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Care Management Services and Patient Navigation Services:

A Comparison

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Introduction

In 2023, the Centers for Medicare and Medicaid Services proposed a set of codes to capture and report activities being performed by auxiliary personnel and navigators to support social determinants of health-related needs. As the proposed codes have many activities that parallel that of the Care Management Service code set family, ASCO has developed this resource to assist physicians, other qualified healthcare professionals, and practices to evaluate the proposed codes and how they fit into the activities currently being performed in practices today.

HCPCS Codes Proposed by CMS: Services to Address Social Determinants of Health

Full code descriptions and associated activities may be found in the Appendix.

In response to the increased focus on SDOH to ensure patients are receiving quality, appropriate care while also recognizing the work associated with addressing SDOH, the Centers for Medicare and Medicaid Services (CMS) introduced three new sets of codes in the 2024 Physician Fee Schedule Proposed Rule. These codes are aimed at encouraging access to navigational services and advancing health equity in support of the Cancer Moonshot program. [1]

Community Health Integration (CHI) (G0019 and G0022)	Social Determinants of Health (SDOH) Risk Assessment (G0136)	Principal Illness Navigation (PIN) (G0023, G0024, G0140, G0146)
Activities performed by certified or trained auxiliary personnel (including a community health worker) under the direction of a physician or other practitioner; to address social determinants of health (SDOH) need(s) that are significantly limiting ability to diagnose or treat problem(s).	Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment tool.	Services focused on serious, high-risk illness by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator or certified peer specialist. (G0140 and G0146 limited to the treatment of behavioral health conditions.)

CPT Codes for Care Management Services

Full code descriptions and associated activities may be found in the Appendix.

To describe the activities associated with the management of patients with a single, high-risk condition or multiple chronic conditions, CPT codes were created in the form of "Care Management Services" and "Transitional Care Management Services". These services included activities such as care coordination, facilitation of access, and care planning. CMS has encouraged the use of these

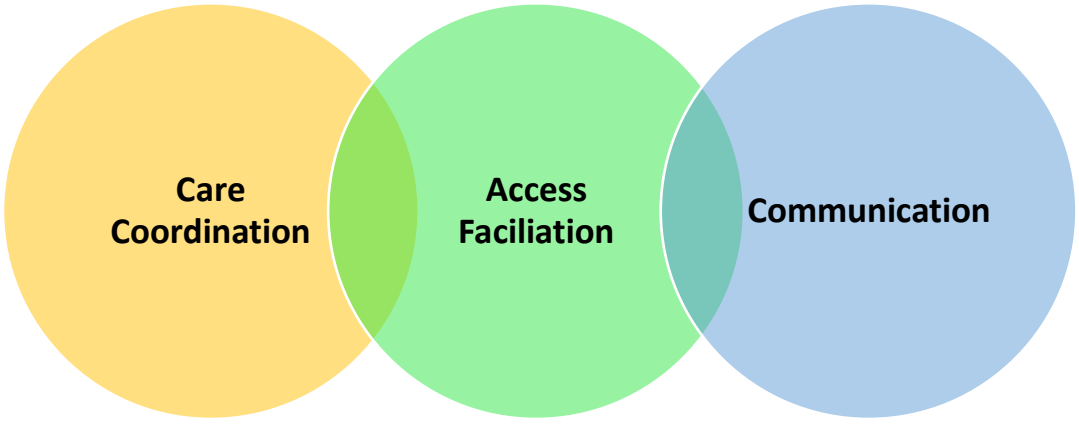
[1] Centers for Medicaid and Medicare Services. "CMS Physician Payment Rule Advances Health Equity." CMS Physician Payment Rule Advances Health Equity | CMS

codes to address a patient's social determinants of health that may significantly impact their condition.

Chronic Care Management (CCM) 99437, 99439, 99490, 99491	Complex Chronic Care Management (CCCM) 99487, 99489	Principal Care Management (PCM) 99424-99427	Transitional Care Management (TCM) 99495, 99496
Services provided by or under the direction of a physician or qualified health care professional or under when medical and/or psychosocial needs require establishing, implementing, revising, or monitoring the care plan for a patient with **multiple chronic conditions** expected to last at least 12 months and place the patient at significant risk of death, exacerbation, or decline.	Chronic care management services that require a **moderate** or **high level of decision making**.	Services provided by or under the direction of a physician or qualified healthcare professional that focus on the medical and/or psychosocial needs of a patient indicated by a **single, high-risk disease** or condition at significant risk of death, exacerbation, or decline	Services for patients with medical and/or psychosocial needs which require moderate to high level of medical decision-making during **transitions of care from an inpatient hospital setting to a community setting**.

CMS vs. CPT Services

The proposed Community Health Integration (CHI), Principal Illness Navigation (PIN), and SDOH Risk Assessment services include many of the same elements of the Care Management and Transitional Care Management activities. These services require communication between the provider of services and the patient and/or caregiver and other medical and community-based providers as part of planning, care coordination, and access facilitation. Patient and/or caregiver education is also at the forefront of these activities.



The table below highlights **differences** between the proposed SDOH codes and the care management services. A full list of activities involved in each service is available in the Appendix.

	Community Health Integration	Principal Illness Navigation	SDOH Risk Assessment	Transitional Care Management	Care Management	Principal Care Management
Provider	Certified/Trained staff		Physician/QHP or certified/trained auxiliary personnel	Physician/QHP and/or clinical staff (depending on code)		
Consent	Informed written or verbal consent required.		N/A	Informed written or verbal consent required.		
Coordination		Identifying and/or referring for services.	N/A	Reviewing discharge information and need for follow up on pending tests and treatments; interaction with other QHP (re)assuming care of system-specific problems.	Ongoing review of patient status.	Ongoing review of patient status.
Plan Required	Action plan		N/A	Care plan		
Assessment	Patient-centered assessment.		Standardized, evidence based SDOH assessment.	Assess adherence to treatment regimen and medication management; collection of health outcomes data and registry documentation.		
Education	Patient education is focused on contextualizing information from the treatment team, how to best participate in medical decision-making, and build self-advocacy skills, providing information and resources to patient to consider participation in clinical trials/research.		N/A	Education to support self-management and daily living.		

	Community Health Integration	Principal Illness Navigation	SDOH Risk Assessment	Transitional Care Management	Care Management	Principal Care Management
Goals and Support	Providing social and emotional support to help patient cope with addressed problem(s), SDOH needs, and daily routines to meet diagnosis and treatment goals; provide support, mentorship, or inspiration to meet treatment goals.		N/A	While supporting adherence of the treatment regimen and medication management is mentioned, how that support is given is not specified.		

Reporting and Documentation

Community Health Integration, Principal Illness Navigation, and the Care Management services are all reported by the physician or other qualified health care professional, even if services are provided by clinical staff or auxiliary personnel as applicable.

Documentation Requirements

Care Management (CCM, CCCM, PCM)	Transitional Care Management (TCM)
☑ Narrative detailing need for care management services. ☑ Beneficiary eligibility for service. ☑ Comprehensive care plan (with measurable goals) established, implemented, revised, or significantly monitored. ☑ Patient or caregiver must be given a copy of the care plan. Medicare does not specify a certain format for care plan. ☑ Discussion narrative with beneficiary and his/her prior permission acceptance (verbally for patients who have been seen in the practice within past 12 months or written for those who have not). ☑ Documentation of verbal acceptance and explanation of cost-sharing and restrictions of care, if applicable, to the patient. ☑ Note regarding beneficiary may terminate consent at any time. ☑ Support services rendered.	☑ Date patient was discharged. ☑ Date of interactive communication with the patient/caregiver. ☑ Any unsuccessful attempts to contact the patient. ☑ Date the face-to-face visit occurred. ☑ Complexity of medical decision making through the care period.

Community Health Integration	Principal Illness Navigation	SDOH Risk Assessment
☑ Initiating visit by billing practitioner who will be furnishing the CHI service, during which SDOH need(s) that significantly limit the practitioner's ability to diagnose/treat the problem addressed at the visit are identified and assessed, and a treatment plan is established. ☑ Time spent furnishing services in relationship to the SDOH needs and clinical problems intended to help resolve. ☑ Description of activities performed. ☑ Record of SDOH need(s) required in medical record. ☑ Reporting of associated ICD-10 Z codes will be encouraged. ☑ Consent obtained by auxiliary personnel prior to providing CHI services and if there's a change in the billing provider.	☑ Initiating visit by billing practitioner that identifies the medical necessity of the navigation services and establishes an appropriate treatment plan. ☑ Time spent in relationship to the serious, high-risk illness with description of activities performed and how they are related to the treatment plan. ☑ Identification of SDOH needs if present. ☑ Reporting of associated ICD-10 Z codes will be encouraged. ☑ Consent obtained by auxiliary personnel on an annual basis either before or after initiating services.	☑ Identified SDOH needs must be documented in the record. ☑ Reporting of associated ICD-10 Z codes will be encouraged.

Reporting with Other Services

It is important to know which services may and may not be reported together, and when.

Care Management	Transitional Care Management	Community Health Integration	Principal Illness Navigation	SDOH Risk Assessment
E/M services may be billed if requirements for both are fulfilled independently.	A TCM service includes a required face-to-face visit in the specified episode of care. An E/M may be reported after the face-to-face-component is completed.	Other care management and E/M services if documentation supports independently. Cannot be reported during home health episode.	Other care management and E/M services if documentation supports independently.	May be reported with: ✓ Outpatient E/M visits ✓ Transitional Care Management ✓ Psychiatric and behavioral assessments ✓ Annual Wellness visit ✓ Hospital Discharge Visits

It is important to note that care management services, transitional care management, and the social determinant services (Principal Illness Navigation, Community Health Integration, and the SDOH risk assessment) include activities that are considered enhanced services or Participant Redesign Activities within CMS' Enhanced Oncology Model (EOM). Enhanced services are paid under the Monthly Enhanced Oncology Services (MEOS) payment and are not reimbursable outside of the EOM program for applicable patients and participants.

Care Delivery Services

Providers

	Care Management	Community Health Integration	Principal Illness Navigation	SDOH Risk Assessment
Reporting	Physician/QHP	Physician/QHP	Physician/QHP	Physician/QHP
Providing	Physician/QHP Clinical staff	Certified/trained auxiliary personnel	Certified/trained auxiliary personnel	Physician/QHP or certified/trained auxiliary personnel
Supervision	General supervision			
Provider restriction	One provider per patient per episode, except for principal management.	One provider per patient per episode	Multiple practitioners allowed, as long as treating different conditions.	N/A.

Auxiliary personnel for CHI/PIN services may be external to, and under contract with, the billing practitioner and/or practice if "incident to" requirements are met, and the billing provider remains appropriately involved. Telehealth allowances are restricted to transitional care management and SDOH risk assessment services only.

To provide care management services, a practice must be able to furnish certain capabilities which include:

- 24/7 access to physicians or other qualified healthcare professionals, providing patients/caregivers with a way to contact healthcare professionals in the practice regardless of the time or day of the week.
- Continuity of care with a designated member of the care team and the ability to schedule successive routine appointments.
- Timely access and management for follow-up after an emergency department visit or facility discharge.
- Electronic health record system utilization for timely access to clinical information.
- Ability to engage and educate patients/caregivers.
- Coordination and integration among all service professional, as appropriate for each patient.
- Care team activity oversight by the reporting physician or other qualified healthcare professional.

- Clinical integration by all care team members who are providing services.

Training

CMS defers to state and local requirements, including certification or licensure. For states where there are no applicable requirements, staff providing CHI and PIN services must be trained in the competencies of and authorized to perform the following service elements:

☑ 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.

Staff providing PIN services must also be certified or trained on the serious, high-risk condition/illness/disease addressed in the initiating visit with the patient.

Peer support training must be consistent with the National Model Standards for Peer Support Certification published by SAMHSA.

Patients

To appropriately report specific services, patient conditions must meet certain criteria.

Chronic Care Management	Complex Chronic Care Management	Principal Care Management	Transitional Care Management
▪ 2 or more chronic illnesses lasting at least 12 months with significant risk of death, exacerbation, or functional decline.	▪ At least 2 chronic conditions expected to last 12 months or more that indicate one of the following: ▪ Need for coordination from multiple specialties, ▪ Poor adherence to treatment plan without substantial caregiver assistance due to inability to perform activities of daily living and/or cognitive impairment, ▪ Psychiatric and other medical comorbidities, ▪ Social support requirements or difficulties with access to care.	▪ Single high-risk disease consisting in complex chronic condition. ▪ Significant risk of hospitalization, acute exacerbation, functional decline, or death. ▪ Condition requires a disease specific care plan. ▪ Frequent adjustments of medication regimen are required and/or the condition management is unusually complex due to comorbidities.	▪ Recently discharged from inpatient hospital setting to community setting. ▪ Medical and/or psychosocial problems require moderate to high medical decision making.

Community Health Integration	Principal Illness Navigation	SDOH Risk Assessment
▪ Patient has SDOH need(s) that significantly limit the practitioner's ability to diagnose or treat the problem(s) addressed in the visit. ▪ Patient cannot be under a home health plan of care.	▪ Serious, high-risk condition expected to last 3 months or longer. ▪ Significant risk of hospitalization, nursing home placement, acute exacerbation, functional decline, or death. ▪ Requires disease-specific care plan. ▪ May require frequent adjustment of medication or treatment regimen or substantial assistance from caregiver.	▪ One or more known or suspected SDOH needs that may interfere with diagnosis or treatment. ▪ Must assess food insecurity, housing insecurity, transportation needs, and utility difficulties.

Activities

Care Management

Activities	Care Management (CCM, CCCM)	Principal Care Management (PCM)
Communication	▪ Communication and engagement with patient, family, caregiver, surrogate decision maker, and/or other health care professionals regarding aspects of care. ▪ Communication with home health agencies and other community services.	See *Care Management* activities.
Education	▪ Education for patient and/or family/caregiver to support self-management, independent living, and activities of daily living.	▪ Education of patient, family/caregiver, and/or guardian.
Coordination	▪ Management of care transitions not reported as transitional care management.	▪ Obtaining and reviewing discharge information. ▪ Reviewing the need for follow-up on pending diagnostic tests and treatments.

Activities	Care Management (CCM, CCCM)	Principal Care Management (PCM)
Facilitation/ Navigation	▪ Assessment and support for treatment regimen adherence and medication management. ▪ Facilitating access to care and services needed by the patient and/or family.	▪ (Re)establishment of referrals and arranging for needed community resources. ▪ Assistance in scheduling any requirement follow-up with community providers and services.
Care Planning	▪ Ongoing review of patient status, including review of laboratory and other studies not reported as part of E/M. ▪ Development, communication, and maintenance of a comprehensive or disease-specific plan as applicable.	▪ Development, communication, and maintenance of a disease-specific plan as applicable
Other	▪ Collection of health outcomes data and registry documentation.	▪ All activities listed under *Care Management* activities.

Activities	Transitional Care Management (TCM)
Communication	▪ Interacting with other health care professionals.
Education	▪ Educating the patient, family, and/or caregiver.
Coordination	▪ Obtaining and reviewing discharge information. ▪ Reviewing the need for follow up on tests and treatments.
Facilitation/ Navigation	▪ (Re)establishment of referrals. ▪ Assisting in scheduling any required follow ups. ▪ Assessing and supporting treatment regimen adherence and medication management. ▪ Identifying available community and health resources. ▪ Facilitating access to care and services.
Care Planning	None
Other	None

Social Determinant Services

Activities	Community Health Integration (CHI)	Principal Illness Navigation (PIN)	SDOH Risk Assessment
Initiating Visit	▪ E/M visit OR ▪ Annual Wellness Visit	▪ E/M Visit OR ▪ Psychiatric Diagnostic Evaluation OR ▪ Health Behavior Assessment and Intervention OR ▪ Annual Wellness Visit	N/A
Communication	▪ Communication with all service providers regarding patient's psychosocial needs, deficits, goals, preferences, and desired outcomes.	See *Community Health Integration* activities.	None
Education	▪ Educating patient on how to best participate in medical decision-making. ▪ Building patient self-advocacy skills.	▪ See *Community Health Integration* activities. ▪ Providing the patient with information/resources to consider participation in clinical trials or research as applicable.	None
Coordination	▪ Coordination of services from healthcare, home-, and community-based providers, social service providers, and caregivers. ▪ Coordination of care transitions between and among practitioners and settings.	See *Community Health Integration* activities.	None
Care Planning	Facilitating and establishing an action plan.	See *Community Health Integration* activities	None

Activities (cont'd)	Community Health Integration (CHI)	Principal Illness Navigation (PIN)	SDOH Risk Assessment
Facilitation/ Navigation	▪ Person-centered assessment ▪ Facilitating access to community-based social services to address SDOH needs. ▪ Helping the patient access healthcare, including identifying appropriate healthcare providers and securing appointments. ▪ Facilitating behavioral change to meet diagnosis and treatment goals. ▪ Providing social and emotional support to help cope with condition, SDOH needs, and daily routines. ▪ Leverage lived experience to provide support, mentorship, and inspiration to meet treatment goals.	▪ See *Community Health Integration* activities ▪ Identifying or referring patient and/or caregiver/family to supportive services. ▪ Leverage knowledge of the serious, high-risk condition to provide support, mentorship, or inspiration to meet treatment goals.	None
Other	None.	None.	Administer a standardized evidence-based SDOH risk assessment tool.

Care Delivery Journey

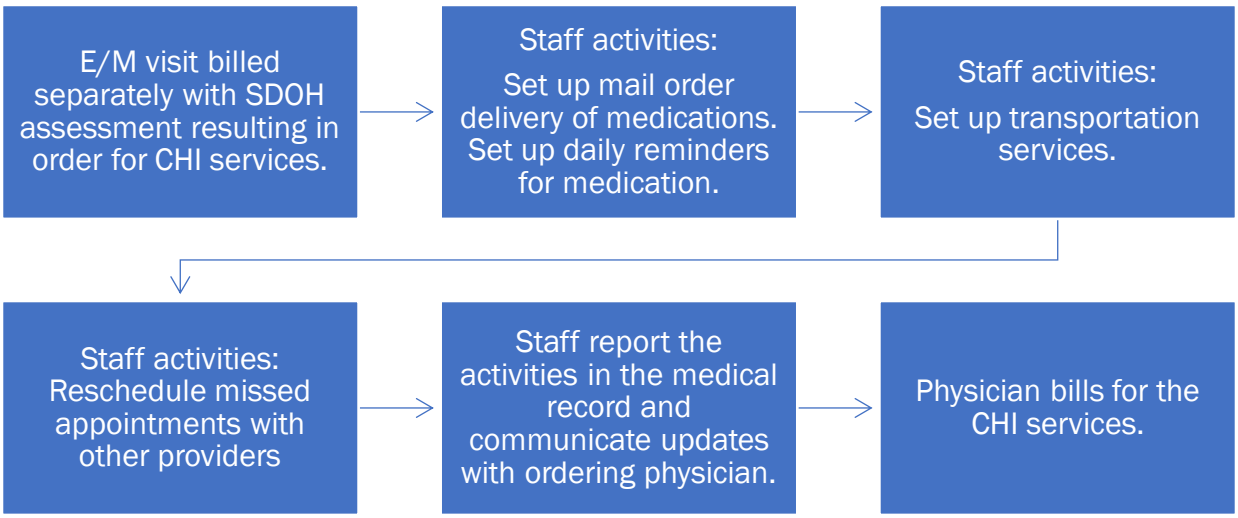
When deciding what service is appropriate to report for a patient's care, consider the following:

- What were the goals of the service?
- What activities were performed?
- Who provided the service to the patient?

It is important to note that except for principal care management services, all care management, transitional care, community health integration (CHI), and principal illness navigational (PIN) services are limited to reporting by only one physician or qualified healthcare professional per episode of care. The expectation is that the reporting care provider would assume care coordination, and by doing so the patient would have a single point of contact for all coordination in a given month.

Community Health Integration

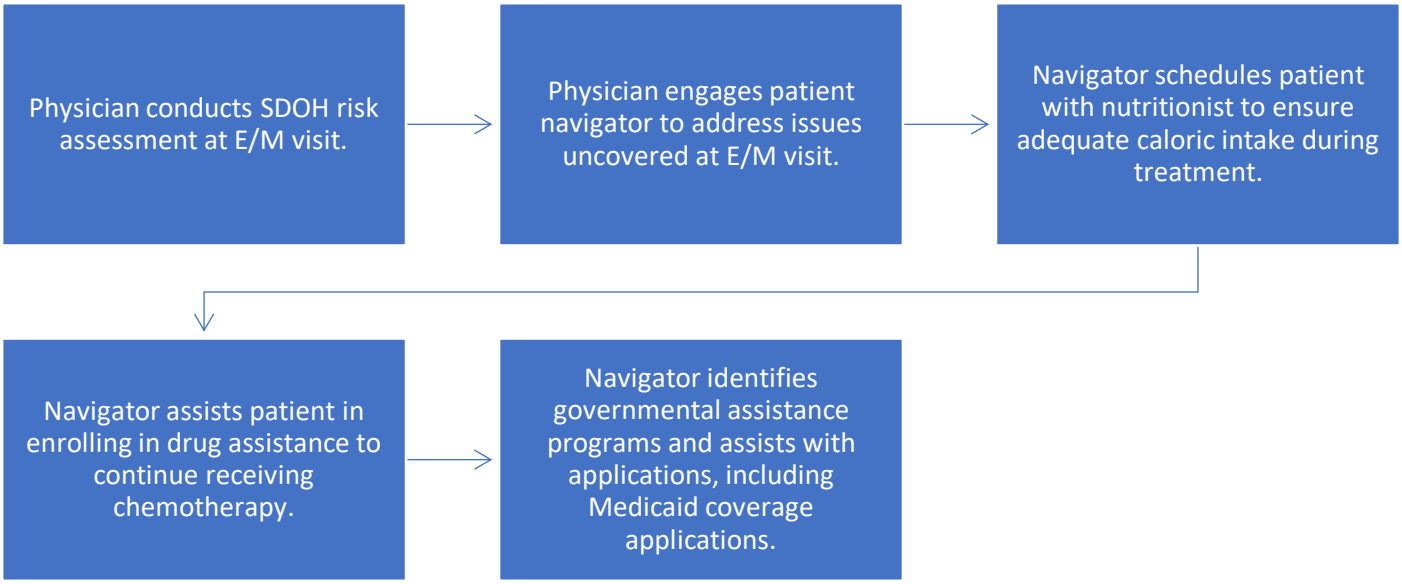
Patient CHI is a patient with breast cancer who the physician noted has short term memory loss due to chemotherapy, lack of caregiver support (lives alone), forgets to take her aromatase inhibitor and fill her prescription and has missed several appointments due to transportation.



The activities performed would be reported with an appropriate level office and/or outpatient evaluation and management service (99202-99215), the SDOH risk assessment code (G0136), and the appropriate CHI service code(s) dependent on time documented (G0019-G0022). Appropriate ICD-10-CM Z codes would be reported to indicate the identified SDOH needs of the patient.

Principal Illness Navigation

Patient PIN was diagnosed with gastric cancer, is undergoing biweekly chemotherapy, and has experience nausea and vomiting as side effects of treatment. Recently, the patient lost employment and subsequently insurance coverage.

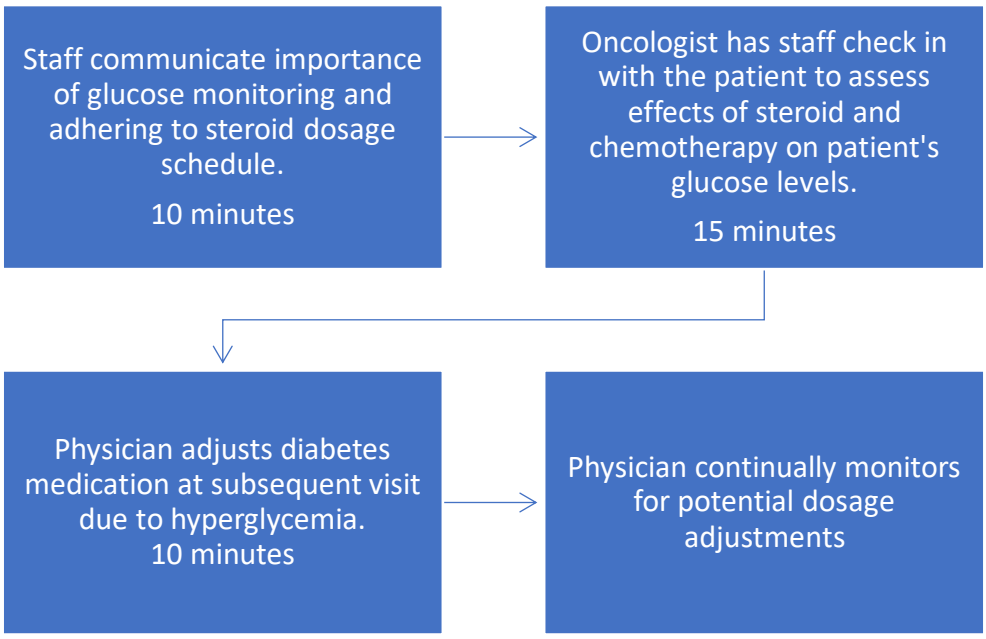


Approximately 105 minutes of time was documented by the navigator in providing these services. The initiating physician/QHP may report the following for the month:

- An appropriate E/M code (99202-99215) along with the G0136 for the SDOH risk assessment as part of the initiating visit
- G0023 and G0024 for the first 60 minutes and an additional 30 minutes of PIN services provided by the navigator
- Any additional E/M visits that occurred between the provider and patient.

Chronic Care Management

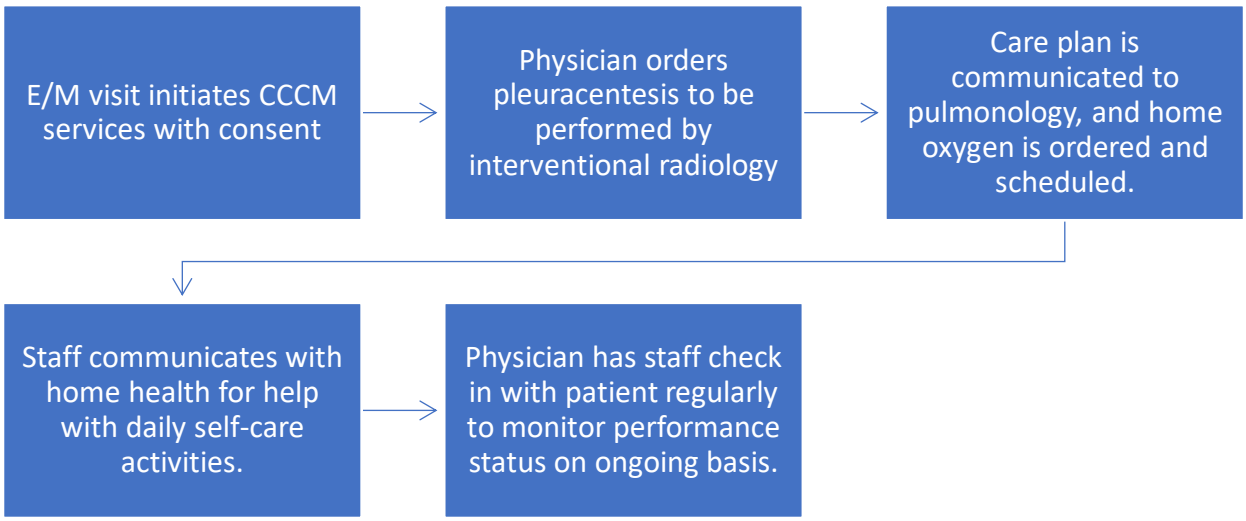
Patient CCCM is a 56-year-old man with prostate cancer along with type 2 diabetes. His oncologist has been managing the prostate cancer and diabetes due to exacerbation of the diabetes from steroid use.



A total of 25 minutes was documented by 99490 would be appropriate to report the education and communication between staff and patient as the 20-minute threshold has been met or exceeded.

Complex Chronic Care Management

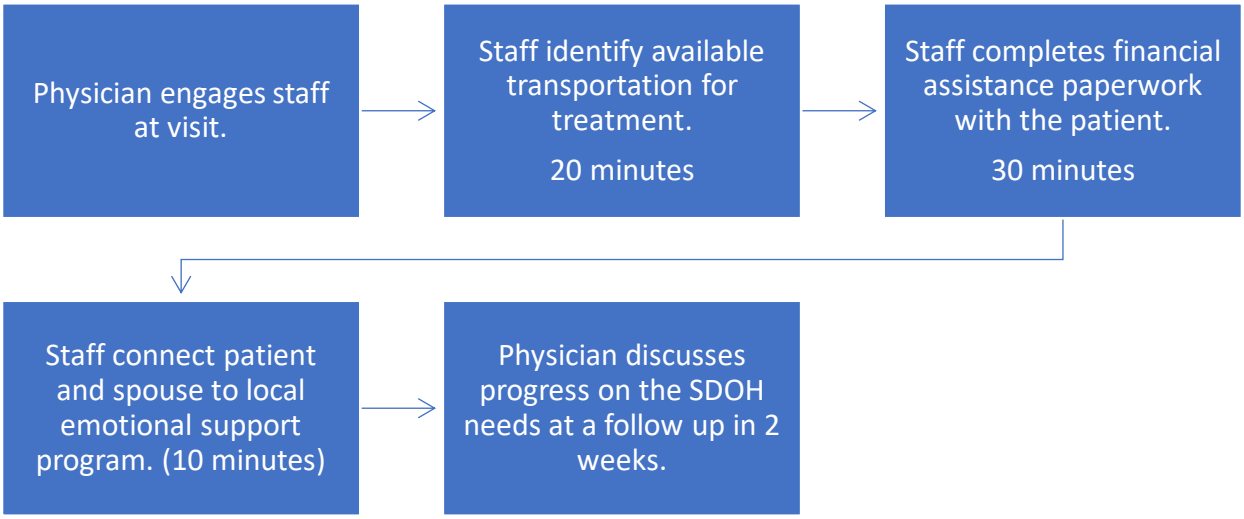
Patient CCCM with lung cancer and chronic obstructive pulmonary disease (COPD) is having difficulty breathing due to pleural effusion. As a result, the patient is having difficulty with daily living activities and is experiencing bouts of weakness and dizziness. Patient lacks caregiver support.



Staff spent a total of 80 minutes performing complex chronic care activities. The physician may report a 99487 for services rendered by the staff.

Principal Care Management

Patient PCM has stage IV colon cancer and will require bimonthly chemotherapy. When discussing the treatment plan with the physician, it is revealed that the patient shares the family vehicle with his spouse who cannot take off work to bring him to treatment. The family is financially strained due to financial obligations relating to diagnosis. Patient communicates that the stress is affecting the marriage.



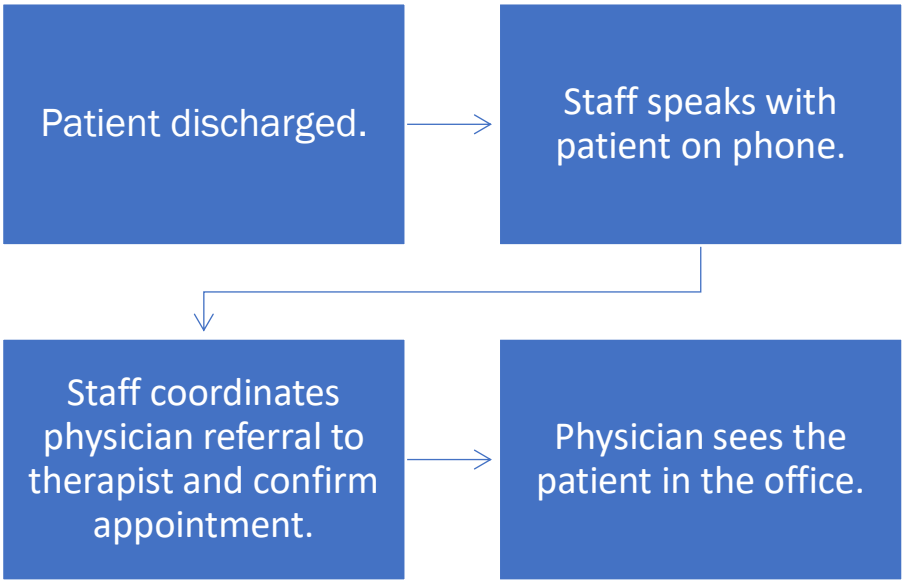
The activities would be reported with CPT codes as follows and appropriate ICD-10 Z codes to identify psychosocial needs:

- An appropriate E/M service code for the initial visit (99202-99215) and a prolonged service code 99417/G2212,
- Principal care Management code 99426 after completing financial assistance paperwork when 30 minutes of service by staff has been attained,
- Principal Care Management code 99427 for 30 additional minutes of service by staff once the time has been attained.
- Time the physician discusses the psychosocial needs at the follow up can be counted for either with an E/M or with a PCM code, however it cannot count for both services.

Transitional Care Management

Patient TCM has been recently diagnosed with double hit lymphoma and discharged from the hospital. During the required interactive call, the patient expresses feelings of depression regarding

the diagnosis. The patient sees the physician in a face-to-face visit on day 12. Because of the aggressive nature of the disease, the physician consults with a specialist at an academic facility by phone and refers the patient for evaluation. Physician renews prescriptions as needed.



The activities performed would be reported with the transitional care management code 99495 due to the moderate level of medical decision making involved.

Reporting and Reimbursement

Reporting

	Chronic Care Management	Complex Chronic Care Management	Transitional Care Management	Principal Care Management
Primary Codes	Staff: 99490 for first 20 minutes Provider: 99491 for first 30 minutes	Staff: 99487 for first 60 minutes	Not time based	Staff: 99426 for first 30 minutes Provider: 99424 for first 30 minutes
Additional Time	Staff: 99439 for each additional 20 minutes Provider: 99437 for each additional 30 minutes (Limit 2)	Staff: 99489 for each additional 30 minutes		Staff: 99427 for each additional 20 minutes Provider: 99425 for each additional 30 minutes (Limit 2)
Episode of care	Per calendar month			

	Community Health Integration	Principal Illness Navigation	SDOH Risk Assessment
Primary code	G0019: First 60 minutes	G0023, G0140*: First 60 minutes	G0136: 5-15 minutes Time spent also counts towards PIN services.
Additional Time	G0022: Each additional 30 minutes (No frequency limit)	G0024, G0146*: Each additional 30 minutes	N/A
Episode of care	Per calendar month	Per calendar month	Every 6 months

*For behavioral only

Reimbursement

Figures are based on the 2025 Medicare Physician Fee Schedule Final Rule for national reimbursement rates for the non-facility setting. Rates will vary by locality and site of service. Cost-sharing amounts may apply to all services and must be explained to patients at time of consent.

	Chronic Care Management	Complex Chronic Care Management	Transitional Care Management	Principal Care Management
Reimbursement Amount	99490: $60.49 99439: $45.93 99491: $82.16 99437: $57.58	99487: $131.65 99489: $70.52	99495: $201.20 99496: $272.65	99426: $61.78 99427: $50.46 99424: $80.87 99425: $58.87

	Community Health Integration	Principal Illness Navigation	SDOH Risk Assessment
Reimbursement Amount	G0019: $77.96 G0022: $48.52	G0023: $77.96 G0024: $48.52 G0140: $77.96 G0146: $48.52	G0136: $18.44

	Evaluation and Management
Reimbursement Amount	99212: $54.99 99213: $88.95 99214: $125.18 99215: $175.64

Appendix

Full Code Descriptions

Social Determinants of Health Codes

Community Health Integration (CHI)

G0019: Community health integration 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 social determinants of health (SDOH) need(s) that are significantly limiting ability to diagnose or treat problem(s) addressed in an initiating visit

G0022: Community health integration services, each additional 30 minutes per calendar month (List separately in addition to G0019).

Principal Illness Navigation (PIN)

G0023: 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.

G0024: Principial illness navigation services, each additional 30 minutes per calendar month.

G0140: Principal Illness Navigation – Peer Support by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a certified peer specialist; 60 minutes per calendar month

G0146: Principal Illness Navigation – Peer Support; additional 30 minutes per calendar month.

SDOH Risk Assessment

G0136: Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment, 5-15 minutes, not more often than every 6 months

Care Management Codes

Chronic Care Management

99490: First 20 minutes of clinical staff time directed by a physician or other qualified health care professional per calendar month, spent on services with the following required elements:

- Two or more chronic conditions expected to last at least 12 months or until the death of the patient.
- Chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.
- Comprehensive care plan established, implemented, revised, or monitored.

99439: Each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.

99491: First 30 minutes personally provided by a physician or other qualified health care professional, per calendar month.

99437: Each additional 30 minutes by a physician or other qualified health care professional, per calendar month.

Complex Chronic Care Management

99487: First 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, spent on services with the following required elements:

- Two or more chronic conditions expected to last at least 12 months, or until the death of the patient.
- Chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.
- Comprehensive care plan established, implemented, revised, or monitored.
- Moderate or high complexity medical decision making.

99489: Each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional per calendar month.

Principal Care Management

99424: First 30 minutes provided personally by a physician or other qualified health care professional per calendar month on services for a single high-risk disease with the following required elements:

- One complex chronic condition expected to last at least 3 months that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death.
- Condition requires development, monitoring, or revision of disease-specific care plan.
- 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.

99425: Each additional 30 minutes provided personally by a physician or other qualified health care professional per calendar month.

99426: First 30 minutes of clinical staff time directed by a physician or other qualified health care professional per calendar month.

99427: Each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional per calendar month.

Transitional Care Management

99495: Transitional care management services with the following required elements:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- At least moderate level of medical decision making during the service period
- Face-to-face visit within 14 calendar days of discharge

99496: Transitional care management services with the following required elements:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- High level of medical decision making during the service period
- Face-to-face visit within 7 calendar days of discharge

Activities Comparison

Chronic Care Management / Complex Chronic Care Management	Principal Care Management	Transitional Care Management
☑ Communication and engagement with patient/family/caregiver, and/or other professionals regarding aspects of care ☑ Communication with home health agencies and other community services ☑ Collection of health outcomes data and registry documentation ☑ Patient/family/caregiver education to support self-management, independent living, and activities of daily living ☑ Assessment and support for treatment regimen adherence and medication management ☑ Identification of available community and health resources ☑ Facilitating access to care and services needed by patient/family ☑ Management of care transitions ☑ Ongoing review of patient status ☑ Development, communication, and maintenance of a comprehensive care plan	☑ Communication and engagement with patient/family/caregiver, and/or other professionals regarding aspects of care ☑ Communication with home health agencies and other community services ☑ Collection of health outcomes data and registry documentation ☑ Patient/family/caregiver education to support self-management, independent living, and activities of daily living ☑ Assessment and support for treatment regimen adherence and medication management ☑ Identification of available community and health resources ☑ Facilitating access to care and services needed by patient/family ☑ Management of care transitions	☑ Communication and engagement with patient/family/caregiver, and/or other professionals regarding aspects of care ☑ Communication with home health agencies and other community services ☑ Patient/family/caregiver education to support self-management, independent living, and activities of daily living ☑ Assessment and support for treatment regimen adherence and medication management ☑ Identification of available community and health resources ☑ Facilitating access to care and services needed by patient/family ☑ Obtaining and reviewing discharge information ☑ Reviewing need for or follow-up on pending diagnostic tests and treatments

	☑ Ongoing review of patient status ☑ Development, communication, and maintenance of a disease-specific care plan	☑ Interaction with other qualified health care professionals assuming/reassuming care of the patient's system specific problems ☑ Education of patient, family, guardian, and/or caregiver ☑ (Re)establishment of referrals and arranging for needed community services ☑ Assistance in scheduling any required follow-up with community providers and services

Community Health Integration	Principal Illness Navigation
☑ Person-centered assessment to understand individualized context of the intersection between the SDOH need(s) and the problem(s) addressed in the initiating visit and 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 to patient as needed to accomplish treatment plan ☑ Coordinating receipt of needed services from healthcare practitioners, providers, and facilities, home- and community-based providers, social service providers, and caregiver ☑ Communication with practitioners, home-and community-based service providers, hospitals, and skilled nursing facilities regarding patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes ☑ 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	☑ 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 to patient as needed to accomplish treatment plan ☑ Coordinating receipt of needed services from healthcare practitioners, providers, and facilities, home- and community-based providers, social service providers, and caregiver ☑ Communication with practitioners, home-and community-based service providers, hospitals, and skilled nursing facilities regarding 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 ☑ Facilitating access to community-based social services to address SDOH needs ☑ Helping the patient contextualize health education provided by the treatment team

☑ Facilitating access to community-based social services to address SDOH needs ☑ Helping the patient contextualize health education provided by the treatment team and educating the patient on how to best participate in medical decision-making ☑ Building patient self-advocacy skills ☑ Helping the patient access healthcare including identifying appropriate practitioners or providers for clinical care and helping secure appointments with them ☑ Facilitating behavioral change 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 patient cope with the problem addressed, the SDOH needs, and adjust daily routines to better meet diagnosis and treatment goals ☑ Leverage lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals.	and educating the patient on how to best participate in medical decision-making ☑ Building patient self-advocacy skills in ways that are more likely to promote personalized and effective treatment of their condition ☑ Helping the patient access healthcare including identifying appropriate practitioners or providers for clinical care and helping secure appointments with them ☑ Providing patient with information/resources to consider participation in clinical trials/research ☑ Facilitating behavioral change 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 patient cope with the condition, the SDOH needs, 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

Principal Illness Navigation – Peer Support
☑ Person-centered interview to better understand the individual context of the serious, high-risk condition and 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 to patient as needed to accomplish treatment plan. ☑ Identifying or referring patient (and caregiver or family) to appropriate supportive services.

Principal Illness Navigation – Peer Support (cont'd)
☑ Assist the patient in communicating with practitioners, home-and community-based service providers, hospitals, and skilled nursing facilities regarding patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors. ☑ Facilitating access to community-based social services to address SDOH needs. ☑ Helping the patient contextualize health education provided by the treatment team and educating the patient on how to best participate in medical decision-making. ☑ Building patient self-advocacy skills in ways that are more likely to promote personalized and effective treatment of their condition. ☑ Developing and proposing strategies to help meet person-centered treatment goals and supporting the patient using chosen strategies to reach person-centered treatment goals. ☑ Facilitating and providing social and emotional support to help patient cope with the condition, the SDOH needs, 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.

References

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