Principal Illness Navigation & Principal Care Management Codes FAQ

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I. Introduction

This document was drafted by the American Cancer Society (ACS), the American Cancer Society Cancer Action Network, and the ACS National Navigation Roundtable for the purposes of providing general information about the Principal Illness Navigation (PIN) Codes and the Principal Care Management (PCM) Codes.

This document does not represent the views of the Centers for Medicare and Medicaid (CMS) and should not be considered a substitute for CMS's Physician Fee Schedule (PFS) Final Rule. This document should not be construed as providing legal advice. For more information on CMS or the PFS Final Rule please visit cms.gov. For specific legal questions, please consult an attorney.

One section of this document provides information about the **CMS PIN Codes**. The next section of this document provides information about the **American Medical Association's (AMA) PCM codes**, which can be used by clinical staff under the supervision of a physician or other qualified health care professional. You will also find information regarding commitments from **seven leading health insurance companies**, serving 150 million Americans, to cover navigation services, as well as commitments from **40 comprehensive cancer centers and community oncology practices** to provide effective navigation services for serious health conditions, like cancer.

This document is intended to be a living document that the ACS National Navigation Roundtable will update periodically to reflect the latest information. Please check back at navigationroundtable.org for updates.

II. Principal Illness Navigation Codes FAQs

CMS reimburses physicians for care provided under Medicare Part B based on the Medicare PFS. The PFS determines reimbursement for services including the professional services of physicians and other enrolled health care providers, services covered "incident to" physicians' services, and certain diagnostic tests. CMS updates the PFS on a regular basis with payment policy changes published annually.

The 2024 PFS included new codes specific to health-related social needs including PIN Codes to help people with Medicare who are diagnosed with high-risk conditions identify and connect with appropriate clinical and support resources.

1. Employment Settings

a. How can a navigator who is employed in a non-clinical setting utilize the PIN codes?

A navigator who is in a non-clinical setting may provide PIN services, however they must do so under the general supervision of a billing provider, after the billing provider has conducted an initiating visit with the patient and establishes an appropriate treatment plan that includes PIN services. A billing provider includes a physician, nurse practitioner, physician assistant or anyone who can furnish a qualifying initiating visit, which includes evaluation and management (E/M) visit (other than low level E/M visits that can be conducted by clinical staff), annual wellness visit or transitional care management. Auxiliary personnel include Community Health Workers, patient navigators, etc. When auxiliary personnel (either on staff or under contract with the billing provider) provide the PIN services, the billing provider bills for these services "incident to" their professional services. The PIN codes are live and can be used as of January 1, 2024.

b. Will the Centers for Medicare and Medicaid (CMS) provide guidance on utilizing the PIN codes in hospital outpatient settings?

In the CMS PFS final rule people were unclear on how hospital outpatient departments can bill for PIN services. CMS shared this specific health-related social needs FAQ that explains this unintended discrepancy that initially resulted in hospital outpatient settings appearing ineligible for reimbursement. CMS priced these codes for facility, including hospital outpatient settings, and non-facility settings. CMS has clarified it does intend for these codes to be used in hospital outpatient settings.

c. How can a nonprofit or community-based organization (that employs navigators) utilize the PIN codes?

Community based organizations (CBOs) can engage in contracts with qualified providers to deliver patient navigation services. CMS is not directly involved in contracts between CBOs and providers and payment from CMS goes directly to the provider who bills for these services. However, CMS actively encourages both CBOs and health systems/provider to work together to perform these services. CBOs can employ navigators and provide PIN services under contract and general supervision with a billing practitioner. CMS does not manage these contracts but encourages them.

2. Training and Certification

a. How does a supervising provider attest to certification?

In general, the billing practitioner is responsible for ensuring that all certification requirements are met in order to bill to Medicare and has to attest that the auxiliary personnel (i.e., the patient navigator) has completed all required CMS and/or state required training and certifications. CMS has a Medicare learning network article that lists the specific trainings requirements.

3. Billing and Payment

a. How can an organization (such as a community-based nonprofit) utilize the PIN codes if they do not charge patient copays?

CBOs can engage in contracts with qualified providers to deliver patient navigation services. CMS is not directly involved in contracts between CBOs and providers and payment from CMS goes directly to the provider who bills for these services. However, CMS actively encourages both CBOs and health systems/provider to work together to perform these services. CBOs can employ navigators and provide PIN services under contract and general supervision with a billing practitioner. CMS does not manage these contracts but encourages them.

b. Is there a limit to the number of navigators who can bill incident to one provider? Is there a limit to the number of navigators who can navigate a single patient?

PIN services can be billed by one provider per condition per month. There cannot be multiple practitioners per condition but there can be one billing practitioner for *each* condition if there are multiple conditions present. For example, if a patient has both cancer and heart failure, one practitioner bills for PIN services for the patient's cancer and another practitioner bills each month for treating the patient's heart failure condition. The one exception to this point is that a single billing practitioner may not bill PIN for multiple conditions for the *same* beneficiary. As such, the billing limit is informed by how many conditions the patient has, and who is billing for PIN for each condition.

In contrast, the actual *delivery* of PIN services can occur across a team. PIN services are often delivered by auxiliary personnel providing services incident to the billing provider. These auxiliary personnel may operate as a team, with their cumulative time spent providing PIN services to a given patient contributing to the initial 60-minute code and subsequent 30-minute add-on codes that are submitted by the single billing provider.

c. Are there specific training requirements for patient navigators?

In the event that states have their own requirements, CMS defers to those state requirements that auxiliary personnel meet the appropriate state training and licensure/certification requirements. In the absence of specific state requirements, CMS requires auxiliary personnel to be trained on the list of core competencies described in the PFS Final Rule and in the Medicare Learning Network Matters document found here. Auxiliary personnel can have different backgrounds, as long as said personnel fulfill training requirements.

d. Is there a limit to the number of providers who can bill PIN codes for a single patient (e.g., if the patient is receiving navigation from multiple providers regarding multiple conditions)?

   PIN services are limited to one provider, per condition, per month. For example, if a patient has both cancer and heart failure, one practitioner bills for PIN services for the patient's cancer and another practitioner bills each month for treating the patient's heart failure condition. There cannot be two practitioners both billing for the same condition, and one practitioner cannot bill separately for multiple conditions for the same patient. As long as there is one practitioner billing per condition this will suffice the billing requirement. PIN services can be provided for serious, high-risk conditions, including cancer. Please see the CMS Medicare learning network article for more information.

e. Can codes be "stacked," or can multiple codes be utilized in one visit?

   These are monthly codes and you add up all the time spent per month and apply the codes accordingly (i.e. first 60 minutes, and then each additional 30 minutes). The billing of these codes does not happen by visit but rather by total time in a month.

   In addition to other care management codes, provided that you do not count time and effort more than once, PIN codes can also be billed if the individual requirements to bill each service are met, and the services are reasonable and necessary.

f. Will a CPT code ultimately be necessary to codify the PIN codes?

   When CMS creates codes, other payors can use those codes. In this case, payors can use these PIN codes as of January 1, 2024, and Medicare is currently paying providers who use these codes. Further, the American Medical Association provided special guidance on the appropriate use of CPT codes for clinical navigation services.

g. Will patients have a copayment?

   Traditional Medicare in general has a 20% coinsurance requirement for services provided under Medicare Part B (which covers specific services), including PIN services. However, some patients may have supplemental forms of insurance that will cover their coinsurance amount. For those with Medicare and Medicaid, often Medicaid covers the full cost of the coinsurance and there is not cost sharing for many patients. If a patient has private supplemental insurance ("Medigap"), that patient's insurance may cover the coinsurance amount. Additionally, if the patient is enrolled in a Medicare Advantage plan, the patient's coinsurance obligations will depend on the details of the specific plan. If a patient does not have these forms of coverage, that patient may have a copay. Please see Harvard Law School's Center for Health Law and Policy Innovation FAQ to learn more.

4. Service Delivery

a. How can CMS be inclusive of navigation across the additional components in the continuum of care such as prevention, screening, or early detection?

   By statute, Medicare can only pay for prevention and screening services if those services are given a Grade A or B by the United States Preventative Services Task Force (USPSTF). Because the USPSTF has not given a Grade A or B recommendation to navigation services for these screenings this is not currently included in the PIN codes. However, Medicare in general pays for preventative care as part of annual wellness visits and so CMS anticipates that during these annual wellness visits patients will receive referrals to appropriate screening services.

b. With PIN services not included on the telehealth services list, will telehealth services be included in future iterations of the PIN codes?

   CMS clarified that there is not a requirement for PIN services to currently be provided face-to-face and therefore PIN services can be provided via telehealth. CMS only puts services on the telehealth services list if there is a requirement that said service must be performed face-to-face, which is not the case here. As such, PIN services and any portion of them can be provided via telehealth.

c. CMS finalized that patient consent is required in advance of providing PIN services either in writing or verbally. Can patients be consented virtually?

   Yes, patients can consent virtually, provided it is documented in the patient's medical record. CMS anticipates that patient consent will happen during the initiating visit required to provide PIN services prior to billing of these services. CMS also explained that patients do not need to consent again each month. Patient consent is only required prior to the PIN services being provided and to inform that cost sharing may apply. Consent can be provided to a billing practitioner or to an auxiliary personnel under general supervision. Consent must be re-obtained annually or in the event that the billing practitioner changes.

d. Is a diagnosis required before PIN services can be provided?

   A definitive diagnosis is not required before a practitioner makes a clinical determination that the patient has a serious high-risk condition that requires the application of PIN codes.

e. Do PIN codes cover survivorship care?

   Yes, if a patient's survivorship condition constitutes a high-risk condition (e.g., have post-radiation symptoms, etc.) based on clinical judgement and medical documentation.

5. Other Questions

a. Are there current or future efforts by CMS to monitor the use of PIN codes?

   Yes, CMS shared that there are payers and providers that the White House Cancer Moonshot is working with for a shared effort to roll out, use, and monitor the codes and measure care

quality. In addition to the reimbursement codes, the Administration announced new commitments from seven leading health insurance companies, serving 150 million Americans, to cover navigation services, as well as commitments from 40 comprehensive cancer centers and community oncology practices to provide effective navigation services for serious health conditions, like cancer.

III. Principal Care Management Services Codes FAQs

The American Medical Association (AMA) released a Current Procedural Terminology (CPT) Assistant Special Edition on the Appropriate CPT codes for reporting clinical oncology navigation services. The AMA Principal Care Management Codes represent services that "focus on the medical and/or psychological needs manifested by a single, complex chronic condition expected to last at least three months and includes establishing, implementing, revising, or monitoring a care plan specific to that single disease." These codes are not limited to oncology patients but are inclusive of oncology. These services help improve coordination of care, reduce avoidable hospital services, decrease overutilization of services, improve patient engagement, and decrease care fragmentation due to decentralized patient throughput.

1. Employment Setting

a. How can a nonprofit or CBOs (that employs clinical navigators/Qualified Health Professionals) contract with a physician to utilize the PCM codes?

PCM codes are a specific subset of codes that focus on the medical and/or psychological/social needs manifested by a single, complex condition expected to last at least 3 months and is not limited to a specific condition. PCM codes can apply to cancer as well as other diagnoses. PCM codes are codes that exist for treatment of complex condition that already exists. For other components of the continuum of care, there are other CPT codes that can be used by physicians such as well visits and screening codes. CBOs that are not owned by a hospital, ambulatory care setting, or other clinical setting can use PCM codes in contract with an institution/physician in order to utilize the codes.

2. Training and Certification

a. Will the training and certification verification be proven through attestation by the supervising provider?

Multiple individuals, such as a social worker, medical assistant, nurse navigator or peer specialist, can provide these services when working under the supervision of physician or qualified health professional, such as physician, nurse practitioner, or physician assistant who is qualified by training/licensure and is able to bill for these services. The billing provider will attest to the appropriate training and certification of the auxiliary personnel providing the navigation services.

3. Navigation Focus

a. How can CMS be inclusive of navigation across the additional components in the continuum of care such as prevention, screening, or early detection?

These PCM codes are for the treatment of a complex condition that already exists (e.g. cancer, autoimmune disease, or diabetes) and require care coordination expected to last at least three months. However, these PCM codes are not limited to cancer, or any other special condition, and the code defines the appropriate patients for these codes. There are other CPT codes that provide preventative services like screening codes prior to when a patient presents with disease and those other codes can be used by payors but those are services offered by a physician or qualified healthcare professional.

4. Billing and Payment

a. Is there a limit to the number of navigators who can bill incident to one provider?

No. The total amount of clinical staff time providing the services is the key factor, not the physical number of individuals servicing in that capacity. These PCM codes may be reported by different physicians or qualified health care professionals in the same calendar month for the same patient and the documentation in the patient medical record should reflect said coordination.

b. Is there a limit to the number of providers who can bill PCM codes for a single patient (e.g., if the patient is receiving navigation from multiple providers regarding multiple conditions)?

No, it's total amount of time spent navigating a patient, not number of navigators that matters. PCM codes can be reported by different physicians if said providers are managing different conditions in same calendar month. Documentation in the medical record is also necessary.