Definition of qualifying patients (Principal Illness Navigation Services):

PIN services could be furnished following an initiating E/M visit addressing a serious high-risk condition/illness/disease, with the following characteristics:

• One serious, high-risk condition expected to last at least 3 months and that places the patient at significant risk of hospitalization, 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.

Billable activities:

-Initial 60 min code per calendar month G0023

-Additional 30 mins per calendar month G0024

The PIN initiating visit would serve as a pre-requisite to billing for PIN services, during which the billing practitioner would identify the medical necessity of PIN services and establish an appropriate treatment plan. The PIN Initiating visit would be an Evaluation and Management visit performed by the billing practitioner who will also be furnishing the PIN services during the subsequent calendar month(s).The subsequent PIN services would be performed by auxiliary personnel incident to the professional services of the practitioner who bills the PIN initiating visit. The same practitioner would furnish and bill for both the PIN initiating visit and the PIN services

Principal Illness Navigation services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator or certified peer specialist; 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.

    ++ 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.

Limit to one practitioner for PIN services:

We are proposing that only one practitioner per beneficiary per calendar month could bill for PIN services for a given serious, high-risk condition, because we are concerned about potential care fragmentation if the patient has more than one navigator for their condition during a given month. Our proposal would allow the patient to have a single point of contact for navigation of their condition.

3rd party PIN services:

We are proposing that a billing practitioner may arrange to have PIN services provided by auxiliary personnel who are external to, and under contract with, the practitioner or their practice, such as through a community-based organization (CBO) that employs CHWs, if all of the ''incident to'' and other requirements and conditions for payment of PIN services are met. While we are proposing to allow PIN services to be performed by auxiliary personnel under a contract with a third party, we wish to be clear, as we have in our regulations for current care management services, that there must be sufficient clinical integration between the third party and the billing practitioner in order for the services to be fully provided, and the connection between the patient, auxiliary personnel, and the billing practitioner must be maintained.

We would expect the auxiliary personnel performing the PIN services to communicate regularly with the billing practitioner to ensure that PIN services are appropriately documented in the

medical record, and to continue to involve the billing practitioner in evaluating the continuing need for PIN services to address the serious, high-risk condition