Billing Guidance for Community Health Integration and Principal Illness Navigation

Peer Support Services for Federally Qualified Health Centers and Rural Health Centers

Partnership to Align Social Care

A National Learning & Action Network

Contents

Federally Qualified Health Centers (FQHCs) are reimbursed based on the Prospective Payment System (PPS). FQHCs began switching to a Prospective Payment System (PPS) in 2014 due to Section 10501 of the Patient Protection and Affordable Care Act of 2010.[1] In contrast, Rural Health Centers (RHCs) are paid using an all-inclusive rate (AIR) formula.

Under the PPS and AIR regulations, FQHCs/RHCs reimbursement rates take into consideration the costs of the individual center. FQHCS/RHCs operate in designated medically underserved areas (MUA) or health professional shortage area (HPSAs). Generally, FQHCs/RHCs can only be reimbursed for one (1) medical encounter per beneficiary per day.[2]

Together FQHCs and RHCs provide services to millions of Americans annually. The purpose of this billing guidance is to help FQHCs and RHCs understand the billing regulations for community health integration (CHI), principal illness navigation (PIN), and principal illness navigation – peer support (PIN-PS).

FQHCs and RHCs: An Overview

FQHCs are outpatient clinics that provide comprehensive primary and preventive care to individuals in underserved and rural areas. There are 1,400 FQHCs and 20,000 collective service sites and look-alike service sites nationwide.

RHCs are clinics located in a rural, underserved area with a shortage of primary care providers, personal health services, or both. There are 5,200 RHCs nationwide.

1 CMS. FQHC PPS. Available online: https://www.cms.gov/medicare/payment/prospective-payment-systems/fqhc_pps

2 Ibid.

Community Health Integration (CHI) Service Billing Overview

CMS created a set of Healthcare Common Procedure Coding System (HCPCS) codes to capture the labor of auxiliary staff to address identified health related social needs (HRSNs) that directly impact the ability of a qualified practitioner to treat or diagnose a health condition. The benefit reimburses based on time spent addressing identified HRSNs during the course of a calendar month. CHI services are delivered by auxiliary personnel, operating under general supervision of a qualified practitioner including a physician, nurse practitioner, physician assistant, nurse practitioner or clinical nurse specialist. Auxiliary personnel, including community health workers (CHWs), health coaches, nurses, or social workers, or other personnel with applicable training, may perform CHI services, incident to the billing practitioner, under general supervision. Prior to the delivery of CHI services, the qualified practitioner that is providing general supervision, of auxiliary personnel, must complete an initiating visit. The same practitioner that completed the initiating visit, bills for the subsequent CHI services provided by the auxiliary personnel. Please note that FQHCs/RHCs can contract with community-based organizations (CBOs)/community care hubs (CCHs) for purposes of providing CHI/PIN/PIN-PS services. The CBO/CCH can provide auxiliary personnel that deliver CHI/PIN/PIN-PS services, under general supervision of the billing practitioner at an FQHC/RHC.

CHI Eligibility

Medicare Part B beneficiaries who have unmet HRSN(s) need that interfere with, or presents a barrier to, the diagnosis and treatment of the problems identified during an initiating CHI visit are eligible for the program. An individual is not eligible to receive CHI services if they do not have an HRSN identified that has a direct impact on the ability of the provider to treat or diagnose a health condition.[3]

CHI Service Implementation

The steps for CHI implementation include the following:

1. Identify one or more HRSNs (e.g., living environment, access to food, employment status, education and literacy levels, family circumstances).[4]
2. Conduct an initiating visit.
3. Obtain consent (verbal or written).
4. Document HRSNs in the medical record that impact the ability of the healthcare practitioner to treat or diagnose a health condition.
    a. The practitioner should exercise clinical judgment to determine the relative impact of the HRSNs on the ability of the practitioner to treat or diagnose a health condition.
5. Development of a CHI intervention plan.
6. Deployment of services that have a reasonable expectation of addressing the HRSNs impacting the health condition.
7. Documentation of the services performed.

Identifying Health Related Social Needs (HRSNs)

CMS encourages practitioners to utilize a standardized, evidence-based screening tool for health-related social needs in clinical settings.[5] One evidence-based HRSN screening tool is the Accountable Health Communities (AHC) HRSN screening tool. The AHC HRSN screening tool is a 10-item screening tool, with 16 supplemental questions, to identify patient's needs that can be addressed through community services in 4 domains (economic stability, social and community context, neighborhood and physical environment, food. [6]

3 CHI-Reimbursement-Tips.pdf
4 Social determinants of health risk assessment | Medicare
5 Standardized Screening for Health-Related Social Needs in Clinical Settings: The Accountable Health Communities Screening Tool - NAM
6 The AHC Health-Related Social Needs Screening Tool

CHI Initiating Visit

CHI services require an initiating visit with an eligible practitioner. The initiating visit serves as a pre-requisite to the delivery of CHI services. During the initiating visit, the practitioner documents HRSNs that directly impact the ability of the practitioner to treat or diagnose a health condition. The list of HRSNs should be added to the problem list within the medical record, during the initiating visit. Lastly, a CHI intervention plan should be initiated to guide the general supervision of CHI services that will be deployed by auxiliary personnel.

An initiating visit must be an outpatient visit and be at least one of the following visit types:

- Evaluation and Management (E/M) (level 2 or higher)
- Transitional Care Management (TCM)
- Annual Wellness Visit (AWV)

The initiating visit can include a claim for the completion of a SDOH Risk Assessment. Filing a claim for SDOH Risk Assessment is not a requirement for the provision of CHI services.

If HRSN(s) are identified during an inpatient admission, observation, or SNF short stay, the individual must have a separate post-discharge outpatient visit, to serve as the initiating visit for CHI services. Please note that many acute care hospitals have implemented HRSN screening on admission to the hospital. The identification of HRSNs during an inpatient admission does not meet the criteria of an initiating visit for ongoing CHI services.

The practitioner that serves as the rendering provider for subsequent CHI services must be the same practitioner that completed the initiating visit.

Obtain Consent

CHI services are a Medicare Part B benefit. As a Part B benefit there are cost sharing requirements that apply to the receipt of non-exempt Part B benefits. The Medicare Part B cost sharing is referred to as co-insurance. The Medicare Part B co-insurance is 20% of applicable costs.

- The 20% co-insurance requirements for Part B services apply to CHI services.
- The 20% co-insurance requires that the beneficiary be responsible for 20% of the allowable reimbursement for all services rendered.

Each time an individual receives CHI services, the individual is responsible for all applicable deductible and co-insurance fees.

- If an individual has a Medigap policy, the Medigap policy is generally responsible for cost sharing amounts.
- If a person is dual eligible (Medicare + Medicaid), generally Medicaid is responsible for cost-sharing requirements.

Since CHI services mandate that the individual be responsible for applicable cost sharing, it is required that a provider secure a consent from the beneficiary prior to the initiation of CHI services. The consent must be obtained one-time and there is no requirement beyond the initial consent that a repeat consent be obtained.

- Consent must be obtained prior to the initiation of services.
- Consent can be written or verbal.
- Consent must be documented in the medical record.
- The consent process must include the provision of information to the beneficiary regarding the cost-sharing requirements.

The consent process should include informing the individual that only one provider can deliver CHI services at one time. In addition to defining that only one provider can deliver CHI services at a time, the consumer must be made aware of the cost sharing requirements.

Billing for CHI

There are two CPT codes for CHI services. See the billing section below for more detail. The labor expended by auxiliary personnel that operate under general supervision to the provider can be included in the claims for reimbursement, under the CHI codes. CMS allows RCHs and FQHCs to bill concurrently for care management services. This means they can provide CHI, Transitional Care Management (TCM), and other care management services for the same service period.

Principal Illness Navigation (PIN) Overview

Principal Illness Navigation services provide reimbursement for labor expended to provide navigation and case management services for individuals with serious health conditions. PIN services help patients understand their medical diagnoses and navigate the healthcare system effectively.

PIN Services can be performed by the following Medicare Provider types:

- Physician (MD or DO)
- Non-Physician Provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist)
- Clinical Psychologist
- Clinical Social Worker (CSW)

Eligible practitioners can use auxiliary personnel to provide PIN services. PIN services must be performed under general supervision of the billing practitioner.

PIN Eligibility

Medicare Part B beneficiaries who have a serious, high-risk condition that is expected to last at least three (3) months and has the likelihood experiencing worsening health outcomes that could include hospitalization, placement in a nursing facility, physical or mental decline, a sudden worsening of preexisting symptoms, or death. The condition can last more than three (3) months but the minimum threshold is that the condition must be expected to last at least three (3) months.

The determination that a condition meets the criteria of being a qualifying serious, high-risk condition that is expected to last at least three (3) months is at the discretion of the practitioner. The practitioner should exercise clinical judgment to determine if a person has a qualifying condition.

The following list includes some conditions that could be considered serious, high-risk conditions that could qualify an individual for PIN services:

- Dementia
- HIV/AIDS
- Diabetes
- Congestive Heart Failure (CHF)
- Chronic Obstructive Pulmonary Disease (COPD)
- Serious Mental Illness (SMI)
- Substance Use Disorders (SUD)

PIN Program Implementation

The steps for PIN implementation include the following:

1. Identifying one or more health navigation needs.
2. Documentation of a serious, high-risk condition that is expected to last at least three months, and have a likelihood of deterioration or health complications to include hospitalization, nursing home placement, or even death.
3. Clinical judgment exercised by supervising provider that the PIN services are medically necessary resulting from the serious, high-risk condition
4. Development of a PIN intervention plan
5. Deployment of PIN Intervention(s)
6. Documentation of PIN services performed should be included in the EMR

PIN Initiating Visit Requirements

PIN services require an initiating visit. The initiating visit serves as a prerequisite to the delivery of PIN services. The individual must have an initiating visit with an eligible practitioner. During the initiating visit, the practitioner documents the serious, high-

risk condition that is expected to last at least three (3) months and the rationale that PIN services are required. The serious, high-risk condition should be included in the problem list. Lastly, a PIN intervention plan should be initiated to guide the general supervision of PIN services that will be deployed by auxiliary personnel.

An initiating visit must be at least one of the following visit types:

- Evaluation and Management (E/M) level 2 or higher
- Transitional Care Management (TCM)
- Annual Wellness Visit (AWV)
- Psychology Visit
- Health Behavior Assessment and Intervention (HBAI)

The initiating visit must be an outpatient visit.

The initiating visit can include a claim for the completion of a SDOH Risk Assessment. However, filing a claim for SDOH Risk Assessment is not a requirement for the provision of PIN services. A practitioner visit that occurs during an inpatient stay, observation stay, or SNF short stay does not qualify as an initiating visit, for purposes of initiating PIN services. If a person requires PIN services based on the identification of a serious, high-risk condition during an inpatient admission, observation, or SNF short stay, the beneficiary will require a separate post-discharge outpatient visit to serve as the initiating visit for PIN services.

The practitioner that serves as the rendering provider for subsequent PIN services must be the same practitioner that completed the initiating visit. A consent must be obtained prior to the initiation of PIN and CHI services. The consent must be obtained one-time and there is no requirement beyond the initial consent that a repeat consent be obtained. Lastly, the auxiliary personnel or the provider have the authority to obtain a consent for PIN services. The consent must be written or verbal. Documentation of the consent and the required consent elements must be included in the consent documentation.

PIN Billing

There are two HCPCS codes for PIN services. See the billing section below for further guidance. PIN services can be billed once per calendar month, per practitioner. Other care management services can be furnished in the same month if the services are medically reasonable and necessary, meet the requirements, and≈efforts are not counted more than once.

FQHC/RHC Billing Requirements

The billing requirements for CHI/PIN/PIN-PS changed beginning CY2025. Effective January 1, 2025 FQHCs/RHCs must transition to billing for CHI/PIN/PIN-PS using the individual HCPCS codes that were established for these services; and, refrain from using the bundled care management HCPCS code G0511. Prior to CY2025, FQHCs/RHCs used the bundled HCPCS code G0511. The practice of using the bundled HCPCS code G0511, for CHI/PIN/PIN-PS was terminated CY2025. The reimbursement rate for all FQHCs/RHCs, delivering CHI/PIN/PIN-PS is the National Payment Rate, regardless of the geographic location of the FQHC/RHC. In addition, the rate, for CHI/PIN/PIN-PS, is paid outside of the Prospective Payment System (PPS) rate, for FQHCs or the All-Inclusive Rate for RHCs. Lastly, the rate

structure includes payment for the add-on code for CHI/PIN/PIN-PS, based on the amount of time-spent addressing identified needs in a specific calendar month. There is no cap or limit for CHI/PIN/PIN-PS, per calendar month, as long as the services are medically necessary and the interventions deployed are documented in the electronic medical record.

Billing Codes

The following table details the codes that FQHCs/RHCs will use to bill for CHI/PIN/PIN-PS beginning CY2025. FQHCs/RHCs will be paid the National Rate for these services. Payment for CHI/PIN/PIN-PS will be made outside of the Prospective Payment System (PPS) rate for FQHCs or All-Inclusive Rate (AIR) for RHCs.

Please note that CHI/PIN/PIN-PS requires an initiating visit - prior to the delivery of applicable CHI/PIN/PIN-PS services. The initiating visit is billed separately. The initiating visit should be an evaluation/management (level 2 or higher), transitional care management visit (TCM), or annual wellness visit (AWV). The reimbursement for the initiating visit is reimbursed based on the FQHC Prospective Payment System (PPS) rate or RHC All-Inclusive Rate (AIR) structure and paid separately from the reimbursement for CHI/PIN/PIN-PS.

Table 1

CHI/PIN/PIN-PS HCPCS Codes for FQHCs and RHCs

HCPCS Code	Descriptor	National Rate (2025)
Community Health Integration (CHI)		
G0019	Community Health Integration Services (CHI) SDOH 60 min	$77.96
G0022	Community Health Integration Services (CHI); add ea. 30 min	$48.52
Principal Illness Navigation (PIN)		
G0023	PIN Service, 60 minutes per month	$77.96
G0024	PIN Service, add ea. 30 min	$48.52
Principal Illness Navigation - Peer Support (PIN-PS)		
G0140	PIN-Peer Support, 60 minute	$77.96
G0146	PIN-PS, Peer Support, add ea. 30 min	$48.52

FQHCs/RHCs are paid the National Rate regardless of the location that the organization provides services. In addition, the fee for CHI/PIN/PIN-PS is not adjusted based on the current PPS or AIR rate formula for the organization. Lastly, FQHCs/RHCs must bill for CHI/PIN/PIN-PS using the standard approved codes (listed in the table above) with no cap or limit per calendar month.[7]

FQHCs/RHCs can contract with community-based organizations (CBOs), to deliver CHI/PIN/PIN-PS services, to obtain the labor for providing the applicable service. The services are billed based on time (labor). The labor costs are compensated from the reimbursement. Therefore, the reimbursement obtained for the delivery of CHI/PIN/PIN-PS can be used to pay the labor provided to deliver the service. If a CBO provides the labor to deliver CHI/PIN/PIN-PS, the cost of labor is reimbursed from the earned revenue from billing CHI/PIN/PIN-PS.

7 Centers for Medicare & Medicaid Services. CY2025 Physician Fee Schedule Final Rule. Federal Register. Volume 89, No. 236, Page 98009. December 9, 2024. Available online: https://www.govinfo.gov/content/pkg/FR-2024-12-09/pdf/2024-25382.pdf

Partnership to Align Social Care

A National Learning & Action Network

The Partnership to Align Social Care ("Partnership") is a national learning and action network whose purpose is to enable cross-sector collaboration focused on co-designing and sharing solutions that advance sustainable and aligned health and community care delivery systems leveraging community care hubs (CCHs) to promote whole-person health. The Partnership consists of leaders from across the healthcare and social care sectors, including health plans, health systems, providers, community-based organizations, national associations, and government. Partnership stakeholders collectively advance initiatives that build awareness about opportunities to promote whole-person health through coordination across health care providers and CCHs, expand CCH and CBO adoption of opportunities to bill for labor and services that improve whole-person health, and elevate innovative practices among health care sector stakeholders, CCHs, and CBOs pursuing cost-effective partnerships to drive high-quality care.

The Partnership thanks participants in the Billing and Coding Workgroup for developing and contributing to this resource. In particular, the Partnership acknowledges the efforts of:

- **Timothy McNeill,** Chief Executive & Founding Member, Freedmen's Health Consulting
- **Bonnie Ewald,** Managing Director, Center for Health and Social Care Integration, Department of Social Work and Community Health, Rush University Medical Center

For more information about the Partnership to Align Social Care, visit **www.partnership2asc.org**.