arise. All three adult children verbalize a desire to stay involved in Maria's care and help her achieve her goals.

Reviewed importance of caregiver self-care with family present. Reviewed disconnect that can exist between Maria's perceptions of daily life vs their perceptions and importance of managing that disconnect.

Reviewed exercise as the most important part of slowing the progression of disease and helping to manage mood. Referral to PT was made 11/16/24. Maria agrees to attend PT evaluation and work on home exercise routine once established.

Reviewed importance of eating lean and green and maintaining good protein intake to prevent frailty.

Discussed importance of socialization. Maria is very socially active and plans to continue to engage in routine social engagements (breakfast with friends, shopping with family, etc.)

Advance Care Planning discussed. Maria has an advance directive and no changes or updates are needed at this time. Lori will provide a copy to this office.

All questions were answered. The care plan was reviewed at the end of the visit. Maria, Lori, Trevor, and KellyAnn verbalized understanding and agreement. Care plan provided via print out and patient portal.

I personally spent 140 minutes on the date of the encounter, including review of medical records, discussion with Maria and family, and documentation.

Maria's goal is to maintain or improve cognition, prevent or slow progression to dementia with lifestyle change and other treatments if indicated, and appropriately plan for the future.

1. Maria's significant amnestic deficit is the most concerning symptom for her family. Offered option to refer to SLP for cognitive training but declined at this time. This office will make the referral should Maria and her family decide to pursue this option. Reviewed the use of cognitive aids to manage symptoms, optimizing responses to forgetfulness, and selective reorientation for issues of safety and well-being. Handouts from Alzheimer's Association provided.
2. Maria, KellyAnn, Trevor and Lori agree that Maria is currently driving safely. All agree to report any driving concerns to this office, and Maria will explore resources to help older adults continue to drive safely. Should concerns be reported, a formal driving evaluation can be conducted. Driving safety resources:
    a. https://www.dot.state.pa.us/Public/DVSPubsForms/BDL/BDL%20Publications/Pub%20381.pdf
    b. https://www.pa.gov/agencies/dmv/resources/driver-safety-and-vehicle-maintenance/mature-driver-safety-tips.html
3. Maria, KellyAnn, Trevor and Lori will review information about legal and financial planning and putting protections in place. They will meet with appropriate experts as needed. Handouts from Alzheimer's Association provided.
4. KellyAnn and Trevor will review home safety checklist and make recommended changes, including installing railings in outdoor porches and walkways with stairs.
5. KellyAnn will assist Maria with weekly planning for medications. Continue with Aricept prescribed by neurology.
6. Referral to audiology was placed 11/16/24. Appointment scheduled for 12/30/24. Lori will follow up with Maria to make the appointment.
7. Lori will provide a copy of Maria's advance directive to this office.
8. Exercise is an important part of maintaining cognitive functioning. The goal is to achieve at least 6000 steps daily. Lori/KellyAnn will follow up on PT referral made to PT: 234-555-6789
9. Eating "lean and green" is important. Lori, KellyAnn, and Trevor will help Maria find a protein shake/supplement that she likes to maintain a good protein intake and continue to make sure kitchen is stocked with a variety of fruits and vegetables.
10. KellyAnn, Trevor and Lori will consider how to care for themselves during this journey and make plans for their own mental and physical well-being. Consider support groups and mental health services as needed. Handouts for local support group and mental health therapist provided.
11. Lori/Trevor will help Maria keep all scheduled appointments with neurology, cardiology, and other specialists.
12. Follow up with Dr. Smith in 3 months.
13. Retest and repeat Cognitive Care Planning in 6 months.

APPENDIX J: PAYMENT RATES FOR NAVIGATION/CARE MANAGEMENT

Rates reflect national non-facility payment rate as of January 1, 2026. Rates are subject to change.

SERVICES PERFORMED BY CLINICAL AND AUXILARY STAFF

CPT/ HCPCS	Short Description	2026 National Non-Facility Payment Rate	wRVU
G0023	PIN, first 60 minutes per month	$87.18	1.00
G0024	PIN, time add on, 30 min	$54.44	0.70
G0019	CHI, first 60 minutes per month	$86.17	1.00
G0022	CHI, time add on, 30 min	$54.11	0.70
99426	PCM (Staff), first 30 minutes per month	$67.80	1.00
99427	PCM (Staff), time add on, 30 min	$54.11	0.71
99439	CCM (Staff), time add on, 20 min	$50.44	0.70
99490	CCM (Staff), first 20 minutes per month	$66.13	1.00
99487	Complex CCM, first 60 minutes per month	$144.29	1.81
99489	Complex CCM, time add on (30 min)	$78.16	1.00
99484	General BHI	$57.45	0.93
99492	First Month CoCM, 70 minutes	$160.32	1.88
99493	Subsequent Month CoCM, 60 minutes	$144.96	2.05
99494	CoCM Time Add-On (any month), 30 minutes	$61.46	0.82
G2214	Initial or Subsequent CoCM, 30 minutes per calendar month	$60.79	0.77
99483	Cognitive Assessment and Care Planning	$292.93	3.84

SERVICES PERSONALLY PERFORMED BY THE BILLING PROVIDER

CPT/ HCPCS	Short Description	National Non-Facility Payment Rate	wRVU
99424	PCM (Provider), first 30 minutes per month	$87.51	1.45
99425	PCM (Provider), time add on, 30 min	$61.46	1.00
99491	CCM (Provider), first 30 minutes per month	$89.18	1.50
99437	CCM (Provider), time add on, 30 min	$63.13	1.00
G0506	CCM Care Planning	$66.47	0.87
G2212	Prolonged Outpatient/Office Visit, 15 min.	$34.07	0.61

APPENDIX K: ADDITIONAL RESOURCES

NAVIGATION & COMMUNITY HEALTH TRAINING/PROGRAMS AND RESOURCES

1. https://www.c3council.org/
2. https://www.cancer.org/health-care-professionals/resources-for-professionals/patient-navigator-training.html
3. https://chwregistry.com/training-partners/
4. https://chwtraining.org/
5. https://nachw.org/generalresources/networks-and-training-programs/
6. https://patientnavigatortraining.org/

7. https://www.ruralhealthinfo.org/toolkits/community-health-workers
8. https://www.ruralhealthinfo.org/toolkits/care-coordination/2/care-coordinator-model/patient-navigators

CARE MANAGEMENT/NAVIGATION SERVICE & BILLING

Principal Illness Navigation & Community Health Integration

1. *https://www.cms.gov/files/document/health-related-social-needs-faq.pdf*
2. *https://www.cms.gov/files/document/mln9201074-health-equity-services-2024-physician-fee-schedule-final-rule.pdf-0*
3. *https://youtu.be/7xJoPXD4BCM?si=17IbcURB7r0ntnp1*
4. *https://youtu.be/uwrSxdxwQcw?si=URT9dlwFcOu4_hM9*
5. *https://youtu.be/Syd8abuHqu4?si=3J7iPewV8x6PXH4u*
6. *https://www.cms.gov/files/document/zcodes-infographic.pdf*

Clinical Care Management

1. https://www.cms.gov/files/document/chronic-care-management-faqs.pdf
2. https://www.cms.gov/files/document/mln909432-behavioral-health-integration-services.pdf
3. https://www.cms.gov/files/document/mln9201074-health-equity-services-2024-physician-fee-schedule-final-rule.pdf-0
4. https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/chroniccaremanagement.pdf
5. https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/downloads/behavioral-health-integration-faqs.pdf
6. https://www.cms.gov/medicare/payment/fee-schedules/physician/care-management
7. https://www.ngsmedicare.com/documents/20124/121705/2330_0923_pcm_cm_rev_508.pdf/6ff9a38c-ecc0-e8e5-40f1-50c0a8dccec7?t=1695044987894

COCM

1. https://www.cms.gov/files/document/mln909432-behavioral-health-integration-services.pdf
2. https://www.govinfo.gov/content/pkg/FR-2016-11-15/pdf/2016-26668.pdf
3. https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/downloads/behavioral-health-integration-faqs.pdf
4. https://aims.uw.edu/
5. https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=39266&ver=3
6. https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=59036

CACP

1. https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=39266
2. https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=59036&ver=13&keyword=&keywordType=starts&areaId=all&docType=6,3,5,1,F,P&contractOption=all&hcpcsOption=code&hcpcsStartCode=99483&hcpcsEndCode=99483&sortBy=title&bc=1

PATIENT FACING RESOURCES

1. https://www.medicare.gov/coverage/principal-illness-navigation-services
2. https://www.medicare.gov/coverage/community-health-integration-services
3. https://www.medicare.gov/coverage/chronic-care-management-services

4. https://www.medicare.gov/coverage/principal-care-management-services
5. https://www.medicare.gov/coverage/behavioral-health-integration-services
6. https://www.medicare.gov/coverage/cognitive-assessment-care-plan-services#:~:text=Medicare%20Part%20B%20(Medical%20Insurance,and%20develop%20a%20care%20plan.

APPENDIX L: NEUROPSYCH BILLING OPTIONS

In addition to typical neuropsychological testing evaluation services, psychologists and clinical psychologists have other options for reimbursement when participating in the brain health care team.

E-CONSULTS

E-consults, also known as interprofessional telephone/internet/electronic health record consultations, are a service where providers can request a consultation for their patient from another physician or qualified health care practitioner outside of their specialty where the consulting provider does not have direct contact with the patient. Rather, the treating provider sends relevant information to the consulting provider (e.g., visit notes, labs, test results, etc.) who reviews the records and provides feedback to the treating provider. This service is designed to speed access to specialist input, especially for patients who may not have access to specialists or whose condition will be managed by the treating provider.

DEFINITIONS

Treating Provider

The treating provider is the physician, non-physician practitioner (NPP) or other qualified health care professional (QHP) who has initial contact with the patient and identifies the need for consultant input. For the purpose of this document, the terms "treating provider," "referring provider," "requesting provider," and "primary care provider" (PCP) will be used interchangeably, and often these terms are used this way in other guidance related to the performance of e-consult services. The treating provider may be of any specialty, and the consulting provider may be any specialty, as long as they are not the same specialty (i.e., a Family Medicine physician or NPP may not request an e-consult from another Family Medicine physician, but the Family Medicine physician or NPP may request an e-consult from an Internal Medicine or Neurology physician).

Consulting Provider

The consulting provider (consultant) is the physician, non-physician practitioner (NPP) or other qualified health care professional (QHP) who does not have contact with the patient. The consulting provider reviews records and provides feedback to the treating provider. The patient may be a new patient for the consultant, or an established patient who has a new problem/symptom or exacerbation of an existing problem. However, the consultant must not have seen the patient in the past 14 days.

Treating Provider E-Consult Responsibilities and Billable Activities

The following activities are required of care for the PCP who is requesting the consultation:

1. Obtain and document consent from the patient/caregiver to request the consultation. The consent must make clear the nature of the consultation (why a consultation is being requested and who will provide the consultation) and the patient responsibility for cost-sharing.
2. Written or verbal request for the consultation
3. Preparation and delivery of medical records to the consultant

While not a required element of the billing code, the PCP is also required to follow any pertinent regulations from HIPAA or other applicable laws regarding the sharing of patient records. Institutional requirements for sharing patient records may also exist.

The gathering of records and preparation of the request need not be personally performed by the PCP; staff may assist in documenting the patient's consent, completing required patient releases, gathering

and sending medical records, and confirming receipt with the consultant's office. However, only time personally spent by the PCP may count towards billable activities.

When the consultant has reviewed the records, they may provide a written report only, or they may couple the written report with an interactive verbal report to the PCP. The PCP is responsible for personally discussing the case with the consultant. This may not be delegated to a member of the staff.

Consulting Provider E-Consult Responsibilities and Billable Activities

The consultant is responsible for the review and analysis of the patient's data, and requests for any additional data needed from the PCP. The consultant must prepare a written report. Depending on how the consultant wishes to bill the service, they may choose to personally discuss the case with the PCP or provide the written report only. The total time spent on the collection, review, and analysis of the data, even if it occurs over multiple days, may be counted towards the service. Total time in preparation of the report and interactive verbal feedback to the PCP may be counted towards the total service time, even if more than one discussion is required and these events take place over multiple days.

Generally, the consultant will provide some or all of the following as part of the written report and/or interactive verbal feedback to the PCP:

- Analysis of the patient's problem, including alternative diagnoses and management approaches
- Provide relevant scientific and medical background on the problem
- Suggestions for long-term management
- Respond to questions from the referring provider

If the consultant schedules the patient to be seen within 14 days of the consultation (or first available appointment), they should not report any e-consult services.

Excluded Activities

Time spent in discussion with the patient/caregiver is excluded from e-consults. If the provider-to-provider communication is exclusively to arrange a transfer of care, e-consult services may not be reported by the PCP or consultant.

WORKFLOW

Before beginning the e-consult workflow, the PCP and consultant should agree on how consultations will be requested, which data should be provided as part of the consultation, how the written report will be delivered, and, if verbal feedback will be provided, how and when that feedback will occur.

1. The PCP has contact with the patient (typically in an office visit). The PCP may gather data, perform tests, place orders, or otherwise manage the care of the patient during this visit.
2. Based on their evaluation, the PCP recommends an e-consult to the patient and obtains/documents their consent to proceed.
3. The PCP prepares and sends the patient records and written request for consultation.
4. The consultant receives, reviews, analyzes, and documents a written report. If the consultant requires additional information, they may request it from the PCP.
5. The written report is provided to the PCP, and optionally, the consultant provides interactive verbal communication to the PCP.

This process may take place over multiple days. Claims for e-consults should not be submitted until the completion of the service.

CONSULTANT BILLING

The consultant should track all time spent in review and analysis of patient data, preparation of the written report, and discussion with the PCP, even if that time occurs over multiple days. When the service is complete, if at least 50% of the total time spent on the service is in preparation of the report and verbal discussion with the PCP, the consultant may bill based on the total time. If more than 50% of the time is spent on data review and analysis, these services may not be reported.

**Note that payment rates provided are full physician rates; if the consultant is a NPP or other QHP, their payment rate is adjusted accordingly as a percentage of the physician payment rate.*

CPT/ HCPCS	Short Description	National Non-Facility Payment Rate*	wRVU
99446	E-Consult, 5-10 minutes of consultative discussion and review	$17.14	0.35
99447	E-Consult, 11-20 minutes of consultative discussion and review	$34.61	0.7
99448	E-Consult, 21-30 minutes of consultative discussion and review	$51.43	1.05
99449	E-Consult, 31 or more minutes of consultative discussion and review	$69.54	1.4

When the consultant does not provide interactive verbal discussion to the PCP, the only service they may bill is:

CPT/ HCPCS	Short Description	National Non-Facility Payment Rate	wRVU
99451	E-Consult, 5 or more minutes of medical consultation	$32.99	0.7

99446-99449 and 99451 may not be reported more than once every seven days and may not be reported if the consultation results in a patient visit within 14 days (or the next available appointment). 99451 may not be reported if the consultant has seen the patient face-to-face (including telehealth) within the past 14 days.

TREATING PROVIDER BILLING

If the PCP personally spends time preparing records and documentation for the consultant on the same day that they see the patient for an E/M visit (including telephone and telehealth visits), the time spent on the consultation request may be included in the total time spent on the day of service for selecting the appropriate E/M billing code. If the total time spent preparing the referral exceeds the maximum level 5 visit time by at least 30 minutes, add-on time (using codes G2212/99417) may be reported.

If the time personally spent by the PCP preparing records and documentation does not occur on the same day as an E/M service, the provider may report 99452 if they spend 30 minutes* preparing the referral on a single day. Bill the code on the date of service that the time was spent. If the PCP personally

spends 30 minutes* in discussion with the consultant as part of the consultant's interactive verbal feedback, the PCP may bill 99452.
However, this code may not be reported more than once in a 14-day period.

**Note: unlike the other e-consult codes, 99452 is subject to the CPT Time Rule which states that a unit of time is met when the midway point is reached. For 99452, the PCP must spend at least 16 minutes to bill the service.*

CPT/ HCPCS	Short Description	National Non-Facility Payment Rate	wRVU
99452	E-Consult, 30 minutes interprofessional referral services by the referring provider	$32.99	0.7

FAQ

Q: Is a clinical psychologist able to bill e-consults?
A: Yes. A clinical psychologist is a Qualified Health Care Professional (QHP) and is able to request and provide e-consult services.

Q: If I am an Internal Medicine physician specializing in brain health, can my colleagues in primary care request an e-consult from me and may I bill for performance of that service?
A: It depends. E-consults are not billable when the referring and consulting provider have the same specialty. This is determined by the taxonomy code for the specialty used to register for an NPI.

For instance, Internal Medicine uses identifier 207R00000X. Generally, this is based on the board certification or residency the physician completed and where they are practicing. Non-physician practitioners, such as nurse practitioners, and Qualified Health Care Professionals, such as psychologists, dieticians, and speech language pathologists, have their own taxonomy codes associated with their NPI. For instance, a Nurse Practitioner working in adult health uses identifier 363LA2200X but would change to 363LF0000X if working in family health.

It's likely that an internal medicine physician specializing in brain health is using the internal medicine taxonomy. Other providers using the internal medicine taxonomy cannot request billable e-consult services from you.

Working within the same geographic location/TIN does not impact the specialty. It's based on provider NPI.

Q: Does the consultant have to have verbal interactive feedback with the referring provider in order to bill the e-consult?
A: No, the consultant may bill the e-consult using CPT 99451 when they provide a written report without discussion to the referring provider.

Q: I am the referring provider. When I get the report back from the consultant, I call to discuss the results with the patient. Does this time count towards billing CPT 99452?
A: No, time spent in discussion with the patient/caregiver is not counted in e-consult time. However, there may be other codes available to bill for this time.

TELEPHONE ASSESSMENT & MANAGEMENT SERVICES

Psychologists may bill telephone assessment and management services. These codes are used to report episodes of care that are unrelated to any assessment and management services provided by the psychologist in the past 7 days and may only be provided to established patients (and their caregivers) of the psychologist.

During the telephone A/M visit, the psychologist may:

- Answer patient/caregiver questions about the treatment plan
- Assess new or worsening symptoms the patient is experiencing
- Make changes to the treatment plan
- Provide education about the patient's condition and treatment plan

Some activities are not considered part of the telephone A/M service, including:

- Calls to schedule or re-schedule appointments
- Calls related to billing
- Calls to relay test results if the call does not include assessment and management of the patient

Note that Telephone A/M visits must be initiated by the patient/caregiver. That does not mean the visit can't be scheduled, but rather that the psychologist may not initiate the outreach to the patient/caregiver without their consent.

The care provided during the telephone A/M service must be documented in the patient's chart, along with the patient's consent for the service and the psychologist's attestation of total time spent rendering the telephone A/M service.

CPT/ HCPCS	Short Description	National Non-Facility Payment Rate	wRVU
98966	Telephone A/M, 5-10 minutes of medical discussion	$12.94	0.25
98967	Telephone A/M, 11-20 minutes of medical discussion	$23.94	0.5
98968	Telephone A/M, 21+ minutes of medical discussion	$32.99	0.75

If the episode of care leads to an in-person visit within the next 24 hours (or first available urgent visit), do not bill telephone A/M as they are considered part of the pre-service work for the in-person visit.

DIGITAL ASSESSMENT & MANAGEMENT SERVICES

Psychologists may bill digital assessment and management services. These codes are used to report episodes of care that are unrelated to any assessment and management services provided by the psychologist in the past 7 days and may only be provided to established patients (and their caregivers) of the psychologist. The digital A/M service is rendered via the patient portal or other secure messaging. The patient/caregiver initiates a message to the psychologist via an online/digital platform; the psychologist may offer a single response, or the psychologist and patient may exchange several messages. The total time spent on the exchange of messages over a 7-day period is considered in determining the total time spent on the service.

During the digital A/M visit, the psychologist may:

- Answer patient/caregiver questions about the treatment plan

- Assess new or worsening symptoms the patient is experiencing
- Make changes to the treatment plan
- Provide education about the patient's condition and treatment plan

Some activities are not considered part of the digital A/M service, including:

- Messages to schedule or re-schedule appointments
- Messages related to billing
- Messages to relay test results if the message does not include assessment and management of the patient

Note that Digital A/M visits must be initiated by the patient/caregiver through a HIPAA-compliant secure messaging platform.

The care provided during the digital A/M service must be documented in the patient's chart, along with the patient's consent for the service and the psychologist's attestation of total time spent rendering the digital A/M service. The documentation of the care provided may be a summary of the exchange or may be an exact transcription of the exchange; however, the total digital exchange must be part of the permanent medical record, whether this is retained digitally or via hard copy. Documentation options vary by EMR; discuss the best documentation workflow with your EMR team.

Time for digital A/M services is cumulative; the total psychologist time spent over 7 days on the service is documented and used to determine the appropriate billing code.

CPT/ HCPCS	Short Description	National Non-Facility Payment Rate	wRVU
98970	Digital A/M, 5-10 minutes cumulative time of medical services	$11.32	0.25
98971	Digital A/M, 11-20 minutes cumulative time of medical services	$21.25	0.44
98972	Digital A/M, 21+ minutes cumulative time of medical services	$32.35	0.69

CARE MANAGEMENT CARE TEAM

As part of the care management team, psychologists can render care management services under the general supervision of the billing provider. *Note that psychologists may not independently report management services.*

Patients may be enrolled in principal care management, chronic care management, or behavioral health integration services by their PCP or specialist. To participate as part of the care team who is carrying out the care management plan, psychologists must have a relationship with the overseeing provider; the provider and psychologist do not need to be in practice together, but the formal relationship must exist that allows the psychologist to participate as part of the care team under the general supervision of the billing provider. There are several options to accomplish this, most commonly a "leased employee" agreement.

As part of the care management care team, the psychologist will assist the patient/caregiver in making progress against the care plan or treatment plan. Often, this care is rendered over the telephone, through secure messaging like a patient portal, or via telehealth technology rather than in person with

the patient/caregiver. This may include activities such as:

- Providing education to the patient/caregiver about the patient's diagnosis/condition, treatment options, symptom management, etc.
- Responding to patient/caregiver questions
- Helping the patient/caregiver understand the next steps in the patient's care plan (e.g., formal evaluations, imaging, bloodwork, etc.)
- Assisting the patient/caregiver to make lifestyle adjustments or overcome barriers to carrying out their self-management plan (e.g., helping to develop a safe plan for managing self-administration of medication)
- Consulting with other members of the care team to develop the patient's care plan
- Other activities described by care management services

When participating as part of the care management team, the psychologist must track the time spent in care management and document the care rendered to the patient. Time spent on care management services may not be counted towards other billable services. For instance, if the psychologist reviews and discusses testing results with the PCP as part of an e-consult, time spent reviewing results, discussing the case with the PCP, and preparing the e-consult report may not be counted towards the care management time.

SUPPLEMENT 1 EXECUTIVE SUMMARY OF BILLING CODE CATEGORIES

	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	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	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	Separate documented consent is not required.

		services	the required information and whether the patient accepted or declined services	services	
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.

SUPPLEMENT 2 DECISION FLOWCHART