# CHI & SDOH Risk Assessment Documentation, Coding, and Billing for Oncology Providers and Administrators & Series Wrap-up

Teri Bedard, BA, RT(R)(T)(ARRT), CPC
Revenue Cycle Coding Strategies
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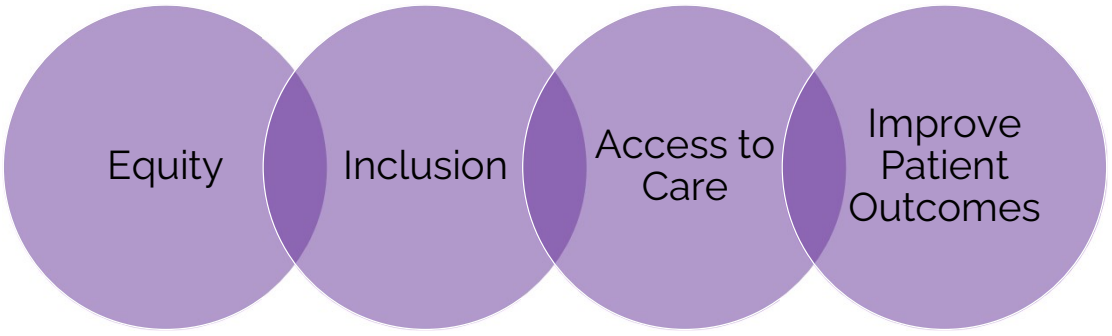
## CMS Strategic Plan Pillars



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## 2024 – New Codes from Medicare

| CHI | SDOH | PIN & PIN-PS |
|---|---|---|
| • Community Health Integration<br>  • G0019 and G0022<br>  • Practitioner must identify any SDOHs which significantly limit their ability to diagnose or treat the problem(s) addressed in the visit | • Social Determinants of Health<br>  • G0136<br>  • Risk Assessment<br>  • Provided no more than once every 6 months<br>  • Include a large set of factors:<br>  • Economic stability,<br>  • Education access and quality,<br>  • Healthcare access and quality,<br>  • Neighborhood and build environment,<br>  • Social and community context (factors such as housing, food, nutrition access, and transportation needs) | • Principal Illness Navigation<br>  • G0023 and G0024<br>  • Cancer (& other serious, high-risk illnesses)<br>• Principal Illness Navigation – Peer Support<br>  • G0140 and G0146<br>  • Behavioral health<br>  • Provided by peer support specialists |



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## Staff Training

Must meet State requirements - Certification *or* Licensure

If no State requirements must be trained or certified in the following:

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 local community-based resources



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## G0136

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



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## Social Determinants of Health (SDOH)

**01**

**1 new code**

G0136

**02**

**Risk Assessment**

Part of comprehensive social history in relation to E/M visit

**03**

**Specific Factors**

Economic stability, Education access and quality, Healthcare access and quality, Neighborhood and building environment, Social and community context

**04**

**Format**

Standardized, evidence-based SDOH risk assessment tool tested and validated through research

**05**

**Domains Included**

Food insecurity, housing insecurity, transportation needs, and utility difficulties (providers may assess for additional domains as culturally pertinent to community)



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## Factors for Application

| | |
|---|---|
| Physician determines unmet SDOH could interfere with diagnosis and treatment of patient | Not meant for routine screening – assesses 1 or more suspected SDOH impacting diagnosis and treatment of patient |



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## Requirements of SDOH Tool Examples

- CMS Accountable Health Communities (AHC) tool
- Protocol for Responding to & Assessing Patients' Assets
- Risks & Experiences (PREP ARE) tool
- Instruments identified for Medicare Advantage Special Needs Population Special Risk Assessment
- Per CMS – examples are non-exhaustive



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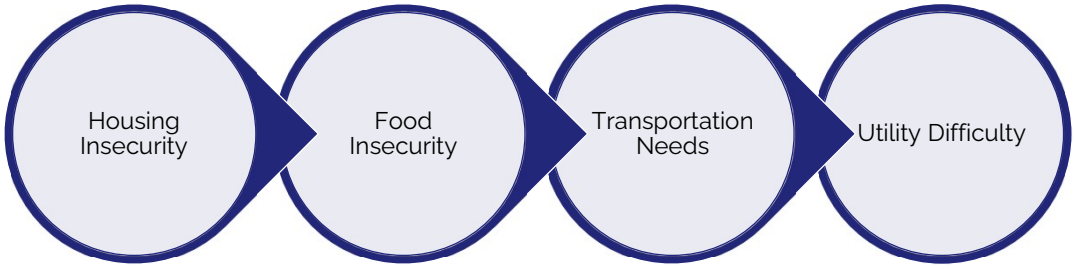
## SDOH Tools Used to Assess For…



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## CMS Example

mln BOOKLET
KNOWLEDGE • RESOURCES • TRAINING

**Example:** 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 requests a refill of refrigerated medication that went bad when the electricity was terminated at their home. If the patient hasn't gotten an SDOH risk assessment in the past 6 months, you could have the patient fill out an SDOH risk assessment 7–10 days in advance of an appointment as part of intake to ensure that you have enough information to appropriately treat them. You may also furnish SDOH risk assessments as an optional element of the AWV, in which case it's a preventive service and cost sharing won't apply.



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## Documentation in the Medical Record

Any SDOH need identified through the risk assessment (HCPCS code G0136) must be documented in the patient's medical record

May document using ICD-10-CM codes Z55–Z65, to document SOH data to facilitate high-quality communication between providers.



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| Social Determinants of Health (SDOH) ICD-10-CM Codes | |
|---|---|
| Z55 (Z55.0 – Z55.9) | Problems related to education and literacy |
| Z56 (Z56.0-Z56.9) | Problems related to employment and unemployment |
| Z57 (Z57.0-Z57.9) | Occupational exposure to risk factors |
| Z58 (Z58.0-Z58.9) | Problems related to physical environment |
| Z59 (Z59.0-Z59.9) | Problems related to housing and economic circumstances |
| Z60 (Z60.0-Z60.9) | Problems related to social environment |
| Z62 (Z62.0-Z62.9) | Problems related to upbringing |
| Z63 (Z63.0-Z63.9) | Other problems related to primary support group, including family circumstances |
| Z64 (Z64.0-Z64.9) | Problems related to certain psychosocial circumstances |
| Z65 (Z65.0-Z65.9) | Problems related to other psychosocial circumstances |



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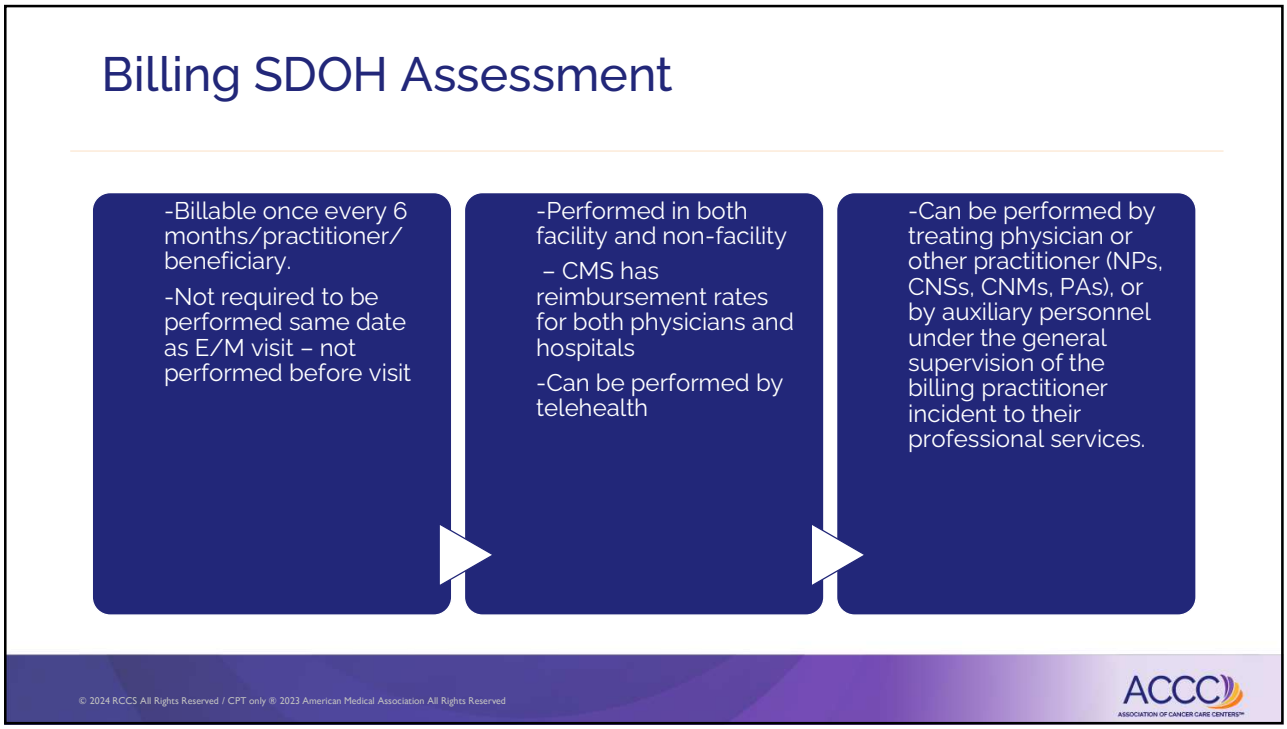


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| Code | Description |
|---|---|
| G0019 | Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner; 60 minutes per calendar month, in the following activities to address social determinants of health (SDOH) need(s) that are significantly limiting the ability to diagnose or treat problem(s) addressed in an initiating visit:<br>• 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.<br>o Conducting a person-centered assessment to understand patient's life story, strengths, needs, goals, preferences and desired outcomes, including understanding cultural and linguistic factors and including unmet SDOH needs (that are not separately billed).<br>o Facilitating patient-driven goal-setting and establishing an action plan.<br>o Providing tailored support to the patient as needed to accomplish the practitioner's treatment plan.<br>• Practitioner, Home, and Community-Based Care Coordination<br>o Coordinating receipt of needed services from healthcare practitioners, providers, and facilities; and from home- and community-based service providers, social service providers, and caregiver (if applicable).<br>o 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.<br>o 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.<br>o Facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) to address the SDOH need(s).<br>• 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 the SDOH need(s) and educating the patient on how to best participate in medical decision-making.<br>• Building patient self-advocacy skills, so that 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.<br>• Health care access / health system navigation<br>o Helping the patient access healthcare, including identifying appropriate practitioners or providers for clinical care and helping secure appointments with them.<br>• Facilitating behavioral change as necessary for meeting diagnosis and treatment goals, including promoting patient motivation to participate in care and reach person-centered diagnosis or treatment goals.<br>• 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.<br>• 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) |

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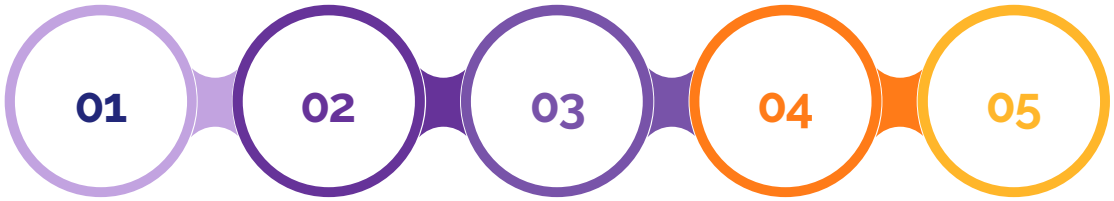
## Community Health Integration (CHI)




**2 new codes**
G0019 and G0022

**Auxiliary Staff**
Certified or trained, provided incident to and under general supervision

**Initiating Visit**
Continued visits furnished monthly, as needed, following CHI initiating visit

**Excluded Visits**
Inpatient/observation, emergency department, or SNF

**SDOH Identified**
Practitioner identify SDOHs which significantly limit ability to diagnose or treat problem(s) addressed in visit



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## Focus of CHI

- Person-Centered Planning
- Health System Navigation
- Facilitating Access to Community-Based Coordination
- Practitioner, Home, and Community-Based Coordination
- Patient Self-Advocacy Promotion



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## Auxiliary Staff Training

| Hours of Training | State Regulations | CMS Competency Training |
|---|---|---|
| • No set required number of training hours required by CMS<br>  • If State requirements identify number of hours to complete training, must abide by State regulations | • Adhere to State regulations for certification and/or licensure<br>• If no applicable requirements, follow CMS competency requirements | • Patient and family communication<br>• Interpersonal and relationship-building<br>• Patient and family capacity building<br>• Service coordination and systems navigation<br>• Patient advocacy, facilitation, individual and community assessment<br>• Professionalism and ethical conduct<br>• **Development of an appropriate knowledge base, including local** |



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## Initiating Visit

| Required when… | Types of initiating visits… | Discussion… | Excluded visits… |
|---|---|---|---|
| • Patient is a new patient or not seen by billing practitioner within a year prior to the beginning of the care management services | • Comprehensive E/M (99212-99205)<br>• Annual Wellness Visit (AWV)<br>• Initial Preventative Physical Exam (IPPE) | • Must discuss the care management services with the patient during the initiating visit or it does not count<br>• Must obtain consent from patient prior to start of care management services | • Low level E/M visits able to be performed by staff, emergency department (ED), inpatient or observation, skilled nursing facility (SNF)<br>• AWV by dietitian |



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## Patient Consent

| | |
|---|---|
| Written or verbal consent is required for CHI services and must be documented in medical record | Must be obtained annually or if billing practitioner changes, and can be obtained by auxiliary staff before or at same time as beginning CHI services |



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## Comprehensive Care Plan

- A problem list of SDOH needs significantly limiting ability to diagnosis or treat the patient
- Expected outcome and prognosis (indicate how will addressing unmet SDOH help accomplish the plan)
- Measurable treatment goals,
- Who is responsible for any planned interventions,
- Any ordered specific services (person-centered assessment, health education, etc. ), and
- How any services provided by outside organizations will be coordinated and managed in support of the care plan



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## Documentation

- Describe the SDOH and CHI service elements performed by auxiliary staff - TRACK YOUR TIME!
- Describe the medical necessity of CHI services to the principal illness
- Unmet SDOH needs are being addressed – must be documented in medical record and may be documented using associated ICD-10-CM Z-code (Z55-Z65)
- Auxiliary staff providing CHI services to communicate regularly with billing practitioner to provide management of services
- Describe the ongoing need or changes to the treatment plan that allow for the cessation of CHI services
- Regardless of who did the work throughout the month the billing practitioner is responsible for ensuring appropriate documentation of the CHI services provided to the patient is included in the medical record



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## Billing

**Not Limited**

-Not limited to only underserved communities

-Meant for patients who have unmet SDOH need(s) that are significantly limiting the practitioner's ability to diagnose or treat the problem addressed during the CHI initiating visit, or other such SDOH needs that may be identified during the course of providing CHI services

**Additional Services**

-Can bill for CHI in addition to other care management services

-No duplication of services can occur (cannot count time and effort more than once)

-Must be medically necessary for both

**Billing Practitioner**

-Same practitioner must do initiating visit and manage the services

-Billed incident to the practitioner on claim

-Billable in nonfacility and facility settings

-Only one practitioner can bill for CHI services per month



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## Billing CHI and Other Care Management Codes

CMS.gov

Can CHI and PIN be billed with other care management codes?

a. Care management services are focused heavily on clinical aspects of care rather than social circumstances that impact clinical care and are generally performed by auxiliary personnel who may not have lived experience or training in the specific illness being addressed. You can furnish CHI services in addition to other care management services if you don't count time and effort more than once, you meet the requirements to bill the other care management services, and the services are reasonable and necessary.



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## Monthly Components

CMS.gov

For CHI, PIN, or PIN-PS services, do all service elements included in the code descriptor have to be furnished each month?

a. The code does not represent a listing of mandatory monthly elements. But we expect those service elements that are reasonable and necessary for the individual patient would generally be performed during the month. In other words, the billing and supervising practitioner and the auxiliary personnel providing the services should perform the service elements based on the specific patient's needs and should be prepared to provide each element of the billed code (CHI, PIN, or PIN-PS) as needed.



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## Use of Telehealth

CMS.gov

Can CHI, PIN, and PIN-PS services be furnished via telehealth?

a. CHI, PIN, and PIN-PS can be performed using telecommunications technology. Because these services are ordinarily furnished outside of an in-person, face-to-face visit, they are outside the scope of Medicare telehealth services, similar to other care management services. For this reason, it was not necessary to add these services to the Medicare Telehealth Services List.



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## Changes During Course of Treatment

CMS.gov

If under the course of treatment outside of the initiating visit, additional unmet SDOH needs affecting the diagnosis and treatment are identified, can they be addressed through CHI and PIN?

a. Yes, if the billing practitioner determines the additional unmet SDOH need(s) are significantly limiting their ability to diagnose or treat the medical problem(s) addressed in the initiating visit. Auxiliary personnel should consult with the billing practitioner if they discover additional needs they believe are related and need to be addressed.



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Highlights of other Care Management Services
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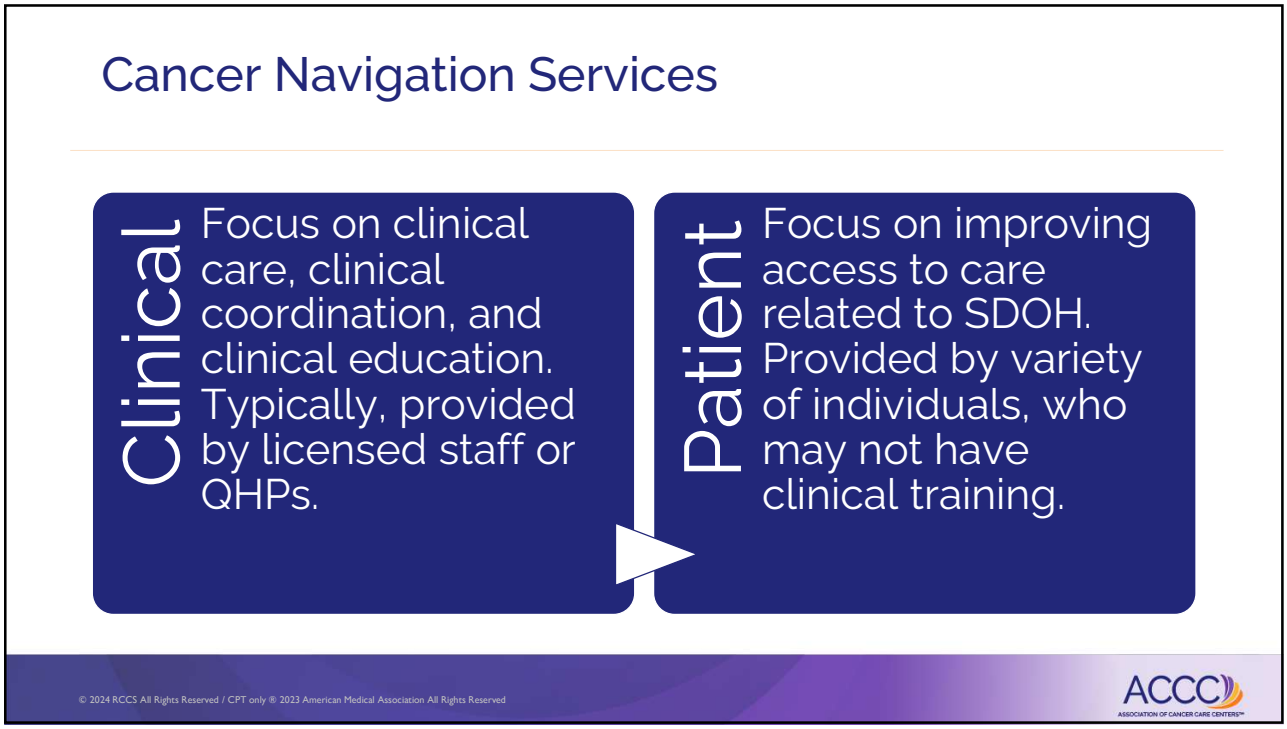
Cancer Navigation Services
Clinical
Focus on clinical care, clinical coordination, and clinical education. Typically, provided by licensed staff or QHPs.
Patient
Focus on improving access to care related to SDOH. Provided by variety of individuals, who may not have clinical training.
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## CPT® Care Management Services

| | Principal Care Management (99424/99426) | Complex Chronic Care Management (99487) | Chronic Care Management (99490/99491) |
|---|---|---|---|
| **Threshold Time (minutes)** | 30 | 60 | 20/30** |
| **Expected Duration** | At least 3 months | At least 12 months | At least 12 months |
| **Staff Type** | MD/QHP/Clinical Staff | Clinical Staff | MD/QHP/Clinical Staff |
| **Patient Conditions** | Serious high-risk condition & 1 complex chronic condition | 2 or more chronic conditions | 2 or more chronic conditions |
| **Care Plan** | Disease specific | Comprehensive | Comprehensive |



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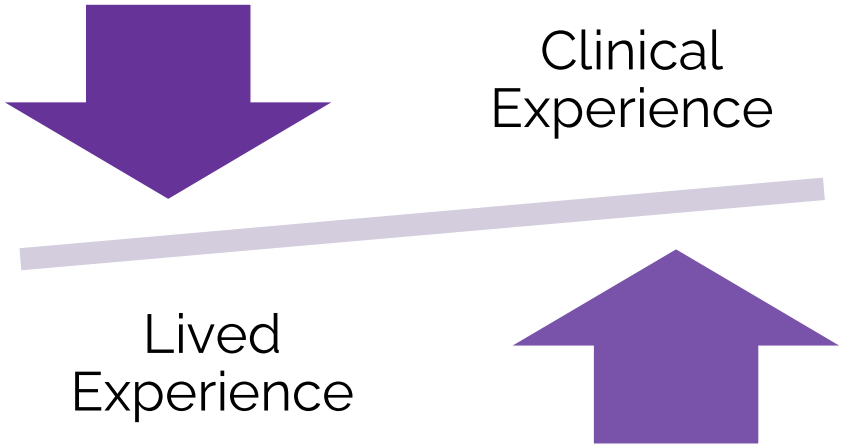
## Differing Auxiliary Staff Experiences



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## Criteria for PIN Visits

**1.** One serious, high-risk condition expected to last at least 3 months and that places the patient at significant risk of hospitalization, nursing home placement, acute exacerbation/decompensation, functional decline, or death;

**a.** Examples of serious high-risk conditions/illness/disease include, but are not limited to, cancer, chronic obstructive pulmonary disease, congestive heart failure, dementia, HIV/AIDS, severe mental illness, and substance use disorder.

**2.** The condition requires development, monitoring, or revision of a disease specific care plan, and may require frequent adjustment in the medication or treatment regimen, or substantial assistance from a caregiver.



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## Principal Illness Navigation (PIN)

| 01 | 02 | 03 | 04 | 05 |
|---|---|---|---|---|
| **2 new codes** | **Individualized** | **Initiating Visit** | **Continued Visits** | **Excluded Visits** |
| G0023 and G0024 | Help to identify appropriate practitioners for care needs and support, timely access to care, especially when need is complex and delaying care can be deadly | Must address a serious high-risk condition/illness/disease | Continued visits furnished monthly, as needed, following PIN initiating visit | Inpatient/observation, emergency department, or SNF |



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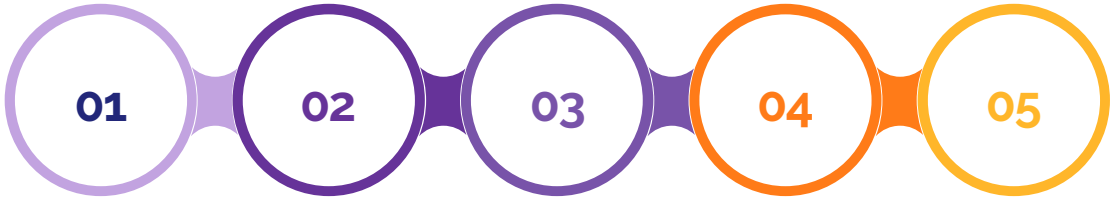
## Principal Illness Navigation Peer Support




**2 new codes**
G0140 and G0146

**Individualized**
Help to identify appropriate practitioners for treatment of behavioral health conditions that satisfy the definitions of high-risk condition(s)

**Initiating Visit**
Must address a serious high-risk condition/illness/disease

**Continued Visits**
Continued visits furnished monthly, as needed, following PIN-PS initiating visit

**Excluded Visits**
Inpatient/observation, emergency department, or SNF



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## Clarification


Based on Clinical Judgement of the Physician

Less than 60 minutes per month by auxiliary staff, other care management services may be better suited

PIN services expected to necessitate care over the course of several months



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# Code Comparison

| | Principal Care Management (99426) | Complex Chronic Care Management (99487) | Chronic Care Management (99490/99491) | CHI (G0019) | PIN (G0023) | PIN-PS (G0140) |
|---|---|---|---|---|---|---|
| **Threshold Time (minutes)** | 30 | 60 | 20/30** | 60 | 60 | 60 |
| **Expected Duration** | At least 3 months | At least 12 months | At least 12 months | At least 3 months | At least 3 months | At least 3 months |
| **Staff Type** | Clinical Staff | Clinical Staff | Clinical Staff | Clinical Health Worker (CHW) certified or trained | Certified or trained Navigator | Peer support, State guidelines or SAMSHA* |
| **Patient Conditions** | Serious high-risk condition & 1 complex chronic condition | 2 or more chronic conditions | 2 or more chronic conditions | Social Determinants Of Health | 1 Serious high-risk condition | Behavioral health condition |
| **Care Plan** | Disease specific | Comprehensive | Comprehensive | Address SDOH | Disease specific | Disease specific |

*SAMSHA – Substance Abuse and Mental Health Services Administration
**20-minute threshold clinical staff time per month for CPT 99490, or 30-minute threshold physician/QHP time per month for CPT® 99491



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# Medicare Rates and Patient Responsibility

| Type of Visit | Initiating E/M Visit Required | Provided by Certified/Trained Auxiliary Staff | 2024 MPFS Nonfacility Rate | 2024 MPFS Facility Rate | 2024 HOPPS Rate |
|---|---|---|---|---|---|
| Community Health Integration (CHI) | Yes | Yes | G0019 = $80.56<br>+G0022 = $50.26 | G0019 = $49.60<br>+G0022 = $34.62 | G0019 = $84.93<br>+G0022 = packaged |
| Social Determinants of Health (SDOH) | No | Yes | G0136 = $18.97 | G0136 = $8.99 | G0136 = $27.34 |
| Principal Illness Navigation (PIN) | Yes | Yes | G0023 = $80.56<br>+G0024 = $50.26 | G0023 = $49.60<br>+G0024 = $34.62 | G0023 = $84.93<br>+G0024 = packaged |
| Principal Illness Navigation – Peer Support (PIN-PS) | Yes | Yes | G0140 = $79.24<br>+G0146 = $49.45 | G0140 = $48.79<br>+G0146 = $34.05 | G0140 = $84.93<br>+G0146 = packaged |
| Principal Care Management | Yes | Yes | 99424 = $82.55<br>+99425 = $59.92<br>99426 = $61.91<br>+99427 = $47.27 | 99424 = $73.57<br>+99425 = $50.60<br>99426 = $48.93<br>+99427 = $34.29 | 99424 = N/A<br>+99425 = N/A<br>99426 = $84.93<br>+99427 = packaged |
| Complex Chronic Care Management | Yes | Yes | 99487 = $134.15<br>+99489 = $72.23 | 99487 = $89.21<br>+99489 = $49.60 | 99487 = $151.91<br>+99489 = packaged |
| Chronic Care Management | Yes | Yes | 99490 = $62.58<br>+99439 = $47.93<br>99491 = $84.55<br>+99437 = $59.58 | 99490 = $49.60<br>+99439 = $34.62<br>99491 = $74.56<br>+99437 = $49.93 | 99490 = $84.93<br>+99439 = packaged<br>99491 = N/A<br>+99437 = N/A |



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## CMS Focus of Efforts for Beneficiaries




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## References

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# Association of Cancer Care Centers

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**ACCC is a multidisciplinary association**

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*ACCC has changed its name in 2024 from "Association of Community Cancer Centers" to the "Association of Cancer Care Centers." The change is a step forward to better align with the dynamic landscape of cancer care, while assuring our members, stakeholders, and the broader community that the values and principles we stand for remain unchanged.

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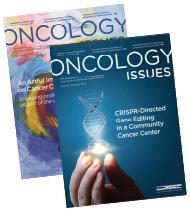


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