HealthTech

Care Coordination:
What’s New in 2024 for Programs and Reimbursements?

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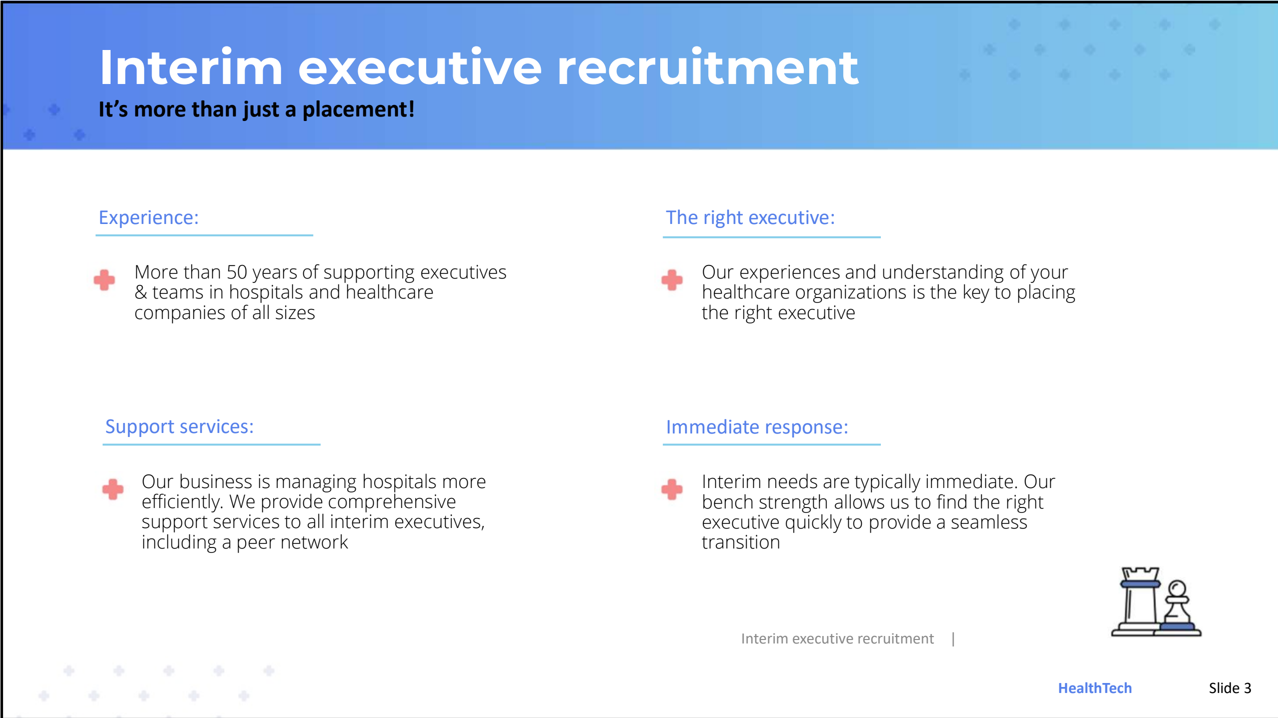

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Financial performance technology platform

Optimum Financial Statements
Financial statement, budgeting & benchmarking package

Optimum Productivity
Productivity measurement & monitoring platform

Optimum Supply Chain
Productivity measurement & monitoring platform

Optimum BI
Basic business intelligence package focused on operations, volume & payment rate analytics

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Instructions for Today's Webinar

- You may type a question in the text box if you have a question during the presentation
- We will try to cover all your questions – if we don't get to them during the webinar, we will follow-up with you by e-mail
- You may also send questions after the webinar to our team (contact information is included at the end of the presentation)
- The webinar will be recorded, and the recording will be available on the HealthTech web site: www.health-tech.us

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Presenter

Faith Jones is the Director of Care Coordination and Lean Consulting for HealthTech. She currently implements care coordination programs for the Medicare population and teaches care coordination and team-based approach to care nationally. Ms. Jones began her healthcare career in the Navy 40+ years ago and her practice has spanned clinical, education, administration, and consulting. She is certified in Advance Care Planning, Lean for Healthcare and as a Nurse Executive Advanced. She is a fellow of the American Nurses Advocacy Institute and the ANA-PAC Leadership Society.

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Objectives

Care Coordination Updates for 2024

Upon completion of the webinar, the participant will understand:

1. The various opportunities for reimbursement through all of the care coordination service lines.
2. The new reimbursement opportunities related to community health, navigation, and social determinants of health.

Care Coordination

Growth and Development

Team Based Care AWV 2011

2013/2015: TCM / CCM

2016: CCM for RHCs and FQHCs; ACP

2017: Complex CCM, BHI, CoCM

2018: RHC and FQHC change to CM; DPP

2019: Team based Documentation; CCRPM

2020: Additional Time allowed for CCM; allow for billing of concurrent services; PCM;

Additional units for CCRPM

2021: Added a G code for 30 min of CoCM

Changed CCRPM to RPM

2022: added additional units for PCM

2023: Chronic Pain Management (CP);

CM for Behavioral Health billing for CSWs and Clinical Psy

2024: Community Health Integration (CHI); Principal Illness Navigation (PIN); inclusion of all care management services into the RHC/FQHC CM service;

Social Determinant of Health (SDOH)

Care Delivery Models

Why??

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Vol. 80 Wednesday, No. 135 July 15, 2015, P 226

"…new and evolving care delivery models, which feature an increased role for non-physician practitioners (often as care coordination facilitators or in team-based care) have been shown to improve patient outcomes while reducing costs, both of which are important Department goals as we move further toward quality- and value-based purchasing of health care services in the Medicare program and the health care system as a whole."

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Quadruple Aim

More Whys

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Annual Wellness Visit

2011

Team Based Approach to Visits

Who is Eligible to Provide the Annual Wellness Visit (AWV)?

- A physician who is a doctor of medicine or osteopathy (as defined in section 1861(r)(1) of the Social Security Act (the Act); or,
- A physician assistant, nurse practitioner, or clinical nurse specialist (as defined in section 1861(aa)(5) of the Act); or,
- A medical professional (including a health educator, registered dietitian, or nutrition professional or other licensed practitioner) or a team of such medical professionals, working under the direct supervision (as defined in CFR 410.32(b)(3)(ii))

The ABC's of the AWV

What's the Point?

Required Elements:

- Administer a Health Risk Assessment (HRA)
- Establish a list of current providers and suppliers
- Establish the beneficiary's medical/family history
- Review the beneficiary's potential risk factors for depression
  - Depression Screening
- Review the beneficiary's functional ability and level of safety
  - Cognitive Screening
  - Fall Risk Assessment and Home Safety Screening
- Assess height, weight, BMI, BP, other routine measures appropriate to medical history
- Furnish a personalized preventative plan of care

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html#AWV

Annual Wellness Visit (AWV)

Reimbursements

2023

IPPE Billed only once within the first 12 months of Part B Coverage

- CPT Code G0402 RVU 2.6
- National Average Reimbursement ~$162.66

AWV Billed only once if first wellness is after 12 months of Part B Coverage – Initial wellness visit

- CPT Code G0438 RVU 2.6
- National Average Reimbursement ~$162.33

Billed one per year – Subsequent wellness visit

- CPT Code G0439 RVU 1.92
- National Average Reimbursement ~$126.95

2024

IPPE Billed only once within the first 12 months of Part B Coverage

- CPT Code G0402 RVU 2.6
- National Average Reimbursement ~$163.07

AWV Billed only once if first wellness is after 12 months of Part B Coverage – Initial wellness visit

- CPT Code G0438 RVU 2.6
- National Average Reimbursement ~$162.74

Billed one per year – Subsequent wellness visit

- CPT Code G0439 RVU 1.92
- National Average Reimbursement ~$128.03

RHC = AIR

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Advance Care Planning (ACP)

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2016

Definition of Voluntary Advance Care Planning

- "Voluntary ACP means the face-to-face service between a physician (or other qualified health care professional) and the patient discussing advance directives, with or without completing relevant legal forms. An advance directive is a document appointing an agent and/or recording the wishes of a patient pertaining to his/her medical treatment at a future time should he/she lack decisional capacity at that time. "
- "ACP enables Medicare beneficiaries to make important decisions that give them control over the type of care they receive and when they receive it."

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdf

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Who Can Perform ACP Services?

2016

Team Based Approach to Care

…"appropriately provided by physicians or using a team-based approach provided by physicians, nonphysician practitioners (NPPs) and other staff under the order and medical management of the beneficiary's treating physician."

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-Advance-Care-Planning.pdf

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ACP

Reimbursements

2023

Billed per 30 minutes of dedicated time for conversation and completion of documentation as appropriate - Initial 30 minutes

- CPT Code 99497 RVU 1.5
- National Average Reimbursement ~$81.00

Bill in addition to 99497 for each additional 30 minutes

- CPT Code 99498 RVU 1.4
- National Average Reimbursement ~$70.09

2024

Billed per 30 minutes of dedicated time for conversation and completion of documentation as appropriate - Initial 30 minutes

- CPT Code 99497 RVU 1.5
- National Average Reimbursement ~$80.55

Bill in addition to 99497 for each additional 30 minutes

- CPT Code 99498 RVU 1.4
- National Average Reimbursement ~$69.75

Optional Service Offered with AWV

Paid at 100%

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Transitional Care Management (TCM)

2013

Service Components

- Interactive contact within 2 business days of Discharge
- Medication Reconciliation
- Clinical review of the discharge to ensure all reports and results are completed
- Provider review of the discharge
- Follow up with community resources & referrals
- Face to Face visit with provider within 7 or 14 days
- Care coordination for the full 30-day period

Patient Eligibility

- Medicare Patient (other Insurances)
- Discharged from:
- Inpatient acute care hospital
- Inpatient psychiatric hospital
- Long Term Care Hospital
- Skilled Nursing Facility
- Inpatient Rehabilitation Facility
- Hospital Outpatient Observation or Partial Hospitalization
- Partial Hospitalization at a Community Mental Health Center
- Discharged to:
  - Patient's home
  - Domiciliary Center
  - Rest Home or nursing home
  - Assisted Living

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Transitional Care Management (TCM)

Reimbursements

2023

Post Hospital Office visit within 7 days

- CPT Code 99496 RVU 3.79
- National Average Reimbursement ~$271.43

Post Hospital Office visit within 14 days

- CPT Code 99495 RVU 2.78
- National Average Reimbursement ~$200.35

2024

Post Hospital Office visit within 7 days

- CPT Code 99496 RVU 3.79
- National Average Reimbursement ~$275.05

Post Hospital Office visit within 14 days

- CPT Code 99495 RVU 2.78
- National Average Reimbursement ~$203.34

RHC = AIR

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Chronic Care Management (CCM)

2015

Practice Eligibility

- Qualified EMR
- Availability of electronic communication with patient and care giver
- Collaboration and electronically communication with community resources & referrals
- After hours coverage
- Care Plan Access
- Primary Care Provider general supervision of clinical staff

Patient Eligibility

- Medicare Patient (other Insurances)
- Two or more chronic conditions expected to last at least 12 months or until the death of the patient
- At significant risk of death, acute exacerbation, decompensation, or functional decline without management
- Patient Consent
- CCM initiated by the primary care provider
- Time tracking of at least 20 min per calendar month

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Complex Chronic Care Management (CCCM)

2017

Practice Eligibility

- Qualified EMR
- Availability of electronic communication with patient and care giver
- Collaboration and electronically communication with community resources & referrals
- After hours coverage
- Care Plan Access
- Primary Care Provider general supervision of clinical staff

Patient Eligibility

- Medicare Patient (other insurances)
- Two or more chronic conditions expected to last at least 12 months or until the death of the patient
- At significant risk of death, acute exacerbation, decompensation, or functional decline without management
- Patient Consent
- CCM initiated by the primary care provider
- Time tracking of at least 60 min per calendar month
- With Moderate or high complexity medical decision making

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CCM and CCCM

Reimbursements

2023

Billed per calendar month for 20 min of care coordination

- CPT Code 99490 RVU 1.0
- National Average Allowable ~$61.16

Billed with 99490 for each additional 20 min of care coordination – Max of 2

- CPT Code 99439 RVU 0.7
- National Average Allowable ~$46.28

Billed per calendar month for 60 plus minutes of Complex Chronic Care Management

- CPT Code 99487 RVU 1.81
- National Average Allowable ~$129.93

Billed with 99487 for additional 30 min per calendar month for Complex Chronic Care Management

- CPT Code 99489 RVU 1.0
- National Average Allowable ~$68.77

2024

Billed per calendar month for 20 min of care coordination

- CPT Code 99490 RVU 1.0
- National Average Allowable ~$61.56

Billed with 99490 for each additional 20 min of care coordination – Max of 2

- CPT Code 99439 RVU 0.7
- National Average Allowable ~$47.15

Billed per calendar month for 60 plus minutes of Complex Chronic Care Management

- CPT Code 99487 RVU 1.81
- National Average Allowable ~$131.96

Billed with 99487 for additional 30 min per calendar month for Complex Chronic Care Management

- CPT Code 99489 RVU 1.0
- National Average Allowable ~$71.05

Behavioral Health Integration (BHI)

2017

Service Components

- BHI initiated by the primary care provider
- Initial assessment
- Initiating visit (if required, separately billed)
- Administration of applicable validated rating scale(s)
- Systematic assessment and monitoring, using applicable validated clinical rating scales
- Care planning by the primary care team jointly with the beneficiary, with care plan revision for patients whose condition is not improving
- Facilitation and coordination of behavioral health treatment
- Continuous relationship with a designated member of the care team

Patient Eligibility

- Medicare Patient (other insurances)
- "Any mental, behavioral health, or psychiatric condition being treated by the billing practitioner, including substance use disorders, that, in the clinical judgment of the billing practitioner, warrants BHI services. The diagnosis or diagnoses could be either pre-existing or made by the billing practitioner and may be refined over time".
- Patient Consent
- Documentation of at least 20 minutes per calendar month

https://www.cms.gov/files/document/mln909432-behavioral-health-integration-services.pdf

Collaborative Care Management (CoCM)

2017

Enrolled as a BHI Patient

- All elements of General BHI apply
- Behavioral health care manager or care coordinator must have formal education in one of the following – Nursing, Social Work, Psychology and performs proactive, systematic follow-up using validated rating scales and a registry
- Assesses treatment adherence, tolerability, and clinical response using validated rating scales; may provide brief evidence-based psychosocial interventions such as behavioral activation or motivational interviewing
- Regular case load review with psychiatric consultant – The primary care team regularly (at least weekly) reviews the beneficiary's treatment plan and status with the psychiatric consultant and maintains or adjusts treatment, including referral to behavioral health specialty care as needed

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BHI and CoCM

Reimbursements

2023

Behavior Health Integration

Billed per calendar month for 20 plus minutes of care coordination

- CPT Code 99484 RVU 0.61
- National Average Allowable ~$41.99

Collaborative Care Management

Billed per calendar month for at least 30 min but less than 60 of Psych collaborative care

- CPT Code G2214 RVU 0.77
- National Average Allowable ~$57.20

Billed per calendar month for 1st month of at least 70 plus minutes of Psych collaborative care

- CPT Code 99492 RVU 1.88
- National Average Allowable ~$147.17

Billed per calendar month for subsequent month of at least 60 plus minutes of Psych collaborative care

- CPT Code 99493 RVU 2.05
- National Average Allowable ~$139.19

Billed with 99492 or 99493 for additional 30 min per calendar month for Psych collaborative care

- CPT Code 99494 RVU 0.82
- National Average Allowable ~$56.53

RHC/FQHC - Billed per calendar month for 1st month of at least 70 plus minutes of Psych collaborative care and subsequent month of at least 60 minutes

- CPT Code G0512 RVU 1.97
- National Average Reimbursement ~$143.15

2024

Behavior Health Integration

Billed per calendar month for 20 plus minutes of care coordination

- CPT Code 99484 RVU 0.93
- National Average Allowable ~$54.03

Collaborative Care Management

Billed per calendar month for at least 30 min but less than 60 of Psych collaborative care

- CPT Code G2214 RVU 0.77
- National Average Allowable ~$56.32

Billed per calendar month for 1st month of at least 70 plus minutes of Psych collaborative care

- CPT Code 99492 RVU 1.88
- National Average Allowable ~$150.62

Billed per calendar month for subsequent month of at least 60 plus minutes of Psych collaborative care

- CPT Code 99493 RVU 2.05
- National Average Allowable ~$137.53

Billed with 99492 or 99493 for additional 30 min per calendar month for Psych collaborative care

- CPT Code 99494 RVU 0.82
- National Average Allowable ~$58.28

RHC/FQHC - Billed per calendar month for 1st month of at least 70 plus minutes of Psych collaborative care and subsequent month of at least 60 minutes

- CPT Code G0512 RVU 1.97
- National Average Reimbursement ~$144.07

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Remote Physiologic Monitoring

2019

Service Components

- RPM is initiated by the billing provider
- An order for RPM must include:
- The device used
- The reason to for monitoring
- Treatment plan in place that reflects the need for monitoring with
- The monitors must wirelessly sync the readings in real time for the care coordinator/practice to be able to view the results

Patient Eligibility

- Medicare Patient (other insurances)
- Any condition that warrants daily monitoring of a physiologic measurement.
- Patient Consent
- Documentation of at least 20 minutes per calendar month
- Must include interaction with the patient or care giver
- Must have at least 16 data days in the month

RPM

Reimbursements

2023

Billed per calendar month for at least 20 minutes of patient and or care giver interaction related to remote physiologic monitoring treatment management services

- CPT Code 99457 RVU 0.61
- National Average Reimbursement ~$47.61

Billed with 99457 for additional 20 min of physiologic monitoring management services with the patient and or care giver in the month

- CPT Code 99458 RVU 0.61
- National Average Reimbursement ~$38.68

Billed on initiation for initial set-up and patient education of the monitor and service

- CPT Code 99453 RVU 0
- National Average Reimbursement ~$18.84

Billed each 30 days of supplying the device with daily recording ability

- CPT Code 99454 RVU 0
- National Average Reimbursement ~$48.93

2024

Billed per calendar month for at least 20 minutes of patient and or care giver interaction related to remote physiologic monitoring treatment management services

- CPT Code 99457 RVU 0.61
- National Average Reimbursement ~$48.13

Billed with 99457 for additional 20 min of physiologic monitoring management services with the patient and or care giver in the month

- CPT Code 99458 RVU 0.61
- National Average Reimbursement ~$38.64

Billed on initiation for initial set-up and patient education of the monitor and service

- CPT Code 99453 RVU 0
- National Average Reimbursement ~$19.65

Billed each 30 days of supplying the device with daily recording ability

- CPT Code 99454 RVU 0
- National Average Reimbursement ~$46.50

Principal Care Management (PCM)

2020

Service Components

- Qualified EMR
- Availability of electronic communication with patient and care giver
- Collaboration and electronically communication with community resources & referrals
- After hours coverage
- Care Plan Access
- Billing Provider has general supervision of clinical staff

Patient Eligibility

- Medicare Patient (other Insurances)
- One serious chronic conditions or high-risk disease expected to last between 3 months and a year or until the death of the patient
- Condition may have led to a recent hospitalization or places patient at significant risk of death, acute exacerbation, decompensation, or functional decline without management
- Patient Consent
- PCM initiated by the provider
- Time tracking of at least 30 min per calendar month

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PCM

Reimbursements

2023

Billed per calendar month for 30 min of care coordination by clinical staff

- CPT Code 99426 RVU 1.0
- National Average Reimbursement ~$59.84

Billed with 99426 for additional 30 min per calendar month of care coordination by clinical staff

- CPT Code 99427 RVU .71
- National Average Reimbursement ~$46.28

2024

Billed per calendar month for 30 min of care coordination by clinical staff

- CPT Code 99426 RVU 1.0
- National Average Reimbursement ~$60.90

Billed with 99426 for additional 30 min per calendar month of care coordination by clinical staff

- CPT Code 99427 RVU .71
- National Average Reimbursement ~$46.50

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Chronic Pain Management (CPM)

2023

Provider Care Coordination

"Chronic pain management and treatment, monthly bundle including:

- diagnosis; assessment and monitoring;
- administration of a validated pain rating scale or tool;
- the development, implementation, revision, and maintenance of a person-centered care plan that includes strengths, goals, clinical needs, and desired outcomes; overall treatment management;
- facilitation and coordination of any necessary behavioral health treatment; medication management; pain and health literacy counseling; any necessary chronic pain related crisis care; and ongoing communication and care coordination between relevant practitioners furnishing care, e.g. physical therapy and occupational therapy, and community-based care, as appropriate. …."

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CPM

Reimbursements

2023

Required initial face-to-face visit at least 30 minutes provided by a physician or other qualified health professional

CPT Code for applicable E/M visit

- 30-39 minutes (mod complexity) CPT Code 99214 RVU 1.92
- National Average Reimbursement ~$129.77
- 40-54 minutes (High complexity) CPT Code 99215 RVU 2.8
- National Average Reimbursement ~$175.55

Subsequent Months - First 30 minutes personally provided by physician or other qualified health care professional, per calendar month.

- CPT Code G3002 RVU 1.45

National Average Reimbursement ~ $79.02

Each additional 15 minutes of chronic pain management and treatment by a physician or other qualified health care professional, per calendar month

- CPT Code G3003 RVU 0.50
- National Average Reimbursement ~$28.76

2024

Required initial face-to-face visit at least 30 minutes provided by a physician or other qualified health professional

CPT Code for applicable E/M visit

- 30-39 minutes (mod complexity) CPT Code 99214 RVU 1.92
- National Average Reimbursement ~$126.07
- 40-54 minutes (High complexity) CPT Code 99215 RVU 2.8
- National Average Reimbursement ~$177.47

Subsequent Months - First 30 minutes personally provided by physician or other qualified health care professional, per calendar month.

- CPT Code G3002 RVU 1.45
- National Average Reimbursement ~$81.21

Each additional 15 minutes of chronic pain management and treatment by a physician or other qualified health care professional, per calendar month

- CPT Code G3003 RVU 0.50
- National Average Reimbursement ~$29.80

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Care Management for Behavioral Health Conditions

2023

Performed and Billed under LCSW or CP

- Mirrors the requirements for BHI
- At least 20 minutes of clinical psychologist or clinical social worker time, per calendar month.
- Initial assessment or follow-up monitoring,
- including the use of applicable validated rating scales; behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes;
- facilitating and coordinating treatment such as psychotherapy, coordination with and/or referral to physicians and practitioners who are authorized by Medicare to prescribe medications and furnish E/M services, counseling and/or psychiatric consultation; and continuity of care with a designated member of the care team…"

CM for Behavioral Health Conditions

Reimbursements

2023

Billed per calendar month for 20 plus minutes of coordination when billed by LCSW or CP

- CPT Code G0323 RVU 0.61
- National Average Allowable ~$41.99

2024

Billed per calendar month for 20 plus minutes of coordination when billed by LCSW or CP or MFT or MHC

- CPT Code G0323 RVU 0.93
- National Average Allowable ~$54.03

Rural Health & Federally Qualified Health Clinics

General Care Management

CCM Team based & Provider based

BHI &BH by CSW/CP

PCM & CPM

Care Management

2023

G0511

RVU = 1.23

$76.04

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Rural Health & Federally Qualified Health Clinics

General Care Management

Care Coordination
- Chronic Care Management
- Complex Chronic Care Management
- Principal Care Management
- Remote Physiological Monitoring

Behavioral
- Behavioral Health Integration
- Care Management for Behavioral Health
- Chronic Pain Management

Community
- Community Health Integration
- Principal Illness Navigation

Care Management

2024

G0511

RVU = 1.17

$71.71

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Rural Health & Federally Qualified Health Clinics

General Care Management

Billing for Multiple G0511 codes

- The general care management code applies to all of the care management services
- A patient may be enrolled in more than one service line
- A G0511 may be billed for each service line in a calendar month where all elements are met:
  - Chronic Care Management (at least 20 minutes)
  - Behavioral Health Integration (at least 20 minutes)
  - Principal Care Management (at least 30 minutes)
  - Chronic Pain Management (at least 15 minutes)
  - Care Management for Behavioral Health by LCSW or CP (at least 20 minutes)
  - Remote Physiological Monitoring (at least 20 minutes)
  - Community Health Integration (at least 60 minutes)
  - Principal Illness Navigation (at least 60 minutes)

"An RHC or FQHC may bill HCPCS code G0511 multiple times in a calendar month as long as all requirements are met and there is not double counting."

Page 772 of the 2024 final rules

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Social Determinate of Health Risk Assessment

2024

SDOH Risk Assessment guidelines

- Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment, 5-15 minutes, not more often than every 6 months per patient per provider
- SDOH Risk Assessment that is furnished in conjunction with a qualifying visit
  - E/M visit
  - AWV
  - TCM visit
  - Psychiatric diagnostic evaluation
  - Health Behavior Assessment and Intervention service
- SDOH risk assessment through a standardized, evidence-based tool can more effectively and consistently identify unmet SDOH needs and enable comparisons across populations.
- SDOH Risk Assessment must be billed with the qualifying visit, however data gather of the screening and assessment may be done in advance of the visit
- Billed by a practitioner with an established relationship with the patient and the ability to refer to services to address unmet needs.
- Although not required to report the SDOH diagnosis on the claim – it is recommended to use the Z-codes (Z55-Z65)

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SDOH Risk Assessment

Reimbursements

2023

NEW in 2024

2024

Completion of SDOH screening and risk assessment not more than once every 6 months per patient per provider

- CPT G0136 RVU 0.18
- National Average Reimbursement ~18.66

Optional Service Offered with AWV

Paid at 100%

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Community Health Integration (CHI)

2024

Practice Eligibility

- Provider qualified to bill E/M codes
- Certified (State Specific) or trained auxiliary personnel as a Community Health Worker (CHW)
  - 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
  - Processualism and ethical conduct
  - Development of an appropriate knowledge base of local community-based resources
- Collaboration and communication with practitioners, social service providers, caregivers, healthcare facilities, home and community resources
- Primary Care Provider general supervision of CHW
- Only 1 provider may bill for CHI per patient per month

Patient Eligibility

- Medicare Patient (other Insurances)
- CHI initiating visit with their established provider
- Provider identification of the presence of SDOH need(s) that significantly limit the provider's ability to diagnose or treat the patient's medical condition(s) and establish an appropriate treatment plan.
- The treatment plan specifics how addressing the unmet SDOH need(s) would help patient's medical condition
- Patient Consent – written or verbal
- Time tracking of at least 60 min per calendar month including face to face visits by the CHW in the community with the patient

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CHI

Reimbursements

2023

NEW in 2024

2024

Billed per calendar month for 60 min of care coordination in the community by community health worker

- CPT Code G0019 RVU 1.0
- National Average Reimbursement ~$79.24

Billed with G0019 for additional 30 min per calendar month of care coordination in the community by community health worker

- CPT Code G0022 RVU .70
- National Average Reimbursement ~$49.44

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Principal Illness Navigation (PIN)

2024

Practice Eligibility

- Provider qualified to bill E/M codes
- Certified (State Specific) or trained auxiliary personnel as a Patient Navigator or Certified Peer Specialist
  - Person-centered assessment to understand patient's life story
  - Facilitating patient-driven goal setting and creating action plan
  - Facilitate behavioral change
  - Provide tailored social/emotional support
  - Identifying or referring patient/caregiver/family to appropriate supportive services
  - Providing information to consider related to clinical research/clinical trials
  - Coordinate and navigate care transitions
  - Helping patients contextualize health education
  - Build patient self-advocacy skills
  - Leverage lived experiences and knowledge of serious, high-risk condition
- Collaboration and communication with practitioners, social service providers, caregivers, healthcare facilities, home and community resources
- Navigator functions under general supervision of Provider

Patient Eligibility

- Medicare Patient (other Insurances)
- With a condition that is considered a serious, high-risk disease expected to last at least 3 months, that places the patient at significant risk of hospitalization or nursing home placement, acute exacerbation/decompression, functional decline, or death
- PIN initiating visit that addresses the serious high-risk condition by the billing provider (E/M Psychiatric diagnostic evaluations, BHAI) Provider establishes an appropriate treatment plan for the condition.
- Patient Consent – written or verbal
- Time tracking of at least 60 min of navigation services per calendar month by the navigator or peer specialist

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PIN and PIN-PS

Reimbursements

2023

NEW in 2024

2024

Principal Illness Navigation

Billed per calendar month for 60 min of care navigation by care navigator

- CPT Code G0023 RVU 1.0
- National Average Reimbursement ~$79.24

Billed with G0023 for additional 30 min per calendar month of care navigation by care navigator

- CPT Code G0024 RVU .70
- National Average Reimbursement ~$49.44

Principal Illness Navigation – Peer Support (specific for behavioral health)

Billed per calendar month for 60 min of navigation by peer support specialist

- CPT Code G0140 RVU 1.0
- National Average Reimbursement ~$79.24

Billed with G0140 for additional 30 min per calendar month of care navigation by peer support specialist

- CPT Code G0146 RVU .70
- National Average Reimbursement ~$49.44

Questions?

Online Certificate Courses Offered

Additional Resources

All provide Continuing Education Credit
Check out website: https://www.health-tech.us/certificate-courses/

Current listing:
- Care Coordination Fundamentals Self-Paced Certificate Course
- Annual Wellness Visit Self-Paced Certificate Course
- Advance Care Planning Self-Paced Certificate Course
- Behavioral Health Integration: What a Care Coordinator Should Know Self-Paced Certificate Course
- Transitional Care Management Self-Paced Certificate Course
- Lean Practitioner Self-Paced Certificate Course
- Swing Bed Basics and Advanced Self-Paced Certificate Courses

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January – April webinars

All webinars are recorded for on-demand viewing.

Care Coordination - What's new in 2024 for programs and reimbursements?
Presenter: Faith M Jones, MSN, RN, NEA-BC, Director of Care Coordination and Lean Consulting.
Date: Jan 18, 2024 | Time: 12pm CST
URL: https://bit.ly/3U083iW

Everything you ever wanted to know about Swing Bed! Part 1: The Basics – Meeting Swing Bed Regulatory Requirements
Presenter: Carolyn St. Charles, RN, BSN, MBA – Chief Clinical Officer.
Date: Feb 9, 2024 | Time: 11am CST
URL: https://bit.ly/47v1R5D

Everything you ever wanted to know about Swing Bed! Part 2: Beyond basics
Presenter: Carolyn St. Charles, RN, BSN, MBA – Chief Clinical Officer.
Date: Mar 8, 2024 | Time: 11am CST
URL: https://bit.ly/3vGEadh

Everything you ever wanted to know about Swing Bed! Part 3: Strategies to hardwire your Swing Bed program for success
Presenter: Carolyn St. Charles, RN, BSN, MBA – Chief Clinical Officer.
Date: Apr 12, 2024 | Time: 11am CST
URL: https://bit.ly/3S31QAp

Adaptive leadership in a changing environment
Presenter: Cheri Benander, RN, MSN, CHC, C-NHCE.
Date: Apr 26, 2024 | Time: 12pm CST
URL: https://bit.ly/3Shw6sg

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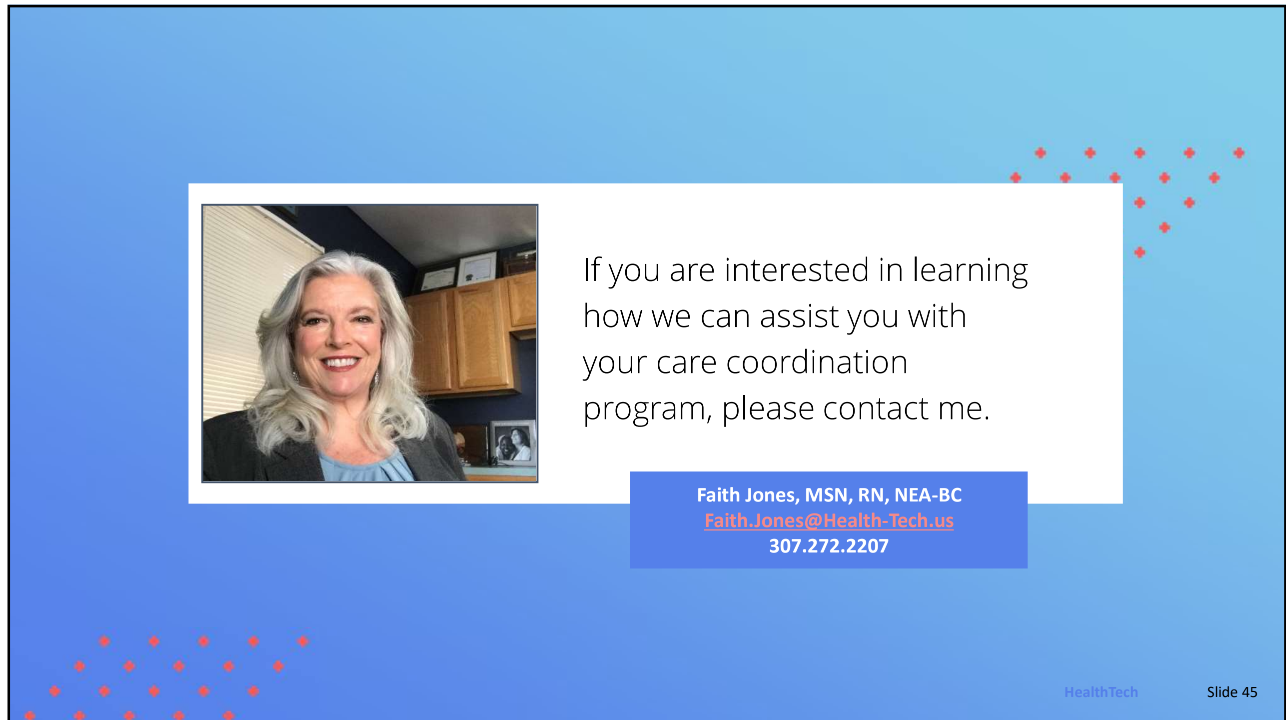

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Thank you

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