Coding Intel: CMS Adopts HCPCS Codes for Community Health Integration (CHI) Services 1/1/2024

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This is information from the 2024 Physician Fee Schedule Final Rule

- https://public-inspection.federalregister.gov/2023-14624.pdf

The effective date for new CPT® and HCPCS codes, and CMS policy is 1-1-2024.

- Practitioner (physician/NPP) identifies Social Determinants of Health (SDoH) needs that interfere with diagnosis or treatment at an initiating visit
- Monthly services performed by certified or trained auxiliary personnel, such as a community health worker
- Practitioner who does the initiating visit bills for the service
- There are incident to services, requiring general supervision

CMS is creating two new HCPCS codes to describe community health integration (CHI) Services performed by certified or trained auxiliary personnel under the general supervision of a billing practitioner. The services would require an initiating E/M visit, typically an office visit. CHI would be furnished monthly as medically necessary when the practitioner identifies the presence of SDoH which interfere with diagnosis or treatment.

Initiating Visit

An E/M service (not 99211 done by staff) or an Annual Wellness Visit done by a physician or NPP qualify as initiating visits. CMS does not allow any facility E/M services or behavioral health services as initiating visits.

During the initiating visit, the practitioner would assess and identify these SDoH needs that limit the practitioner's ability to diagnose or treat the patient's medical condition(s). The practitioner will establish an appropriate treatment plan which would specify how addressing the unmet needs would help with diagnosis and treatment. The work of the CHI services would be done by a community health worker or other auxiliary personnel. The services would be billed by the practitioner who initiated the service. These are incident to services, which means they may not be done in a facility outpatient setting; supervision is general supervision. These are time-based services and may be performed monthly if medically necessary. They involve direct contact with the patient.

CMS notes that the phrase or term "problem addressed" in this section corresponds to the definition in the CPT book related to E/M services.

CMS was specifically asked about a safety net clinic in a facility and replied that services in a facility do not meet incident to services, but they would take this under consideration in future rule making.

SDoH

CMS discusses the definition of SDoH as it relates to this section and to PIN services (discussed in another article on CodingIntel) and states they

"include but are not limited to 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 problem (s)address at the CHI initiating visit." p. 240

See our recent Q&A about SDoH.

Consent

Verbal or written consent is required and must be documented in the medical record.

HCPCS Codes for Community Health Integration (CHI) services

Here are the new codes

G0019 *Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner; 60 minutes per calendar month, in the following activities to address social determinants of health (SDOH) need(s) that are significantly limiting ability to diagnose or treat problem(s) addressed in an initiating E/M 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 E/M visit.*

++ Conducting a person-centered assessment to understand patient's life story, strengths, needs, goals, preferences and desired outcomes, including understanding cultural and linguistic factors.

++ Facilitating patient-driven goal setting and establishing an action plan.

++ Providing tailored support to the patient as needed to accomplish the practitioner's treatment plan.

- *Practitioner, Home-, and Community-Based Care Coordination*

++ Coordinating receipt of needed services from healthcare 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.

++ Facilitating 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 the SDOH need(s) and educating the patient 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 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 healthcare, including identifying appropriate practitioners or providers for clinical care and helping secure appointments with them.

- *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.*
- *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).*

CMS requires that all auxiliary personnel who provide CHI services are certified or trained in all service elements and authorized to perform them under applicable state laws and regulations. If the state does not have applicable licensure or other laws, they are proposing to require auxiliary personnel to be trained to provide the services.

The time spent furnishing to services must be documented as well as the activities that were performed. They are proposing to require that SDoH needs are documented in the medical record and for data standardization, practitioners are encouraged to use the ICD 10 codes from categories Z55—Z65 in the medical record and on the claim.

CMS believes that a substantial portion of the work would be in-person but some could be performed over the phone.

The services will be performed incident to the practitioner who performed the initiating visit. If the auxiliary personnel who perform the service are employed by a community-based

organization or other third-party, CMS wants to be clear that there must be "sufficient clinical integration between the third party and the billing practitioner in order for the services to be fully provided, and the connection between the patient, auxiliary personnel, and the billing practitioner must be maintained." p. 247. These are the exact words that they use in the section on principal illness navigation.

Question from the Final Rule webinar – CHI Services

Question: Is CHI intended for use in primary care settings or can it be used in behavioral health settings too?

Answer: CMS does not include 90791 as an initiating visit for CHI, so these services could not be billed incident to a clinical psychologist. They could be used in a behavioral health setting by a psychiatrist or psychiatric NP/PA who can report an E/M service as the initiating visit.

From page 313 in the Final Rule:

While we considered adding services provided by clinical psychologists, specifically CPT codes 90791 and 96156 to the list of services that could serve as an initiating visit for CHI services based on from commenters, we are not including these services as services that can serve as an initiating visit for CHI. We believe that these services would be better captured under the PIN below and would better serve the needs being addressed with the PIN we will continue to analyze the uptake of CHI services and will consider these comments for future rulemaking.

END of CMS Document