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CONDUCTING THE MEDICARE INITIATING VISIT

Conducting the Initiating Visit

for Community Health Integration (CHI), Principal Illness Navigation (PIN), and Chronic Care Management (CCM) Services

- Program Definitions
- Purpose of the Initiating Visit
- Visit Flow Overview

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Program Definitions

Program	Criteria	Clinical Example
CHI: Community Health Integration	Patient has at least one **health-related social need** (e.g., housing, food, transportation, utilities, safety) that affects their ability to manage a medical condition.	Stable hypertension but can't afford meds, no transportation to appointments.
PIN: Principal Illness Navigation	Patient has **one** serious, high-risk, or complex condition expected to last ≥3 months that requires active care navigation and coordination.	Newly diagnosed heart failure; multiple specialist referrals needed.
CCM: Chronic Care Management	Patient has **two or more** chronic conditions expected to last ≥12 months (or until death) that place the patient at significant risk of death, acute exacerbation, or functional decline.	Diabetes + COPD, requiring ongoing care coordination.

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Purpose of the Initiating Visit

- Establish patient eligibility for CHI, PIN, or CCM
- Gather clinical, functional, and social determinants of health (SDOH) information
- Build the foundation for a 12-month care plan
- Obtain patient consent for participation
- Document findings to meet CMS requirements

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Visit Flow Overview

Step 1

Welcome & build rapport

Step 2

Explain the programs: CHI/PIN/CCM

Step 3

Gather medical history & current conditions

Step 4

Social Determinants of Health (SDOH) Screening

Step 5

Review functional & access barriers

Step 6

Summarize findings & recommend services

Step 7

Document & obtain consent

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Step 1: Welcome & Build Rapport

1. Greet patient warmly, introduce yourself, and explain your role

   To oversee any services the patient may need or receive from us

2. Clarify/state the purpose of the visit

   To learn about the patient's situation, needs, and goals in order to determine if navigation services are appropriate

3. Use patient-friendly language

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EXAMPLE SCRIPT - Introductions

“Good morning, I’m [Name], and I’ll be your doctor [or your correct credential] today.

I understand you have some ongoing health concerns. Today’s visit is designed to make sure we understand your needs and anything that may be making it hard for you to get the care you need.”

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Step 2: Explain the Programs

- **CHI – Community Health Integration**
  - Addresses community resource needs, navigation, and non-clinical barriers

- **PIN – Principal Illness Navigation**
  - Focuses on a single serious or high-risk condition

- **CCM – Chronic Care Management**
  - For patients with multiple chronic conditions needing coordinated care

Emphasize: These programs do not replace your primary care or other care teams; they enhance your support network and provide you services others may not be set up to offer.

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EXAMPLE SCRIPT - Program Descriptions

"Medicare offers programs that provide a patient advocate—someone who can help you coordinate your care, track down test results, arrange appointments, help with medication questions, and connect you with resources in your community.

One program, called ***Community Health Integration****, focuses on social and practical needs like transportation or help at home.*

Another program, ***Principal Illness Navigation****, is for people managing one or multiple serious conditions, to make navigating the healthcare system easier.*

If you qualify for these services, and you'd like to participate, we can start that process today."

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Step 3: Gather Medical History & Current Conditions

- Review chronic conditions and ICD-10 codes
- Ask about recent changes in symptoms
- Review medications and side effects
- Identify pending test results or specialist referrals
- Note functional needs (mobility, self-care, DME)

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EXAMPLE SCRIPT - History Gathering

“Can you tell me what’s been most frustrating or challenging about your care lately?”

“How are you managing your medications? Any side effects or concerns?”

“Have there been delays in getting test results or seeing specialists?”

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Step 4: SDOH Screening

Ask brief, validated questions* about:

- Food insecurity
- Housing stability
- Transportation
- Utilities
- Safety

We provide an assessment tool for you to use and document.

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EXAMPLE SCRIPT - SDOH Assessment

"How do you get to your appointments? Do you have reliable transportation to appointments?"

"Do you live alone, and do you have people who can help you if needed?"

"Do you feel confused about or have any trouble understanding your health information or instructions from providers?"

"Is there anything getting in the way of your getting the healthcare you need?"

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Step 5: Review Functional & Access Barriers

- Can the patient travel to appointments?
- Are they able to afford and manage medications?
- Do they have help at home?
- Do they understand their care plans and results?
- Note gaps in communication between providers.

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Step 6: Summarize Findings & Recommend Services

- Review main issues discovered
- Match needs to the most appropriate program(s)*
  - **CHI** for resource linkage and navigation
  - **PIN** for single high-priority condition support
  - **CCM** for complex, multi-condition coordination
- Confirm patient interest

*We will help with this based on your documentation, but your judgment is key to choosing the right program for the patient.

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EXAMPLE SCRIPT - Closing

"Based on what we discussed, I believe a care advocate could help you [INSERT SPECIFICS FROM THE PATIENT NEEDS, SUCH AS get test results faster, review your medications, and arrange any equipment you need].

These services are subject to Medicare coinsurance (20%). If you have Medigap, or a supplemental plan, your plan may cover that. Otherwise, you may be responsible for a portion of the costs.

If you agree, I'll have our team reach out to you to schedule time with an advocate. You can stop the service at any time,

Shall we get started?"

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Step 7: Document & Obtain Consent

- Explain what participation involves
  - Frequency (daily/weekly/biweekly/monthly, based on their needs)
  - Contact method (do they prefer phone or video conference?)
- Document patient consent (oral or written)
- Record start date for monthly tracking
- We will submit the CMS claim based on your documentation, with your approval, using appropriate CPT/HCPCS code(s) for the initiating visit.

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Program Selection: Step 1 - Identify Patient's Clinical Situation

Program	Criteria	Clinical Example
CHI: Community Health Integration	Patient has at least one **health-related social need** (e.g., housing, food, transportation, utilities, safety) that affects their ability to manage a medical condition.	Stable hypertension but can't afford meds, no transportation to appointments.
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Program Selection: Step 2 - Use SDOH + Medical History

1. If SDOH needs are the main barrier → CHI
2. If one high-priority clinical condition dominates → PIN
3. If multiple chronic conditions are present → CCM

Note: Patients may meet criteria for more than one program, but you choose the one that best addresses their highest-need situation.)

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Program Selection: Step 3 - Apply CMS Documentation Requirements

- **Document**:
  - Diagnosis code(s) for qualifying conditions
  - Impact of condition(s) on daily life and function
  - Specific SDOH needs if applicable

- **Attest** to the medical necessity of the program chosen.

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Program Selection: Step 4 - Check for Consent & Coordination

- Get patient consent (oral or written)
- Coordinate with the assigned Auxiliary Personnel
  - We will facilitate the advocate match and connection with the patient

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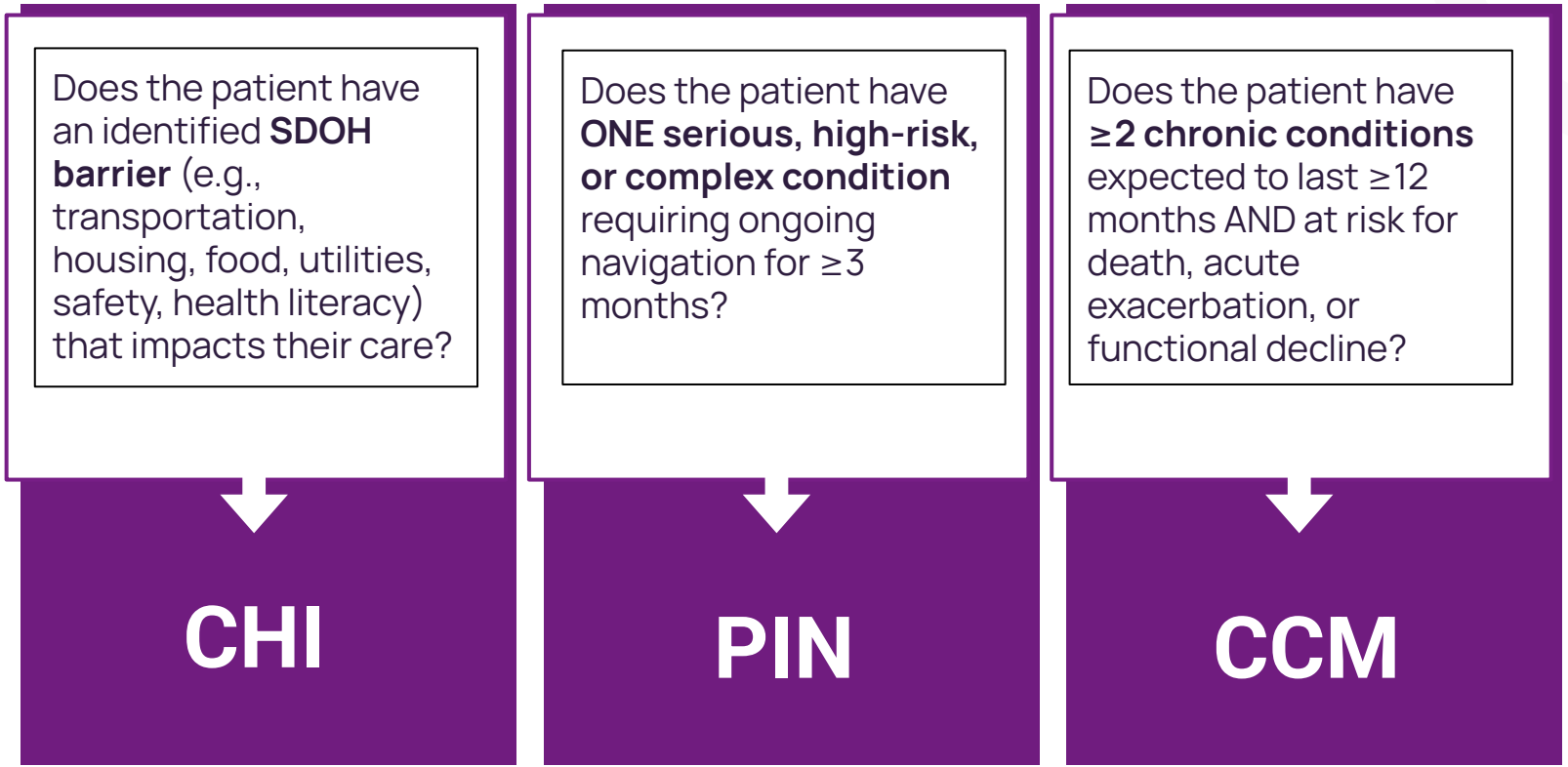
Program Selection Flowchart



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MEDICARE NAVIGATION SERVICES - Community Health Integration (CHI)

Navigation support to address identified social determinants of health gaps

Eligibility	Requirements	Services	Codes
Unmet non-medical needs (social determinants of health) that significantly limit practitioners ability to diagnose and/or treat the patient	Unmet social needs must be identified via assessment and documented	Health system navigation	G0019 - First 60 minutes
Patient must provide consent to receive CHI (which must be renewed if the practitioner changes)	Auxiliary personnel provide services under the supervision of billing practitioner; only one practitioner can provide CHI services at a time	Care planning	G0022 - Additional 30 minutes after initial 60
		Community-based resource facilitation	
	Personnel must be trained or certified in: ● Patient advocacy ● Patient/family communication or capacity-building ● Service coordination/systems navigation ● Individual and community assessment	Home- and community-based care coordination	

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MEDICARE NAVIGATION SERVICES - Principal Illness Navigation (PIN)

Navigation services to help people understand and manage complex conditions

Eligibility	Requirements	Services	Codes
Serious condition likely to last at least 3 months	Initial assessment and annual reassessment by a billing practitioner	Health system navigation	G0023 - 60 minutes/calendar month
Condition poses increased risk for hospitalization or nursing home placement; symptom worsening, or, physical.mental decline	Auxiliary personnel provide navigation services, in compliance with state licensure	Care planning and coordination	G0024 - Additional 30 minutes/calendar month
		Community-based resource and supporting services access facilitation	G0140 - 60 minutes of PIN peer support/calendar month
Examples: ● Cancer ● COPD ● Congestive Heart Failure ● Dementia ● HIV/AIDS ● Mental illness/substance use disorder	Personnel must be trained or certified in: ● Patient advocacy ● Patient/family communication or capacity-building ● Service coordination/systems navigation ● Individual and community assessment	Patient self-advocacy support	G0146 - Additional 30 minutes of PIN peer support/calendar month

MEDICARE NAVIGATION SERVICES - Chronic Care Management

Eligibility	Requirements	Services	Codes
Patients with 2 or more chronic conditions that are expected to last at least 12 months that put them at significant risk of death, acute exacerbation, or functional decline	MDs and non-MDs can bill for CCM services and supervise others: • Nurse Practitioners • Physician Assistants • Certified Nurse Midwives • Clinical Nurse Specialists	Comprehensive care management, including: • Medical, functional, and psychosocial needs assessment • Preventive care access • Support for medication self-management and medication oversight • Coordination with home- and community-based clinical services and non-medical support	99437 - Each additional 30 minutes of chronic care management services by physician or other professional, per calendar month 99439 - Each additional 20 minutes of clinical staff time directed by a physician or other professional,per calendar month
Examples of qualifying condition: • Alzheimers/Dementia • Cancer • Cardiovascular Disease • COPD • Diabetes • Depression • Chronic Kidney Disease • HIV/AIDS • Asthma • Substance Use Disorder	Provider must create and document a comprehensive care plan, including: • Problem list • Prognosis/Expected outcomes • Treatment goals • Functional/cognitive assessment • Planned interventions • Medication management • Caregiver assessment • Environmental evaluation • Coordination with other providers		99487 - First 60 minutes of clinical staff time, per calendar month 99489 - Each additional 30 minutes of clinical staff time, per calendar month 99490 - First 20 minutes of clinical staff time, per calendar month 99491 - First 30 minutes provided personally by a physician or other qualified professional, per calendar month
Patients must consent to services	Patients must have an initiating visit before CCM services can begin		G3002, G3003 - First 30 minutes face-to-face chronic pain management and treatment services provided by physician, additional 15 minutes chronic pain management and treatment by physician or other professional, per calendar month
	Only 1 practitioner can provide CCM services per patient		99424, 99425, 99426, and 9942 - Principal Care Management services for patients with one chronic condition expected to last at least 6-12 months
	24/7 access to clinical staff and secure modes of communication		

SDOH Risk Assessment

- **What is it?**
  - SDOH risk assessment refers to a review of the individual's SDOH needs or identified social risk factors influencing the diagnosis and treatment of medical conditions.

- **Why is it important?**
  - SDOH risk assessment refers to a review of the individual's SDOH needs or identified social risk factors influencing the diagnosis and treatment of medical conditions.

- **What's included?**
  - Any non-medical barrier (e.g., housing, food insecurity, transportation, utilities, etc.)

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SDOH Risk Assessment

- **How to conduct the assessment?**
  - Use standardized, evidence-based SDOH risk assessment tool (provided by Umbra)

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SDOH Risk Assessment

Guidance for Selecting Z Codes:

Use **Z codes** to document SDOH factors identified during the visit.

Examples:

- Z55.0–Z55.9: Problems related to education/literacy (e.g., Z55.6 health literacy)
- Z56.0–Z56.9: Problems related to employment/unemployment
- Z57.0–Z57.9: Occupational exposure risks
- Z59.0–Z59.9: Problems related to housing/economic circumstances (e.g., Z59.82 transportation)
- Z60.0–Z60.9: Problems related to social environment (e.g., Z60.2 living alone)
- Z63.0–Z63.9: Problems related to family/caregiver support

Select **only codes relevant to issues addressed during the visit** and link them to the care plan for CHI, PIN, or CCM.

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MEDICARE NAVIGATION SERVICES - Social Determinants of Health (SDOH) Risk Assessment

Standardized assessment to identify non-medical barriers to diagnosis and/or treatment

Eligibility	Requirements	Services	Codes
Can be conducted as part of an E/M visit, a behavioral health office visit, annual wellness visit, or a telehealth visit	Administration of a standardized, evidence-based, SDOH assessment	Identification of non-medical barriers such as: ● Housing insecurity ● Transportation needs ● Food insecurity	G0136 - One stand-alone SDOH risk assessment performed no more often than every 6 months, lasting 5-15 minutes
Applies when unmet social needs are interfering with practitioner's ability to diagnose and/or treat the patient			

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Documentation Checklist

- ✓ Patient eligibility confirmed
- ✓ Medical history and chronic conditions reviewed
- ✓ SDOH screening completed
- ✓ Functional and access barriers identified
- ✓ Recommended program(s) documented
- ✓ Consent obtained
- ✓ Initiating visit codes recorded
- ✓ Referral to care advocacy services

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Key Takeaways

- Keep language clear and patient-friendly
- Identify both clinical and non-clinical barriers
- Match services to patient's needs
- Obtain and document consent at the same visit
- Your documentation sets the stage for successful care advocacy

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Appendix

Resources

Health Begins Upstream Risks Screening Tool & Guide

References

Medicare and Medicaid Programs; CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program

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Thank you!