Health-Related Social Needs FAQ

This document answers frequently asked questions about a set of codes Medicare adopted for physician payment beginning in 2024 to further address health-related social needs of Medicare beneficiaries: Caregiver Training Services (CTS), Community Health Integration (CHI) services, Principal Illness Navigation (PIN) services, and Social Determinants of Health Risk Assessment (SDOH RA).

Caregiver Training Services

This document answers frequently asked questions about billing Caregiver Training Services (CTS) under the Medicare Physician Fee Schedule (PFS) using CPT codes 96202, 96203, 97550, 97551, and 97552 beginning January 1, 2024.

1. What is CMS's definition of a caregiver?
    a. For caregiver training services, we define a "caregiver" as "an adult family member or other individual who has a significant relationship with, and who provides a broad range of assistance to, an individual with a chronic or other health condition, disability, or functional limitation" and "a family member, friend, or neighbor who provides unpaid assistance to a person with a chronic illness or disabling condition." Under this definition, a caregiver is one who furnishes unpaid assistance to a person with a chronic illness or disabling condition and is in a position to assist the patient in carrying out an established treatment plan or plan of care.
2. Can behavior management/modification CTS services (96202 and 96203) be furnished to the caregiver(s) of an individual beneficiary?
    a. CPT codes 96202 (Mlt fam grp bhv train 1st 60) and 96203 (Mlt fam grp bhv train ea add) can only be furnished in a group setting. There is currently no code for behavior management/modification CTS that describes training for the caregiver(s) of a single beneficiary. The code descriptors for CPT codes 96202 and 96203 are specific to training provided in a group setting. CPT codes 97550 (Caregiver traing 1st 30 min) and 97551 (Caregiver traing ea addl 15) are not for behavior management/ modification. These codes describe CTS to assist beneficiaries with functional performance challenges and are primarily used in therapy settings. CPT codes 97550 and 97551 describe CTS furnished to train one or more caregivers of an individual beneficiary. CPT code 97552 (Group caregiver training) describes CTS furnished to train caregivers of multiple beneficiaries.

3. Can CTS be furnished via telehealth?
    a. No, at this time CTS codes are not included on the Medicare Telehealth Services List, so no Medicare payment is made if these services are furnished via telehealth.
4. Can CTS services be furnished without the consent of the patient or, if applicable, their representative?
    a. No, consent is required from the patient or, if applicable, the patient's representative for a caregiver to receive CTS. The consent must be documented in the patient's medical record.
5. How are group CTS codes billed?
    a. Practitioners should select the appropriate group or individual CTS code based on the number of beneficiaries represented by caregivers receiving training. If multiple caregivers for one beneficiary are trained at the same time, practitioners would use the applicable CTS codes designated as "individual" (97550, 97551), but would not bill separately for each of the beneficiary's caregivers. If caregivers for more than one beneficiary are trained at the same time, practitioners would bill using the applicable CTS codes designated as "group" (96202, 96203, 97552). Practitioners would bill one service per beneficiary, regardless of the number of caregivers. Please see the examples below.
        i. A practitioner furnishes a 60-minute group behavior management/modification CTS for the benefit of both Beneficiary A and Beneficiary B. The group attending the session consists of the husband of beneficiary A (beneficiary A's caregiver) and the two adult children of beneficiary B (beneficiary B's caregivers). CPT code 96202 will be billed two times: once for beneficiary A and once for beneficiary B.
        ii. A practitioner furnishes a 30-minute CTS in strategies and techniques to facilitate the patient's functional performance in the home or community for the benefit of one beneficiary, Beneficiary C. The wife and adult child of beneficiary C (beneficiary C's caregivers) attend the session. CPT code 97550 would be billed one time for beneficiary C.
        iii. A practitioner furnishes a 30-minute CTS in strategies and techniques to facilitate the patient's functional performance in the home or community for the benefit of one beneficiary, Beneficiary D. The partner of beneficiary D (beneficiary D's caregiver) attends the session. CPT code 97550 would be billed one time for beneficiary D.

   iv. A practitioner furnishes a group CTS in strategies and techniques to facilitate the patient's functional performance in the home or community for the benefit of Beneficiaries A, B, C, and D. The group attending the session consists of the husband of beneficiary A (beneficiary A's caregiver), the two adult children of beneficiary B (beneficiary B's caregivers), the wife and adult child of beneficiary C (beneficiary C's caregivers), and the partner of beneficiary D (beneficiary D's caregiver). CPT code 97552 would be billed four times: once for beneficiary A, once for beneficiary B, once for beneficiary C, and once for beneficiary D.

6. Who can furnish CTS?
   a. Physicians, certain non-physician practitioners, and therapists, including:
      i. Nurse practitioners (NPs)
      ii. Clinical nurse specialists (CNSs)
      iii. Certified nurse-midwives (CNMs)
      iv. Physician assistants (PAs)
      v. Clinical psychologists (CPs), clinical social workers (CSWs), marriage and family therapists (MFTs), and mental health counselors (MHCs)
      vi. Physical therapists (PTs), occupational therapists (OTs), and speech-language pathologists (SLPs)
7. Can licensed clinical social workers (CSWs), marriage and family therapists (MFTs), and mental health counselors (MHCs) furnish CTS?
   a. Medicare covers services of CSWs, MFTs, and MHCs for the diagnosis and treatment of mental illnesses including substance use disorders. CSWs, MFTs, and MHCs can furnish and bill for medically necessary CTS to assist their patient in carrying out their treatment plan.
8. Can CTS be provided to multiple caregivers for one beneficiary?
   a. One beneficiary may have more than one caregiver who attends a caregiver training session. If multiple caregivers for the same beneficiary are trained together in the same session, the practitioner would not bill separately for each caregiver. If more than one caregiver for the same beneficiary is trained at the same time, the practitioner would bill for one CTS training session using the applicable individual CTS code (CPT 97550, 97551), regardless of how many of the patient's caregivers are being trained in the same CTS session.
9. Are there limits on how often I can bill CTS?

   a. There are no limits to how often CTS can be billed, however, the medical necessity of CTS for the patient should determine the volume and frequency of the training. The volume and frequency of CTS sessions furnished to caregivers by the treating practitioner for the same patient may be based on the treatment plan, as well as changes in the patient's condition, the patient's diagnosis, or the patient's caregivers. CTS could be considered reasonable and necessary when the treating practitioner determines a caregiver needs more training to ensure a successful patient treatment plan outcome. We require the treating practitioner to document the need for each occurrence of CTS in the medical record.

10. In what settings can CTS be provided and billed?
    a. CTS can be furnished in both facility and non-facility settings.
11. Do deductible/coinsurance amounts apply to this code?
    a. The usual Part B deductible and coinsurance apply. When a beneficiary (or their representative, if applicable) elects to receive CTS, we encourage practitioners to notify the beneficiary that Part B cost sharing will apply as it does for other physicians' services under the Medicare program.
12. Are CTS limited to beneficiaries with certain diagnoses?
    a. There are no limits on the specific diagnosis that a beneficiary must have for their caregiver to receive CTS. We acknowledge that there are many circumstances under which CTS may be reasonable and necessary to train a caregiver who assists in carrying out a treatment plan.
13. Where can I find additional information on CTS?
    a. Please reference the "Health Equity Services in the 2024 Physician Fee Schedule Final Rule" MLN (https://www.cms.gov/files/document/mln9201074-health-equity-services-2024-physician-fee-schedule-final-rule.pdf-0)
    b. CTS policy guidance and discussions can be found in the following Physician Fee Schedule rules:
       i. CY 2024 (88 FR 78818) https://www.federalregister.gov/documents/2022/11/18/2022-23873/medicare-and-medicaid-programs-cy-2023-payment-policies-under-the-physician-fee-schedule-and-other

SDOH Risk Assessment

This document answers frequently asked questions about billing for Social Determinants of Health (SDOH) Risk Assessment under the Physician Fee Schedule (PFS) using G-code G0136 beginning January 1, 2024.

1. What requirements does CMS have for SDOH risk assessment tools?
    a. The SDOH risk assessment can be furnished using any standardized, evidence-based SDOH risk assessment tool that has been tested and validated through research, and includes the domains of food insecurity, housing insecurity, transportation needs, and utility difficulties may be used to conduct the SDOH risk assessment. Examples of evidence-based tools include the CMS Accountable Health Communities (AHC) tool, the Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences (PREP ARE) tool, and instruments identified for Medicare Advantage Special Needs Population Health Risk Assessment. These examples are non-exhaustive. Physicians and other practitioners may also choose to use a tool or ask additional questions to assess other areas of SDOH risk that are prevalent in or culturally important to your patient population, including combining questions from multiple standardized, validated tools.
2. Do the results of the SDOH risk assessment need to be documented in the medical record?
    a. Any SDOH need identified through the risk assessment (HCPCS code G0136) must be documented in the patient's 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.
3. Is HCPCS code G0136 intended to be used with all Medicare patients, or just when a physician or practitioner determines it is relevant for the patient?
    a. The SDOH risk assessment is intended to be used when a practitioner has reason to believe there are unmet SDOH needs that could interfere with the practitioner's diagnosis and treatment of a condition or illness. HCPCS code G0136 is not designed for routine screening. Instead, it is an assessment of one or more known or suspected SDOH needs that may interfere with the practitioners' diagnosis or treatment of the patient.
4. Are there limits on how often I can bill for SDOH risk assessment?
    a. Yes, in the CY 2024 PFS Final Rule, we established a limitation on payment for the SDOH risk assessment service of once every 6 months per practitioner per beneficiary.

5. In what settings can the SDOH risk assessment be performed and billed? Can SDOH risk assessments be furnished in conjunction with any E/M visit, including a home or residence E/M visit?
    a. The SDOH risk assessment can be performed in both facility and non-facility settings and can be furnished in conjunction with an outpatient E/M visit, including transitional care management services and hospital discharge visits, for which the billing practitioner identifies a need for the SDOH risk assessment to evaluate whether there are health-related social needs that may interfere with the practitioner's ability to diagnose or treat the patient. The SDOH risk assessment would not be performed in conjunction with a level 1 E/M visit or other similar low-level visits that could be performed by clinical staff. The SDOH risk assessment can also be performed in conjunction with some behavioral health visits (such as CPT code 90791 or HBAI codes (96156, 96158, 96159, 96164, 96165, 96167, and 96168)) and the Annual Wellness Visit.
6. Who can perform the SDOH risk assessment?
    a. The SDOH risk assessment can be performed by the treating physician or other practitioner (NPs, CNSs, CNMs, PAs), or by auxiliary personnel under the general supervision of the billing practitioner incident to their professional services.
7. How long before the E/M visit can the SDOH risk assessment be furnished?
    a. The SDOH risk assessment is not required to be furnished on the same day as the associated E/M or behavioral health visit. However, in most cases, HCPCS code G0136 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, but rather is covered based on the practitioner's identification of one or more known or suspected SDOH needs that may interfere with the practitioner's diagnosis or treatment of the patient.
8. Do deductible/coinsurance amounts apply to this code?
    a. The usual Part B deductible and coinsurance apply except when the SDOH risk assessment is furnished as an optional element of the AWV (see MLN Matters article MM9271/CR9271 for more information). When a beneficiary (or their representative if applicable) elects to receive the SDOH risk assessment, we encourage practitioners to notify the beneficiary that Part B cost sharing will apply as it does for other physicians' services under the Medicare program (except when furnished as an optional element of the AWV).
9. Can SDOH risk assessment be furnished via telehealth?

   a. Yes, HCPCS code G0136 was added to the Medicare Telehealth Services List on a permanent basis.

10. Where can I find additional information?
    a. Please reference the "Health Equity Services in the 2024 Physician Fee Schedule Final Rule" MLN (https://www.cms.gov/files/document/mln9201074-health-equity-services-2024-physician-fee-schedule-final-rule.pdf-0)
    b. SDOH Risk Assessment policy guidance and discussions can be found in the following Physician Fee Schedule rules:
       i. CY 2024 (88 FR 78818) https://www.federalregister.gov/documents/2022/11/18/2022-23873/medicare-and-medicaid-programs-cy-2023-payment-policies-under-the-physician-fee-schedule-and-other

Community Health Integration

This document answers frequently asked questions about billing Community Health Integration (CHI) under the Physician Fee Schedule (PFS) using G code G0019 & G0022 beginning January 1, 2024.

1. What types of visits may serve as CHI initiating visits?
   a. The CHI initiating visit can be an E/M visit that the practitioner who will bill CHI personally performs, in which they identify unmet SDOH need(s) that significantly limit their ability to diagnose or treat the problem being addressed in the visit. For example, it cannot be a level 1 E/M visit done by clinical staff, a visit where the medical problem is not addressed, or an ED visit or inpatient visit where the furnishing practitioner will not also furnish the subsequent CHI services. The E/M visit included in transitional care management services (or other care management bundles containing an E/M visit) that meets these criteria can serve as the CHI initiating visit. An AWV can serve as a CHI initiating visit if performed by the practitioner who will bill CHI, and if the practitioner furnishing the AWV identifies an unmet SDOH need(s) that will prevent the patient from carrying out the recommended personalized prevention plan. For example, an AWV furnished by a registered dietician could not serve as the CHI initiating visit. The CHI initiating visit is billed separately (if all requirements to do so are met) and is a pre-requisite to the practitioner billing for CHI services.
2. When is it appropriate to furnish and bill CHI services?
   a. CHI services may be reasonable and necessary when the practitioner identifies the presence of SDOH need(s) that significantly limit the billing practitioner's ability to

diagnose or treat the problem addressed in the CHI initiating visit, or other such SDOH needs that may be identified during the course of providing CHI services. CHI services are meant to resolve those specific unmet need(s) to facilitate the 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.

3. Are CHI services using codes G0019 and G0022 only applicable when working with underserved communities? If so, how is this defined?
   a. No, we did not create any requirements specific to the patient's community. Rather, the services are 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.
4. What kind of certification or training is needed for auxiliary personnel providing CHI services under the general supervision of the billing physician or other practitioner?
   a. Auxiliary personnel, including community health workers, must meet applicable State requirements, including certification or licensure. In States with no applicable requirements, auxiliary personnel providing CHI services must be trained or certified in the competencies of:
      i. Patient and family communication
      ii. Interpersonal and relationship-building
      iii. Patient and family capacity-building
      iv. Service coordination and system navigation
      v. Patient advocacy, facilitation, individual and community assessment
      vi. Professionalism and ethical conduct
      vii. Development of an appropriate knowledge base, including of local community-based resources.
5. Can CHI services be furnished without beneficiary consent?
   a. No, we require advance consent for CHI services. Consent may be obtained by the billing practitioner or auxiliary personnel. It only has to be obtained once (in cases where the billing practitioner changes, obtain a new consent). Consent can be written or verbal, so long as it is documented in the patient's medical record. You must explain to the patient that cost sharing will apply and that only one practitioner per month can bill for CHI services.
6. Who can bill for CHI services?

a. CHI services are generally provided by auxiliary personnel incident to and under the general supervision of the professional services of the billing physician or other practitioner who also provides the CHI initiating visit. CHI services can be furnished and billed by physicians, NPs, CNSs, CNMs, and PAs, and must be billed by the same physician or practitioner who performs the initiating CHI visit.

Principal Illness Navigation

This document answers frequently asked questions about billing Principal Illness Navigation Services (PIN) under the Physician Fee Schedule (PFS) using G codes G0023, G0024, G0140, and G0146 beginning January 1, 2024.

1. What types of patients are eligible for PIN services?
    a. PIN services could be furnished following an initiating visit addressing a serious high-risk condition/illness/disease, with the following characteristics:
        i. 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.
        ii. 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.
    b. Some examples of a serious, high-risk condition/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 (SUD).
2. Can a single practitioner bill two separate PIN services for two separate serious, high-risk conditions for the same beneficiary?
    a. No, one practitioner cannot bill PIN for multiple conditions for the same beneficiary. Please see information about Chronic Care Management, as that service may be appropriate for beneficiaries with multiple chronic conditions.
3. Are there limits on how often I can bill PIN?
    a. 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 utilizing the same navigator or billing practitioner. PIN and Principal Illness Navigation—Peer Support (PIN–PS) should not be billed concurrently for the same serious, high-risk

condition. Beneficiaries can receive more than one PIN service at a time, as long as the services are not treating the same condition or furnished by the same practitioner.

4. What types of visits may serve as PIN initiating visits?
    a. The PIN initiating visit can be an E/M visit (other than a low-level E/M visit that can be performed by clinical staff) that is furnished by the practitioner who will bill for the PIN services, and in which the practitioner establishes an appropriate treatment plan for the serious, high-risk condition including PIN services. An ED visit or inpatient visit cannot serve as the PIN initiating visit since the furnishing practitioner will not also furnish the subsequent PIN services. The E/M visit included in transitional care management services (or other care management bundles containing an E/M visit) can serve as the PIN initiating visit. An AWV can serve as a PIN initiating visit if performed by the practitioner who will furnish and bill for the PIN services and identifies in the AWV a high-risk condition that meets the criteria for PIN services. So, for example, an AWV performed by a dietician could not serve as the PIN initiating visit. A psychiatric diagnostic evaluation (CPT code 90791), or the Health Behavior Assessment and Intervention (HBAI) services (CPT codes 96156, 96158, 96159, 96164, 96165, 96167, and 96168) can also serve as initiating visits if the same practitioner will furnish PIN and is addressing the serious, high-risk condition during the initiating service. A PIN initiating visit is a prerequisite to billing for PIN services. You'll bill the PIN initiating visit separately from PIN services (if all requirements for billing the visit are met).
5. What kind of certification or training is needed for auxiliary personnel providing PIN services under the general supervision of the billing physician or other practitioner?
    a. Auxiliary personnel must meet applicable State requirements, including certification or licensure. In States with no applicable requirements, auxiliary personnel providing PIN services must be trained or certified in the competencies of:
        i. Patient and family communication
        ii. Interpersonal and relationship-building
        iii. Patient and family capacity building
        iv. Service coordination and systems navigation
        v. Patient advocacy, facilitation, individual and community assessment
        vi. Professionalism and ethical conduct
        vii. Development of an appropriate knowledge base, including specific certification or training on the serious, high-risk condition, illness, or disease being addressed.
6. Can PIN services be furnished without beneficiary consent?

    a. No, we require consent for PIN services. Consent must be obtained before or at the same time that services commence, and annually thereafter by the billing practitioner. If the billing practitioner changes, obtain a new consent. Consent can be written or verbal, so long as it is documented in the patient's medical record.

7. Who can bill for PIN services?
    a. Physicians and practitioners who can furnish the PIN initiating visit can also furnish and bill for PIN services. PIN services are generally provided by auxiliary personnel incident to and under the general supervision of the professional services of the billing physician or other practitioner who also provides the PIN initiating visit. The PIN services must be furnished and billed by the same physician or practitioner who performs the PIN initiating visit.

Principal Illness Navigation-Peer Support

1. What kind of certification or training is needed for auxiliary personnel providing PIN-PS services under the general supervision of the billing physician or other practitioner?
    a. Auxiliary personnel performing PIN-PS services (HCPCS codes G0140 and G0146), must meet applicable State requirements, including certification or licensure. In States with no applicable requirements, auxiliary personnel providing PIN-PS services must be trained consistent with the National Model Standards for Peer Support Certification published by the Substance Abuse Mental Health Services Administration (SAMHSA). These are the most universally recognized standards for peer support specialists in the country and were developed and are maintained by SAMHSA, which has expertise in this area.
2. Can PIN-PS services be furnished without beneficiary consent?
    a. No, we require consent for PIN-PS services. Consent must be obtained before or at the same time that services commence, and annually thereafter by the billing practitioner. If the billing practitioner changes, obtain a new consent. Consent can be written or verbal, so long as it is documented in the patient's medical record. The practitioner or auxiliary personnel should explain to the patient that cost sharing will apply.
3. Who can bill for PIN-PS services?
    a. Physicians and practitioners who can furnish the PIN-PS initiating visit can also furnish and bill for PIN-PS services. PIN-PS services are generally provided by auxiliary personnel incident to and under the general supervision of the professional services of the

billing physician or other practitioner who also provides the PIN-PS initiating visit. The PIN-PS services must be furnished and billed by the same physician or practitioner who performs the initiating PIN-PS visit.

Community Health Integration, Principal Illness Navigation, and Principal Illness Navigation- Peer Support

This document answers frequently asked questions about billing that are applicable to Community Health Integration (CHI) (G code G0019 & G0022) and Principal Illness Navigation (PIN) (G0023, G0024, G0140, and G0146) services under the Physician Fee Schedule (PFS) beginning January 1, 2024.

1. 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.
2. Can auxiliary personnel provide CHI, PIN, and PIN-PS services? What staff does CMS consider to be auxiliary personnel?
    a. Yes, auxiliary personnel can provide the CHI and PIN services incident to the professional services of the physician or practitioner who bills the initiating visit and associated CHI or PIN services. The CHI or PIN services must be furnished and billed by the same physician or practitioner who performs the CHI or PIN initiating visit. The auxiliary personnel who provide the CHI or PIN services may be external to and under contract with the practitioner or their practice, such as through a community-based organization (CBO) that employs CHWs or other auxiliary personnel, as long as they meet all "incident to" and other requirements and conditions for payment of CHI and PIN services. We would expect the auxiliary personnel providing CHI and PIN services to communicate regularly with the billing physician or practitioner to ensure that CHI and PIN services are appropriately documented in the patient’s medical record, and to continue to involve the billing physician or practitioner in evaluating the continuing need for CHI and PIN services to address the serious, high-risk condition.

i. ***Auxiliary personnel*** refer to individuals who are supervised by physicians or other billing practitioners to perform services incident to the professional services of the practitioner. These individuals can be employees, leased employees, or independent contractors of the billing practitioner. They must not have been excluded from the Medicare, Medicaid, or other federally funded health care programs by the Office of the Inspector General or had their Medicare enrollment revoked. They must meet any applicable requirements to furnish "incident to" services, including licensure, imposed by the State in which the services are being furnished.

3. In what settings can CHI and PIN services be provided and billed?
    a. CHI and PIN services can be furnished in both facility and non-facility settings. We created payment rates under the Physician Fee Schedule (PFS) that appropriately reflect the resources involved in furnishing these physician's services in an institutional or facility setting, and outside of such settings. The CHI and PIN codes are priced in both the facility and non-facility settings. The billing physician or practitioner should report the place of service (POS code) for the location where they would ordinarily provide in-person, face-to-face care to the beneficiary. For instance, a billing practitioner who ordinarily furnishes in-person, face-to-face care to a beneficiary in a hospital outpatient department should bill for CHI or PIN services using the place of service for hospital outpatient departments for the professional work associated with the service, which will be paid at the facility rate.
4. Do deductible/coinsurance amounts apply to these codes?
    a. Yes, the usual Part B deductible and coinsurance apply.
5. 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.
6. What are the documentation requirements for CHI and PIN?
    a. The amount of time spent by the auxiliary personnel, and the activities they performed in relation to the practitioner's plan of care, should be reflected in the patient's medical record. Auxiliary personnel may but are not required to enter this information themselves in the medical record. We do not specify who enters data in the medical record, as long as

the billing practitioner reviews and verifies the documentation. When unmet social determinants of health (SDOH) needs are being addressed, those must be documented in the patient's 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.

7. 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.

8. 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.

9. What are the payment rates for CHI, PIN, and PIN-PS?
    a. Office-based practitioners are paid approximately $80 for the first hour of services, and $50 for each additional half hour. Facility-based practitioners are paid approximately $50 for the first hour of services, and $35 for each additional half hour (these rates reflect that the facility is being paid for their part of the services under other payment systems, such as the hospital outpatient prospective payment system). Payment rates vary slightly annually, and can be looked up here by geographic area, facility type, and other parameters: [Overview of the Medicare Physician Fee Schedule Search | CMS]().

10. Do community health workers, peer support workers, or care navigators need to be enrolled as Medicare providers to be considered auxiliary personnel?
    a. Medicare does not make direct payment to community health workers, navigators, peer support specialists, or other auxiliary personnel. Medicare will pay for the services they provide incident to the services, and under the supervision of the health care practitioner who is enrolled in the Medicare program and bills for their services. See 42 CFR 410.26 and 42 CFR 410.27 for more information. The auxiliary personnel may be external to and

under contract with the practitioner or their practice, such as through a community-based organization (CBO) that employs community health workers, navigators, peer support specialists, or other auxiliary personnel, if they meet all "incident to" requirements and conditions for payment of PIN, PIN-PS, or CHI services.

11. Where can I find additional information?
    a. Please reference the "Health Equity Services in the 2024 Physician Fee Schedule Final Rule" MLN (https://www.cms.gov/files/document/mln9201074-health-equity-services-2024-physician-fee-schedule-final-rule.pdf-0)
    b. CHI, PIN, and PIN-PS policy guidance and discussions can be found in the following Physician Fee Schedule rules:
        i. CY 2024 (88 FR 78818) https://www.federalregister.gov/documents/2022/11/18/2022-23873/medicare-and-medicaid-programs-cy-2023-payment-policies-under-the-physician-fee-schedule-and-other