NATIONAL COUNCIL for Mental Wellbeing

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HEALTH RELATED SOCIAL NEEDS

MODULE 6

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Background

This module supports organizations to implement evidence-based integrated care approaches specific to identifying health-related social needs (HRSN), also called social determinants, or drivers, of health (SDOH). An unequal distribution of SDOH is the root cause of HRSN at the individual level. For example, a particular community may lack affordable housing options, but individuals may experience housing needs differently. For providers of physical and behavioral health care, HRSN

Notes on Terminology

Social determinants of health (SDOH) are the conditions in which people are born, live, learn, work, play, worship and age, which affect a wide range of health, functioning and quality-of-life outcomes. SDOH are fundamental social and structural factors that touch people's lives and impact their wellness and longevity.

Health-related social needs (HRSN) are social needs at the individual level, including affordable housing, healthy foods and transportation.

describes specific barriers to individual treatment goals due to a person's unique social and environmental conditions. Consistent with terminology and intended use clarifications by the Department of Health and Human Services (HHS)[1] and others,[2] this module will primarily use the term "HRSN" unless using direct quotes with alternative terminology, such as when referencing billing code descriptions.

While most mental health and substance use care providers have experience navigating patients' HRSN in their practices, the content of this module is organized to support providers' efforts to implement new sustainable billing options for HRSN. This module should be used in tandem with the Integrated Care Financing Decision Support Tool and provides interactive billing, reimbursement and aggregate financial modeling insights to support implementation. Please contact the Center of Excellence for Integrated Health Solutions if you have any questions or concerns.

Contents

INTRODUCTION

The integrated care movement has long emphasized the importance of better integrating and collaborating care across mental health, substance use and physical health care to improve health outcomes and service delivery across the health care system. Ensuring that evidence-based integrated care approaches are widespread and accessible to all consumers hinges on sustainable financing strategies. This module provides information regarding emerging financing strategies for supporting HRSN assessments and follow-up services that can be used in multiple locations where physical health and/or behavioral health services are provided, as well as in nontraditional health care settings such as community-based organizations (CBOs).

Research tells us that social and structural factors play a critical role in driving disparate health outcomes. Depending on the source of the data, socioeconomic factors can drive 50%-80% of all health outcomes, while clinical care comes in at 10%-20%.[3,4] People with identified behavioral health needs are also more likely to have unmet or adverse HRSN.[5] Recognizing these significant drivers, in November 2023, HHS made a significant policy statement in its "Call to Action: Addressing Health-Related Social Needs in Communities Across the Nation."[6] In this publication, HHS highlights multiple opportunities to address unmet HRSN through Medicaid, Medicare, the Administration for Community Living, the Centers for Disease Control and Prevention (CDC) and the Office of the National Coordinator for Health Information Technology.

Within this context of quickly evolving standards and opportunities, health care organizations and providers are critical partners and collaborators in implementing these new approaches to service delivery. Although it is not the focus of this module, a variety of data sources are available to health care organizations seeking to learn more about local social and environmental conditions.

Data Sources on Local Social and Environmental Conditions

- The Centers for Medicare and Medicaid Services (CMS) Office of Minority Health's Mapping Medicare Disparities Tool can help identify the areas of greatest need for populations served.
- The CDC's data tools and resources can help organizations identify and address SDOH at the system level.[7]
- The Data Set Directory of Social Determinants of Health at the Local Level lists a number of sources on various social, economic and environmental conditions.
- Providers can perform their own analyses by conducting a local needs assessment and may already be required to do so depending on their organization type, such as Certified Community Behavioral Health Clinics (CCBHCs). Needs assessments focused on SDOH are recommended to be conducted in partnership with local community care hubs and/or CBOs.[8]

Understanding local social and environmental conditions at the population level may assist providers when developing a framework to address HRSN at the individual level, including:

- Screening and assessment to identify individual social risk factors and adverse conditions.
- Identifying appropriate clinical adjustments and interventions.
- Establishing closed-loop referral pathways with social services providers and CBOs.
- Implementing data management and coding strategies to track identified needs and impact or resolution.
- Integrated staffing models to implement individual navigation, education and referral tasks related to identified needs.

A large array of social care IT platforms are also available to providers seeking to implement these frameworks at scale.

Supporting these strategies, health insurers are increasingly providing reimbursement for providers to tackle HRSN in their practices. While state-level Medicaid programs have long been able to pay for services to address HRSN of specific populations through coverage of home- and community-based waiver programs, non-emergency medical transportation and services like case management, recent changes in Medicaid policy options and Medicare reimbursement are paving the way to broader adoption and integration across physical health and behavioral health practices, as well as within CBOs.

Coverage Landscape

The national health care financing landscape is complex and variable, often informed by local factors, such as state policy decisions, allocation of categorical grant-based funding, health insurance coverage and payer priorities. The growing shift toward alternative payment models and value-based care has accelerated the interest in addressing HRSN, which can lower health care costs, improve health outcomes and increase the cost-effectiveness of health care services and interventions.[9]

Although this module is focused on fee-for-service financing considerations for HRSN, the insights are universally applicable to organization settings that are financed through alternative payment mechanisms such as cost-based, prospective and value-based payment arrangements, recognizing that fee-for-service cost considerations are often the financial benchmark to structure alternative payment mechanisms. Additional guidance on how to adapt services across various health care settings is highlighted in the "Billing Medicare for New HRSN codes in Different Health Care Settings" subsection and focuses primarily on standards applied to new Medicare billable services for addressing HRSN, as other payer standards lack comparable uniformity.

The national landscape for coverage of services to address HRSN is rapidly evolving, with varying reimbursement opportunities across state-level Medicaid programs, Medicare plans, and qualified health plans offered through state health insurance marketplaces. Despite a general lack of standardization, health care policymakers are making progress on rapidly expanding reimbursement options for organizations looking to implement sustainable HRSN service offerings.

MEDICAID

Coverage of services to address HRSN has historically been limited to state Medicaid programs, particularly for home- and community-based service (HCBS) waiver programs. However, in recent years there has been increased standardization and expansion of Medicaid coverage and billing options.

A series of policy documents have been published by CMS and the Children's Health Insurance Program (CHIP) since 2021 that together clarify, emphasize and support state coverage of services to address health-related social needs in ways that move beyond traditional HCBS waiver approaches and populations. Although not uniformly adopted in all states, these options represent an important shift in federal policy and promote service delivery approaches for new provider types, including physical and behavioral health providers and organizations, to address HRSN.

Recent Medicaid Policy Communications

- The Center for Medicaid and CHIP Services (CMCS) Informational Bulletin: Coverage of Services and Supports to Address Health-related Social Needs in Medicaid and the Children's Health Insurance Program (November 2023). This bulletin compiles recent guidance into a high-level compliance framework for states, with available coverage authorities to address HRSN.
- Medicaid managed care. CMS published a State Medicaid Director Letter in January 2023, describing innovative options states may consider employing in Medicaid managed care programs to address HRSN using a service or setting that is provided to an enrollee "in lieu of" an authorized service or setting (known as an "in lieu of" service or ILOS) covered under the Medicaid state plan. This Medicaid managed care approach allows states to expand HRSN support to populations that don't receive HCBS.
- Since November 2022, a new Medicaid 1115 (innovation) waiver opportunity has also been made available that standardizes expectations for approved states to provide evidence-based housing and nutritional services designed to mitigate the negative health impacts of unmet HRSN. KFF[10] provides a helpful compendium of up-to-date information about states with approved and pending SDOH provisions.

MEDICARE

In Medicare, HRSN historically have been addressed through supplemental benefits in Medicare Advantage and through the Merit-based Incentive Payment System and the Medicare Shared Savings Program in the traditional Medicare program.[11]

This module highlights new Medicare coding and financially sustainable service options to address HRSN, which were finalized by CMS in late 2023 and early 2024. The new covered services under Medicare Part B are expected to be included in Medicare Advantage and Special Needs Plans annual coverage and fee schedule updates by September 30, 2024, and made effective by January 1, 2025. These new options are available for billing practitioners who are eligible to bill under the Medicare physician fee schedule.

New Place of Service (POS) 27 — Outreach Site/Street. CMS created this new POS code, effective in October 2023, to indicate when a service is provided in a nonpermanent location on the street or found environment, not described by any other POS code, where preventive, screening, diagnostic or treatment services are provided to unsheltered, homeless patients.[12]

New Covered Codes — In January 2024, Medicare finalized new rules[13] that expand service options to support both HRSN assessments and services to mitigate and/or address identified needs. The codes are summarized here and are defined in greater detail in the "New Medicare Codes and Specifications" section of this module.

- G0019, G0022: Community health integration
- G0136: SDOH risk assessment
- G0023, G0024: Principal illness navigation
- G0140, G0146: Principal illness navigation — peer support

QUALIFIED HEALTH PLANS

A qualified health plan is an insurance plan that is certified by the Health Insurance Marketplace® and meets the Affordable Care Act requirement for providing "minimum essential coverage."[14] All plans offered in the Marketplace cover 10 essential health benefits;[15] however, specific services covered in each broad benefit category can vary based on each state's requirements. Plans may also offer additional benefits that are not mandated, such as dental coverage, vision coverage and medical management programs (for specific needs like weight management, back pain and diabetes). HRSN services and supports may be included under multiple essential health benefit categories but are not required to be offered. Plan-by-plan adoption will vary, requiring local plan-by-plan outreach efforts to determine if specific reimbursement options exist for enrolled providers and members.

Screening and Assessment for HRSN

There are multiple standardized, evidence-based screening and assessment tools to identify HRSN. Frequently, provider electronic health record (EHR) platforms will also have options to add standardized HRSN questions. Although there is no national consensus around one specific tool for screening or assessment of HRSN, prominent examples include the following:

- The Accountable Health Communities (AHC) Screening Tool is promoted by CMS as part of the AHC model and is appropriate for use in a wide range of clinical settings, including primary care practices, emergency departments, labor and delivery units, inpatient psychiatric units, behavioral health clinics and other places where people access clinical care.
- The Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE) Screening Tool consists of a set of national core measures, as well as a set of optional measures for community priorities.

While many other screening tools are available, these two are also identified by CMS in the recent 2024 Medicare rulemaking[16] as appropriate for use when billing the new G-code, SDOH risk assessment (G0136), which requires clinical practices to use a standardized, evidence-based SDOH risk assessment tool that has been tested and validated through research. The tool is also required to include the domains of food insecurity, housing insecurity, transportation needs and utility difficulties.

Additional resources to evaluate choice of screening tools include the following:

- The Gravity Project[17] provides a downloadable comparison table[18] of social risk screening assessment instruments and their associated SDOH domains, web links where readily available and the status of Logical Observation Identifiers Names and Codes (LOINC) encoding.
- The Social Interventions Research and Evaluation Network[19] provides a downloadable comparison table[20] of social risk screening tools that can support selection decisions. It includes information about each tool's length, target populations, reading level, translations and cost, among other considerations.

Service Delivery Adjustments and Interventions

There are multiple ways for providers to respond when a patient identifies an adverse social or environmental condition as a need. Although health care providers are typically not positioned to "solve" the wide range of social barriers to health, they are often able to take actions in creating care plans that may account for social conditions and help patients access key social services. Examples of adjustments to routine clinical care that seek to accommodate identified social barriers include:[21]

- Providing language- and literacy-appropriate services.
- Reducing the patient panel size for clinicians serving people with socially complex needs.
- Offering open-access scheduling or evening and weekend clinic access.
- Providing telehealth services.

These examples are not interventions focused on changing underlying social risk; they are adaptations to traditional care designed to accommodate patients' social contexts.

In the new 2023 Social Need Screening and Intervention, an improved Healthcare Effectiveness Data and Information Set (HEDIS) measure, the National Committee for Quality Assurance (NCQA) also identified eight categories of appropriate clinical response to identified social risk factors.[22]

INTERVENTION TYPE	INTERVENTION EXAMPLE[23]
Assessment	Discussed in the prior section, "Screening and Assessment for HRSN"
Assistance	Assistance with an application to a homelessness prevention program.
Coordination	Coordination of a care plan.
Counseling	Counseling for readiness to implement a food insecurity care plan.
Education	Education about an area agency on aging (AAA) program.
Evaluation	Evaluation of eligibility for a fuel voucher program.
Referral	Connections to relevant social care resources, such as referral to an AAA.
Provision	Providing needed resources, such as home-delivered meals.
Interventions are captured via Current Procedural Terminology (CPT), Systematized Nomenclature of Medicine (SNOMED) and Healthcare Common Procedure Coding System (HCPCS) codes.	

The National Council for Mental Wellbeing's Toolkit for Designing and Implementing Care Pathways is a useful resource for providers looking to design and implement new care pathways.

Data Management

Data management and tracking for HRSNs includes the following key activities: the ability to capture screening results and to identify clinical adjustments and interventions; the ability to manage needed service referrals; and the ability to receive referral feedback and track outcomes. This section focuses primarily on Z-codes used to support service documentation, recognizing that new codes to document interventions may be available in the future. Additional provider resources from the Office of the National Coordinator for Health Information Technology on HRSN data management include:

- Social Determinants of Health Information Exchange Toolkit (HealthIT.gov)
- Social Determinants of Health (HealthIT.gov)

Z-CODES FOR USE WITH HRSN SCREENING

Z-codes are a set of ICD-10-CM codes used to report social, economic and environmental determinants known to affect health and health-related outcomes. Z-codes are a tool for identifying a range of issues related to education and literacy, employment, housing, ability to obtain adequate amounts of food or safe drinking water, occupational exposure to toxic agents, dust or radiation, and other conditions. Z-codes can be used in any health setting (e.g., doctor's office, hospital, skilled nursing facility) and by any provider (e.g., physician, nurse practitioner). Nine broad categories of Z-codes represent various hazardous social, economic and environmental conditions, each with several sub-codes. These codes should be assigned only when the documentation specifies that the patient has an associated problem or risk factor that influences their health.

New HRSN billing options under Medicare require documentation in the medical record, and Medicare calls out Z-codes (Z55-Z65) as an appropriate documentation method to facilitate high-quality communication between providers and better understand the needs of beneficiaries.

Providers can use the CDC's National Center for Health Statistics ICD-10-CM Browser tool[24] to search for all the current Z-codes. The CMS Health Equity Assistance Program's infographic on how to use Z-codes provides summary level information and does not include the subsets of codes available within each category.

- Z55 – Problems related to education and literacy
- Z56 – Problems related to employment and unemployment
- Z57 – Occupational exposure to risk factors
- Z58 – Problems related to physical environment
- Z59 – Problems related to housing and economic circumstances
- Z60 – Problems related to social environment
- Z62 – Problems related to upbringing
- Z63 – Other problems related to primary support group, including family circumstances
- Z64 – Problems related to certain psychosocial circumstance
- Z65 – Problems related to other psychosocial circumstance

New Medicaid Service Types and Definitions

This section briefly touches on newly available Medicaid coverage options at the federal level, as coding strategies currently have significant variation on a state-by-state basis depending on specifications developed by individual state Medicaid programs and their implementation through Medicaid managed care plans. At the federal level, CMCS has provided new guidance and standards for nutrition and housing HRSN services and supports considered allowable under specific Medicaid and CHIP authorities. This table is adapted from Coverage of Health-related Social Needs Services in Medicaid and CHIP.

HRSN CATEGORY	SERVICE DESCRIPTIONS	MEDICAID COVERAGE AUTHORITY
Nutrition	1. Case management services for access to food/nutrition (e.g., outreach and education and linkages to other state and federal benefit programs, benefit program application assistance and benefit program application fees).	■ Medicaid/CHIP managed care in lieu of service or setting (ILOS) ■ HCBS authorities Section 1915(c), 1915(i), 1915(j), 1915(k) ■ Section 1115 demonstrations ■ CHIP Health Services Initiatives (*not previously approved*)
	2. Nutrition counseling and instruction, tailored to health risk, nutrition-sensitive health conditions and/or demonstrated outcome improvement (e.g., guidance on selecting healthy food and healthy meal preparation).	■ Medicaid/CHIP managed care ILOS ■ HCBS authorities Section 1915(c), 1915(i), 1915(j), 1915(k) ■ Section 1115 demonstrations ■ CHIP Health Services Initiatives
	3. Home-delivered meals or pantry stocking tailored to health risk and eligibility criteria, certain nutrition-sensitive health conditions and/or specifically for children or pregnant people (e.g., meals medically tailored to high-risk expectant people at risk of or diagnosed with diabetes).	■ Medicaid/CHIP managed care ILOS ■ HCBS authorities Section 1915(c), 1915(i), 1915(j), 1915(k) ■ Section 1115 demonstrations ■ CHIP Health Services Initiatives (*not previously approved*) *Limitations on # of meals and coverage duration apply.*

HRSN CATEGORY	SERVICE DESCRIPTIONS	MEDICAID COVERAGE AUTHORITY
Nutrition	4. Nutrition prescriptions tailored to health risk, certain nutrition-sensitive health conditions and/or demonstrated outcome improvement (e.g., fruit and vegetable prescriptions, protein boxes, food pharmacies and healthy food vouchers).	■ Medicaid/CHIP managed care ILOS ■ HCBS authorities Section 1915(c), 1915(i), 1915(j), 1915(k) ■ Section 1115 demonstrations ■ CHIP Health Services Initiatives (*not previously approved*) *Limitations on # of meals and coverage duration apply.*
	5. Grocery provisions for high-risk people to avoid unnecessary acute care admission or institutionalization.	■ Medicaid/CHIP managed care ILOS ■ HCBS authorities Section 1915(c), 1915(i), 1915(j), 1915(k) ■ Section 1115 demonstrations ■ CHIP Health Services Initiatives (*not previously approved*) *Limitations on # of meals and coverage duration apply.*
Housing	1. Housing supports without room and board, such as housing transition and navigation services (e.g., finding and securing housing), pre-tenancy navigation services, one-time transition and moving costs (e.g., security deposits, application and inspection fees, utilities activation fees and payment in arrears, movers), tenancy and sustaining services and individualized case management (e.g., linkages to state and federal benefit programs, benefit program application assistance and fees, eviction prevention, tenant rights education).	■ Medicaid/CHIP managed care ILOS ■ HCBS authorities Section 1915(c), 1915(i), 1915(j), 1915(k) ■ Section 1115 demonstrations ■ CHIP Health Services Initiatives
	2. First month's rent as a transitional service.	■ Medicaid/CHIP managed care ILOS ■ HCBS authorities Section 1915(c), 1915(i), 1915(j), 1915(k) (1915(k) only and via ARP 9817) ■ Section 1115 demonstrations ■ CHIP Health Services Initiatives

HRSN CATEGORY	SERVICE DESCRIPTIONS	MEDICAID COVERAGE AUTHORITY
Housing	3. Short-term pre-procedure and/or post-hospitalization housing with room and board, only where integrated, clinically oriented recuperative or rehabilitative services and supports are provided. Pre-procedure and post-hospitalization housing are limited to a clinically appropriate amount of time.	■ Medicaid/CHIP managed care ILOS ■ HCBS authorities Section 1915(c), 1915(i), 1915(j), 1915(k) ■ Section 1115 demonstrations (time limits apply) ■ CHIP Health Services Initiatives (*not previously approved*)
	4. Caregiver respite with or without room and board.	■ Medicaid/CHIP managed care ILOS ■ HCBS authorities Section 1915(c), 1915(i), 1915(j), 1915(k) ■ Section 1115 demonstrations ■ CHIP Health Services Initiatives (*also available under CHIP state plan*)
	5. Short-term post-transition housing with room and board where clinically oriented rehab services and supports may or may not be integrated, following allowable transitions and limited to a clinically appropriate amount of time.	■ Medicaid/CHIP managed care ILOS ■ HCBS authorities Section 1915(c), 1915(i), 1915(j), 1915(k) *MFP only for HCBS authorities ■ Section 1115 demonstrations (*time limits apply*) ■ CHIP Health Services Initiatives (*not previously approved*)
	6. Utility assistance.	■ Medicaid/CHIP managed care ILOS ■ HCBS authorities Section 1915(c), 1915(i), 1915(j), 1915(k) ■ MFP only for HCBS authorities ■ Section 1115 demonstrations (*time limits apply*) ■ CHIP Health Services Initiatives (*not previously approved*)

HRSN CATEGORY	SERVICE DESCRIPTIONS	MEDICAID COVERAGE AUTHORITY
Housing	7. Day habilitation programs without room and board.	■ Medicaid/CHIP managed care ILOS ■ HCBS authorities Section 1915(c), 1915(i), 1915(j), 1915(k) ■ Section 1115 demonstrations ■ CHIP Health Services Initiatives (*not previously approved*)
	8. Sobering centers (<24 hour stay) without room and board.	■ Medicaid/CHIP managed care ILOS ■ HCBS authorities Section 1915(c), 1915(i), 1915(j), 1915(k) ■ Section 1115 demonstrations ■ CHIP Health Services Initiatives (*not previously approved*)
	9. Home remediations that are medically necessary (e.g., air filtration, air conditioning or ventilation improvements; refrigeration for medications; carpet replacement; mold and pest removal; housing safety inspections).	■ Medicaid/CHIP managed care ILOS ■ HCBS authorities Section 1915(c), 1915(i), 1915(j), 1915(k) ■ Section 1115 demonstrations ■ CHIP Health Services Initiatives
	10. Home/environmental accessibility modifications (e.g., wheelchair accessibility ramps, handrails, grab bars).	■ Medicaid/CHIP managed care ILOS ■ HCBS authorities Section 1915(c), 1915(i), 1915(j), 1915(k) ■ Section 1115 demonstrations ■ CHIP Health Services Initiatives (*Also available under CHIP state plan*)

New Medicare Codes

As mentioned in the earlier section on Coverage Landscape Considerations, starting in January 2024 Medicare established new billing codes to address HRSN, available under the Physician Fee Schedule. The new codes support payment for the administration of SDOH risk assessments, community health integration (CHI) and principal illness navigation (PIN) services provided by certified auxiliary personnel, including community health workers, care navigators and peer support specialists. These changes are the first specifically designed to account for the the involvement of auxiliary personnel in service provision, which in turn encourages their inclusion and reduces the burden on clinicians to expand access to needed services.[25]

SDOH Risk Assessments

CMS has published coding specifications and payment for SDOH risk assessments, to recognize the time and resources providers spend assessing social factors that may impact patient care. The risk assessment is a standard evidence-based tool tailored for a patient's health literacy level, as well as educational, developmental, cultural and linguistic background. With these new codes, Medicare will separately pay for an SDOH risk assessment once every six months. The visit can be on the same day as an in-person or telehealth evaluation and management visit or during a Medicare annual wellness visit.

CHI and PIN Services

CHI services address unmet HRSN that affect the diagnosis and treatment of a patient's medical conditions, while PIN services help people who are diagnosed with high-risk conditions (including mental health and substance use disorders) identify and connect with appropriate clinical and HRSN support resources. Medicare has added coding and payment for both CHI and PIN services to reimburse auxiliary personnel for the time and resources required to connect beneficiaries with the additional HRSN support they need to produce positive health outcomes.

Health Equity and PIN

The Medicare final rulemaking also discusses the important implications that PIN has for health equity. For example, members of historically disadvantaged communities and communities of color often receive lower rates of patient navigation, are often diagnosed with serious, high-risk illnesses like cancer at later stages, and have longer times between suspicion and definitive diagnosis for conditions like cancer. It is hoped that PIN services will fill a critical gap in navigation services, noting that many navigation programs are currently grant funded and unable to serve all patients that might benefit.

BILLING MEDICARE FOR NEW HRSN CODES IN DIFFERENT HEALTH CARE SETTINGS

As stated previously, most Medicare-reimbursed HRSN services may be provided across different health care settings as long as qualified providers furnish the service. CHI services are geared toward physical health care delivery settings, while PIN and peer support services specifically include behavioral health settings and the services furnished by qualified clinical psychologists and certified peers.

Specific to the national movement to address HRSN, HHS also encourages contracts with third-party entities, specifically community care hubs[26] and community-based organizations (CBOs), so each of these new services can be embedded into new locations where qualified auxiliary staff are employed under the general supervision of a qualified billing provider. Auxiliary staff employed through third parties are not limited to CBOs and may include other behavioral health personnel, such as community health workers, certified peers, licensed clinical social workers and nurses (RN or LPN).

Medicare references to CBOs includes public or private not-for-profit entities that provide specific services to the community, or targeted populations in the community, to address the HRSN of those populations. They may include community action agencies, housing agencies, area agencies on aging, centers for independent living, aging and disability resource centers or other nonprofits that apply for grants or contract with health care entities to perform social services. CBOs may receive grants from other agencies in HHS or receive state-funded grants to provide social services.

In late 2023, CMS created POS code 27 to indicate when a preventive, screening, diagnostic or treatment service is provided to unsheltered individuals. The new POS code is used on professional claims to specify the location where service(s) were rendered. This change aligns with broader CMS efforts to address economic, social and other obstacles impacting Medicare beneficiary health care access, by helping identify services provided to those who may be unable to access brick-and-mortar settings, as well as potentially allow tracking of care that is provided through outreach sites. Individual payers will have different reimbursement policies for use of this code, requiring local outreach to determine available use for each provider.[27]

New Medicare Code Specifications

The following tables provide specification for each of the new Medicare codes based on information provided by Medicare in its January 2024 Physician Fee Schedule final rulemaking.[28]

SDOH RISK ASSESSMENT (G0136)

Full code description: Administration of a standardized, evidence-based SDOH assessment, 5-15 minutes, not more often than every six months.

SDOH RISK ASSESSMENT (G0136) SPECIFICATIONS		
Category	**Specifications**	**Notes**
Qualified practitioner	Physicians and qualified practitioners. Behavioral health practitioners may furnish the SDOH risk assessment in conjunction with the behavioral health office visits they use to diagnose and treat mental illnesses and substance use disorders.	Physicians include doctors of medicine, osteopathy, dental surgery or dental medicine, podiatric medicine, optometry and, with respect to certain specified treatment, a doctor of chiropractic legally authorized to practice by a state where they perform this function. Services performed by a physician within these definitions are subject to any limitations imposed by the state on the scope of practice. "The following practitioners may deliver services without direct physician supervision: nurse practitioners and physician assistants in rural health clinics, designated manpower shortage area or HMOs, qualified clinical psychologists, clinical social worker, certified nurse midwives, and certified registered nurse anesthetists."[29]
Auxiliary personnel	Allowed according to Medicare "incident to" billing guidelines.	"Auxiliary personnel means any individual who is acting under the supervision of a physician (or other practitioner), regardless of whether the individual is an employee, leased employee, or independent contractor of the physician (or other practitioner) or of the same entity that employs or contracts with the physician (or other practitioner), has not been excluded from the Medicare, Medicaid and all other federally funded health care programs by the Office of Inspector General or had his or her Medicare enrollment revoked, and meets any applicable requirements to provide incident to services, including licensure, imposed by the State in which the services are being furnished."[30]

Workflow	The SDOH risk assessment is meant to be furnished in conjunction with: - An evaluation and management (E/M) visit, which can include hospital discharge or transitional care management services. - Behavioral health office visits, such as psychiatric diagnostic evaluation and health behavior assessment and intervention. - The Medicare Annual Wellness Visit (AWV). In addition to an outpatient E/M visit (other than a Level 1 visit by clinical staff), SDOH risk assessment can also be furnished with CPT code 90791 (psychiatric diagnostic evaluation) and the health behavior assessment and intervention services, described by CPT codes 96156, 96158, 96159, 96164, 96165, 96167 and 96168.	The SDOH risk assessment may be performed on the same date as the associated E/M or behavioral health visit, but it is not required. This also aligns with when the SDOH risk assessment is performed in conjunction with an AWV, as the AWV may be split over two visits. In most cases, the SDOH risk assessment would not be performed in advance of the associated E/M or behavioral health visit. The SDOH risk assessment is not designed to be a screening. The assessment should be tied to one or more known or suspected SDOH needs that may interfere with the practitioners' diagnosis or treatment of the patient.
Locations	The SDOH risk assessment can be billed in outpatient settings, including physical health and behavioral health. CMS has expressed interest in learning more about the ideal settings for this service and intends to continue examining this issue in future rulemaking.	
Frequency	The SDOH risk assessment may also be furnished with hospital discharge visits, to remain consistent with other CMS policies promoting assessment of SDOH as an indicator of quality care and to promote safe discharge planning.	

Example[31]	A patient who hasn't been seen recently requests an appointment at a specific time or on a specific date due to limited availability of transportation to or from the visit, or they request a refill of refrigerated medication that went bad when the electricity was terminated at their home. If the patient hasn't received an SDOH risk assessment in the past six months, the patient can fill out an SDOH risk assessment 7-10 days in advance of an appointment as part of intake, to ensure that there is enough information to appropriately treat them.
Concurrent services	**Risk assessment, CHI and PIN**: SDOH risk assessment is related to CHI and PIN services, and time spent performing the SDOH risk assessment that is not otherwise billed counts toward the 60 minutes per month spent in the performance of PIN or CHI services. SDOH risk assessments may also be furnished as an optional element of the AWV, in which case it is a preventive service and cost sharing won't apply.
Documentation	The SDOH needs identified through the risk assessment must be documented in the medical record and may be documented using a set of ICD-10-CM codes known as Z-codes (Z55-Z65), which are used to document SDOH data to facilitate high-quality communication between providers. Post risk assessment referral — Medicare expects the practitioner furnishing an SDOH risk assessment to, at a minimum, refer the patient to relevant resources and consider the results of the assessment in their medical decision-making or their diagnosis and treatment plan for the visit. 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. Use a standardized, evidence-based SDOH risk assessment tool to assess for: - Housing insecurity - Food insecurity - Transportation needs - Utility difficulty
Telehealth	Allowed.

COMMUNITY HEALTH INTEGRATION (G0019, G0022)

Full code description

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 SDOH need(s) that significantly limit the ability to diagnose or treat problem(s) addressed in an initiating visit:

- Person-centered assessment performed to better understand the individualized context of the intersection between the SDOH need(s) and the problem(s) addressed in the initiating visit.
  - 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 and unmet SDOH needs (that aren't separately billed).
  - Facilitating patient-driven goal setting and establishing an action plan.
  - Providing tailored support to the patient, as needed, to accomplish the practitioner's treatment plan.
- Practitioner, home- and community-based care coordination.
  - Coordinating receipt of needed services from health care practitioners, providers and facilities and from home- and community-based service providers, social service providers and caregivers (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. wFacilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) to address the 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 and preferences in the context of SDOH need(s), and educating the patient on how to best participate in medical decision-making.

- Building patient self-advocacy skills, so the patient can interact with members of the health care team and related community-based services addressing the SDOH need(s) in ways that are more likely to promote personalized and effective diagnosis or treatment.
- Health care access/health system navigation: Helping the patient access health care, including identifying appropriate practitioners or providers for clinical care and helping secure appointments with them.
- Facilitating behavioral change as necessary to meet 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 problem(s) addressed in the initiating visit, the SDOH need(s) and adjust daily routines to better meet diagnosis and treatment goals.
- Leveraging lived experience, when applicable, to provide support, mentorship or inspiration to meet treatment goals.

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

COMMUNITY HEALTH INTEGRATION (G0019, G0022) SPECIFICATIONS

Category	Specifications	Notes
Qualified healthcare professional	The community health integration services must be provided "incident to" the professional service of a physician or other statutorily qualified practitioner, who must bill for those services.	Services provided by clinical psychologists (CPT codes 90791 and 96156) are not currently services that could serve as an initiating visit for CHI services. However, these services are captured under the PIN service described later in this section.

Auxiliary personnel	These codes were specifically designed to capture services commonly performed by community health workers, which are a type of auxiliary personnel. However, the codes do not limit the types of other health care professionals (e.g., registered nurses and social workers) who can perform CHI services (and PIN services) incident to the billing practitioner's professional services, provided they meet the requirements to provide all elements of the service included in the code, consistent with the definition of auxiliary personnel at Title 42 Code of Federal Regulations § 410.26(a)(1). Auxiliary personnel who provide these services must be under supervision of the billing physician (or other practitioner), and the provided services must be reasonable and necessary for diagnosis and treatment of illness or injury.	**Supervision:** "Incident to" policy requires that the billing practitioner maintains active participation in and management of the course of treatment. Medicare allows for the broadest possible level of supervision of auxiliary personnel (general supervision), and contracting with third parties (such as CBOs) to furnish CHI services is allowable, however this must be part of clinical care and treatment by the billing practitioner. **Example:** It would not be in the scope of practice of the auxiliary personnel to determine that a given HRSN is impacting the billing practitioner's ability to diagnose or treat problems addressed in an initiating visit. Auxiliary personnel must review all unmet HRSN needs they find so they can be addressed by the billing practitioners in the CHI services. CHI service codes were created for auxiliary personnel, including community health workers, to provide tailored support and system navigation to help address unmet social needs that significantly limit a practitioner's ability to carry out a medically necessary treatment plan. CHI services include items like: • Person-centered planning • Health system navigation • Facilitating access to community-based resources • Practitioner, home and community-based care coordination • Patient self-advocacy promotion Group CHI services are not allowed.

Workflow	The billing practitioner initiates CHI services during an initiating visit where the practitioner identifies unmet SDOH needs that significantly limit the ability to diagnose or treat the patient. Initiating visits are personally performed by the practitioner and include: - An E/M visit - A Medicare AWV Additional CHI services: The same practitioner bills for the subsequent CHI services provided by the auxiliary personnel. The same practitioner furnishes and bills for the CHI initiating visit and the CHI services. CHI services must be furnished in accordance with the "incident to" regulation at Title 42 Code of Federal Regulations § 410.26.	During the initiating visit, the billing practitioner establishes the treatment plan, specifies how addressing the unmet SDOH needs would help accomplish that plan and establishes the CHI services as incidental to their professional services. Auxiliary personnel can perform the subsequent CHI services. The Medicare AWV can be a CHI initiating visit when the furnishing practitioner identifies an unmet HRSN that will prevent the patient from carrying out the recommended personalized prevention plan. However, practitioners may bill an E/M visit in addition to the AWV when medical problems are addressed in the course of an AWV encounter.[32] The AWV is not a CHI initiating visit if it is provided by a type of health care professional who does not have an "incident to" benefit for their services under the Medicare program (e.g., a health educator, a registered dietitian or nutrition professional), because they could not then furnish and bill for CHI services incident to their professional services. The initiating visit can also be an E/M visit provided as part of transitional care management services. A patient must be seen for a CHI initiating visit prior to furnishing and billing CHI services. Certain types of E/M visits, such as inpatient and observation visits, emergency department visits and skilled nursing facility visits, do not serve as CHI initiating visits because the practitioners providing the E/M visit wouldn't typically be the one providing continuing care to the patient, including providing necessary CHI services in the subsequent months. Medicare does not require an initiating E/M visit every month that CHI services are billed, but only before commencing CHI services, to establish the treatment plan, specify how addressing the unmet SDOH need(s) would help accomplish that plan and establish the CHI services as "incident to" the billing practitioner's service. **Tip:** This framework is similar to the current requirements for billing care management services, such as chronic care management services.

<table>
<tr><td>Example</td><td colspan="2">Case study: Tailored support could be provided through CHI services to a patient experiencing homelessness with signs of potential cognitive impairment and a history of frequent emergency department admissions for uncontrolled diabetes. The patient's primary care practitioner learns, during a clinic visit after discharge from the emergency department, that the patient has been able to reliably fill their prescriptions for diabetes medication but frequently loses the medication (or access to it) while transitioning between homeless shelters and a local friend's home.
In the medical record, the primary care practitioner documents SDOH needs of housing insecurity and transportation insecurity contributing to medication noncompliance, resulting in inadequate insulin control and a recent emergency department visit for hypoglycemia.
The primary care practitioner's treatment plan is daily diabetes medication, with the goal of maintaining hemoglobin A1c within appropriate levels.
To accomplish the treatment plan, the primary care practitioner orders CHI services to develop an individualized plan for daily medication adherence/access while applying for local housing assistance, and orders a follow-up visit for cognitive impairment assessment and care planning to further evaluate the potential contribution of cognitive impairment.
The primary care practitioner's auxiliary personnel provide tailored support, composed of facilitating communication between the patient, local shelters and their friend to help the patient identify a single location to reliably store their medication while applying for local housing assistance.
The auxiliary personnel also help the patient identify a reliable means of daily transportation to that location for their medication and show the patient how to create a daily automated phone reminder to take the diabetes medication.
The auxiliary personnel document these activities (including the amount of time spent) in the medical record at the primary care practitioner's office, along with periodic updates regarding the status of the patient's housing assistance application.</td></tr>
<tr><td>Consent</td><td>The billing practitioner or the auxiliary personnel under supervision must get advance patient consent before furnishing CHI services.</td><td>Consent can be written or verbal, as long as it is documented in the patient's medical record. As part of consent, providers must explain to the patient that cost sharing applies and that only one practitioner may furnish and bill the services in each month. Consent is not required again, unless the practitioner furnishing and billing CHI changes.</td></tr>
</table>

Community health worker training	According to the new Medicare rules, all auxiliary personnel who provide CHI services must be certified or trained to perform all included service elements and authorized to perform them under applicable state laws and regulations. For CHI services, as with all "incident to" services, it is the billing practitioner's responsibility to ensure that the Medicare criteria for billing and payment of CHI services are met, including applicable state requirements regarding licensure, certification and/or training. Medicare defers to state rules, where they have been established, for training content and hours. For states that do not have applicable rules, Medicare has established that training to provide CHI services must include the competencies of 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, and development of an appropriate knowledge base, including of local community-based resources. Specific training hours are not specified.
Concurrent services	**Medicare** — Only one practitioner can bill for CHI services per month. This helps ensure a single point of contact to address social needs that may span other health care needs. It helps avoid a fragmented approach and duplicated services. Medicare currently makes separate payments under the physician fee schedule for a number of care management and other services that may include aspects of CHI services. Those care management services focus heavily on clinical, rather than social, aspects of care. CHI services can be furnished in addition to other care management services if the practitioner: ■ Doesn't count time and effort more than once. ■ Meets requirements to bill the other care management services. ■ Performs services that are medically reasonable and necessary. **Home health, Medicare Part B** — CHI services may not be billed while the patient is under a home health plan of care under Medicare Part B. **Medicaid** — According the Medicare rulemaking, CHI services are meant to resolve specific concerns to facilitate a patient's medical care, which distinguishes CHI from other social services and programs that may be available through Medicaid state plans or other state or community programs.

Documentation	The patient's unmet social needs that CHI services address must be documented in the medical record. Documenting ICD-10-CM Z-codes can count as the appropriate documentation. Auxiliary staff of third-party organizations — Medicare policy regarding medical record documentation allows any individual who is authorized under Medicare law to furnish and bill for their professional services, whether or not they are acting in a teaching role, may review and verify (sign and date) the medical record for the services they bill, rather than re-document notes in the medical record made by physicians, residents, nurses, students (including students in therapy or other clinical disciplines) or other members of the medical team.[33] Ultimately, documentation is the responsibility of the billing practitioner. CBOs and other contracted entities for auxiliary personnel services may enter data following this general policy, as long as the biller reviews and verifies the documentation.
Frequency	CHI services can be billed monthly as medically reasonable and necessary, billing for the first 60 minutes of CHI services (G0019) and then each additional 30 minutes thereafter (G0022). Also, document the amount of time spent with the patient and the nature of the activities. There is no frequency limitation for the add-on HCPCS code G0022, to allow for flexibility when practitioners do spend more than 60 minutes on CHI services in the month. As long as the time spent by auxiliary personnel is reasonable and necessary for the diagnosis and treatment of injury or illness, Medicare will allow it to be billed.
Telehealth	Combination of in-person and virtual expected.[34]

PRINCIPAL ILLNESS NAVIGATION (G0023, G0024)

Full code description

G0023 — PIN services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator; 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 and unmet SDOH needs (that aren't separately billed).
  - 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 the patient (and caregiver or family, if applicable) to appropriate supportive services.
- Practitioner, home- and community-based care communication.
  - Coordinating receipt of needed services from health care practitioners, providers and facilities; home- and community-based service providers; and caregiver (if applicable).
  - Communicating 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 their 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 health care, 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, to meet 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 and their SDOH need(s) and adjust daily routines to better meet diagnosis and treatment goals.
- Leveraging knowledge of the serious, high-risk condition and/or lived experience, when applicable, to provide support, mentorship or inspiration to meet treatment goals.

G0024 — PIN services, additional 30 minutes per calendar month. (List separately in addition to G0023.)

PRINCIPAL ILLNESS NAVIGATION (G0023, G0024) SPECIFICATIONS		
Category	**Specifications**	**Notes**
Qualified practitioner	Practitioners are physicians or other qualified health care professionals, including clinical psychologists.	
Auxiliary personnel	Certified or trained auxiliary personnel under the direction of a billing practitioner who are involved in the patient's health care navigation. Auxiliary personnel may include a care navigator or certified peer specialist.	Since there isn't a Medicare benefit for paying navigators and peer support specialists directly, Medicare pays for their services as incidental to the services of the health care practitioner who directly bills Medicare. The auxiliary personnel may be external to and under contract with the practitioner or their practice, such as through a CBO that employs navigators, peer support specialists or other auxiliary personnel, if they meet all "incident to" requirements and conditions for payment of PIN services.

PRINCIPAL ILLNESS NAVIGATION (G0023, G0024) SPECIFICATIONS		
Category	**Specifications**	**Notes**
Auxiliary personnel		Supervision — Same as CHI. PIN services are considered care management services that may be furnished under general supervision under Title 42 Code of Federal Regulations § 410.26(b)(5). General supervision means the service is furnished under the physician's (or other practitioner's) overall direction and control, but the physician's (or other practitioner's) presence is not required when performing the service (Title 42 Code of Federal Regulations § 410.26(a)(3)).
Workflow	1. Initiating visits: The billing practitioner initiates PIN services during an initiating visit addressing a serious high-risk condition, illness or disease (included severe mental illness and substance use disorder). The billing practitioner personally performs initiating visits including: • An E/M visit, other than a low-level E/M visit done by clinical staff. • A Medicare AWV provided by a practitioner who meets the requirements to furnish subsequent PIN services.	The initiating visit includes identifying the medical necessity of PIN services and establishing an appropriate treatment plan. For PIN, a serious high-risk condition, illness or disease has these characteristics: ■ One serious, high-risk condition that places the patient at significant risk of: • Hospitalization • Nursing home placement • Acute exacerbation or decompensation • Functional decline or death ■ A condition that 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.

Workflow	• E/M visit done as part of transitional care management services could serve as an initiating visit for PIN services because it includes a high-level office/outpatient E/M visit furnished by a physician or nonphysician practitioner managing the patient in the community after discharge. • CPT code 90791 (psychiatric diagnostic evaluation) or the health behavior assessment and intervention services that CPT codes 96156, 96158, 96159, 96164, 96165, 96167 and 96168 describe. 2. The same practitioner bills for the subsequent PIN services that auxiliary personnel provide. • Auxiliary personnel like patient navigators and peer support specialists to provide navigation when treating a serious, high-risk condition or illness. These services help guide the patient through their course of care, including addressing any unmet social needs that significantly limit the practitioner's ability to diagnose or treat the condition. PIN services include items like: • Health system navigation • Person-centered planning • Identifying or referring patient and caregiver or family, if applicable, to supportive services • Practitioner, home- and community-based care coordination or communication • Patient self-advocacy promotion • Community-based resources access facilitation	■ Examples of a serious, high-risk condition, illness or disease include: • Cancer • Chronic obstructive pulmonary disease • Congestive heart failure • Dementia • HIV/AIDS • Severe mental illness • Substance use disorder Navigation and referral — PIN includes identifying or referring to appropriate supportive services and is especially relevant when a patient is first undergoing treatment for a high-risk illness, condition or disease, due to the extensive need to access and coordinate care from different specialties or service providers for different aspects of the diagnosis or treatment and, in some cases, related social services. Examples: • Cancer — Surgery, imaging and radiation therapy, chemotherapy • Serious mental illness — Psychiatry, psychology, vocational rehabilitation • Substance use disorder — Psychiatry, psychology, vocational rehabilitation, rehabilitation, recovery programs • HIV — Infectious disease, neurology, immunology The definition of a serious, high-risk condition depends on clinical judgment, and the example list of conditions provided by Medicare is not exhaustive. A three-month duration is set as a benchmark for the use of PIN services, as they are considered necessary to treat serious, high-risk conditions that require navigation over the course of several months. HRSN addressed through PIN may include food insecurity, transportation insecurity, housing insecurity and unreliable access to public utilities when they significantly limit the practitioner's ability to diagnose or treat the serious, high-risk illness, condition or disease.

Consent	Consent must be obtained annually and may be obtained by the auxiliary personnel either before or at the same time they begin performing PIN services for the patient.	Consent can be written or verbal, as long as it is documented in the patient's medical record.
Auxiliary staff training	Same as for CHI, all auxiliary personnel who provide PIN services must be certified or trained to perform all included service elements and authorized to perform them under applicable state laws and regulations. It is the billing practitioner's responsibility to ensure that the Medicare criteria for billing and payment of CHI services are met, including applicable state requirements regarding licensure, certification and/or training. Medicare defers to state rules, where they have been established, for training content and hours. For states that do not have applicable rules, Medicare has established that training and certification for auxiliary personnel providing HCPCS codes G0023 and G0024 include the competencies of patient and family communication, interpersonal and relationship building, patient and family capacity building, service coordination and systems navigation, patient advocacy, facilitation, individual and community assessment, professionalism and ethical conduct, and development of an appropriate knowledge base, including specific certification or training on the serious, high-risk condition, illness or disease addressed in the initiating visit. Note — Forty-eight states have established state rules for peer supports, and those rules will apply in those states.	

Concurrent services	**Medicare** — The billing practitioner can't furnish PIN services more than once per practitioner per month for any single serious high-risk condition. This avoids duplication of PIN service elements when using the same navigator or billing practitioner. PIN is best suited for situations in which the navigator can serve as a point of contact for the patient. A patient should not require multiple PIN services for a prolonged period, except in circumstances in which a patient is receiving PIN services for highly specialized navigation, such as for mental health, substance use, or oncology. PIN and PIN peer support should not be billed concurrently for the same serious, high-risk condition. However, practitioners furnishing PIN services may bill care management services, as appropriate, for managing and treating a patient's illness. PIN services can be furnished in addition to other care management services, as long as time and effort are not counted more than once, requirements to bill the other care management services are met and the services are medically reasonable and necessary. Behavioral health integration codes and office-based substance use disorder bundled codes also describe care management services and are considered to be duplicative of PIN, as they also require an initiating visit, but that is specified for those services. **Medicaid** — Similar to CHI services, there are aspects of PIN services, or PIN services for certain conditions, that may be covered under a Medicaid state plan. When Medicare and Medicaid cover the same services for patients eligible for both programs, Medicare generally is the primary payer in accordance with section 1902(a)(25) of the Social Security Act.
Documentation	A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or other qualified health care professional reporting the service. This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient choice. Notation in patient's medical record that another professional is managing the problem without additional assessment or care coordination documented does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service. Referral without evaluation (by history, examination or diagnostic study/studies) or consideration of treatment does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service. Definitive diagnosis — A definitive diagnosis is not required before the practitioner makes a clinical determination that the patient has a serious high-risk condition, as the length of time between suspicion (such as a positive screening test) and definitive diagnosis can stretch into weeks for some conditions, and navigation services may be medically necessary to ensure full diagnosis and treatment of that condition.

Frequency	G0023 — 60 minutes per calendar month. G0024 — Additional 30 minutes per calendar month, as required, no frequency limitation.
Telehealth	Combination of in-person and virtual expected.[35]

PRINCIPAL ILLNESS NAVIGATION — PEER SUPPORTS (G0140, G0146)

Full code description

G0140 — 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, in the following activities:

- Person-centered interview, performed to better understand the individual context of the serious, high-risk condition.
  - Conducting a person-centered interview to understand the patient's life story, strengths, needs, goals, preferences and desired outcomes, including understanding cultural and linguistic factors and unmet SDOH needs that aren't billed separately.
  - Facilitating patient-driven goal setting and establishing an action plan.
  - Providing tailored support, as needed, to accomplish the person-centered goals in the practitioner's treatment plan.
- Identifying or referring the patient (and caregiver or family, if applicable) to appropriate supportive services.
- Practitioner, home- and community-based care communication.
  - Assisting the patient to communicate with their 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, goals, preferences and desired outcomes, including cultural and linguistic factors.
  - 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 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.
- Developing and proposing strategies to help meet person-centered treatment goals and supporting the patient in using chosen strategies to reach person-centered treatment goals.

- Facilitating and providing social and emotional support to help the patient cope with the condition and SDOH need(s) and adjust daily routines to better meet person-centered diagnosis and treatment goals.
- Leveraging knowledge of the serious high-risk condition and/or lived experience, when applicable, to provide support, mentorship or inspiration to meet treatment goals.

G0146 — Peer support, additional 30 minutes per calendar month. (List separately in addition to G0140.)

PRINCIPAL ILLNESS NAVIGATION — PEER SUPPORTS (G0140, G0146) SPECIFICATIONS		
Category	**Specifications**	**Notes**
Qualified practitioner	Same as for PIN, requires the direction of a billing practitioner who is a physician or other qualified health care professional, including clinical psychologists.	
Auxiliary personnel	PIN peer support is provided by certified or trained auxiliary personnel directed by a billing practitioner. These auxiliary personnel are involved in the patient's health care navigation specifically for treatment of behavioral health conditions. Auxiliary personnel include certified peer specialists.	**Supervision** — Same as CHI. PIN services are considered care management services that may be furnished under general supervision under Title 42 Code of Federal Regulations § 410.26(b)(5). General supervision means the service is furnished under the physician's (or other practitioner's) overall direction and control, but the physician's (or other practitioner's) presence is not required during the performance of the service (Title 42 Code of Federal Regulations § 410.26(a)(3)).

PRINCIPAL ILLNESS NAVIGATION — PEER SUPPORTS (G0140, G0146) SPECIFICATIONS		
Category	**Specifications**	**Notes**
Consent	Consent must be obtained annually and may be obtained by the auxiliary personnel before or while they perform PIN services for the patient.	Consent can be written or verbal, as long as it is documented in the patient's medical record.
Auxiliary staff training	Forty-eight states have established state rules for peer support, and those rules will apply in those states. If no applicable state requirements exist, this PIN peer support requires that training must be consistent with the National Model Standards for Peer Support Certification published by the Substance Abuse and Mental Health Services Administration.[36]	
Choice of PIN or PIN peer support	The list of activities described for PIN peer support are slightly modified from the list of activities associated with PIN. PIN peer support services are more closely aligned with the scope of a peer support specialist.	Patients with behavioral health conditions can receive either PIN or PIN peer support services, so long as the auxiliary staff providing them are trained and certified in all parts of those code descriptors.
Concurrent services	**Medicare** — PIN services cannot be provided more than once per practitioner per month for any single serious, high-risk condition, to avoid duplication of PIN service elements when using the same navigator or billing practitioner. Medicare does not expect a patient to require multiple PIN services for a prolonged period, except in circumstances in which a patient is receiving PIN services for highly specialized navigation, such as for mental health, substance use, or oncology. PIN services can be furnished in addition to other care management services, as long as time and effort are not counted more than once, requirements to bill the other care management services are met and the services are medically reasonable and necessary. Behavioral health integration codes and office-based substance use disorder bundled codes also describe care management services and are considered to be duplicative of PIN, as they also require an initiating visit, but that is specified for those services. PIN and PIN peer support should not be billed concurrently for the same serious, high-risk condition. However, practitioners furnishing PIN services may bill care management services as appropriate for managing and treating a patient's illness.	

Documentation	Time spent furnishing PIN services must be documented in the medical record in relationship to the serious, high-risk illness. The activities performed by the auxiliary personnel and how they are related to the treatment plan for the serious, high-risk condition should be described in the medical record, just as all clinical care is documented in the medical record. Medicare requires identified SDOH needs, if present, to be recorded in the medical record, and for data standardization practitioners would be encouraged to record the associated ICD-10-CM Z-codes (Z55-Z65) in the medical record and on the claim.
Frequency	G0140 — 60 minutes per calendar month. G0146 — Additional 30 minutes per calendar month, no frequency limitation.
Telehealth	Combination of in-person and virtual expected. [37]

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