Changes in Medicare….

In 2024 Medicare has created additional codes to support the clinical work provided to patients with a variety of issues from assessment of Social Determinants of Health (SDoH), to complexity, caregiver training and Principle Diagnoses Management. The following is a summary of the new coding process.

The Code G0136 $17.57 (Ohio)	Definition G0136 Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment, 5-15 minutes
Who can use the code	MD, DO, APN, CNS, PA, independently licensed mental health providers. This can be provided incident to by trained support staff.
ICD 10 Considerations	If positive SDoH are identified then the specific ICD 10 codes within the Z code section (Chapter 21) should be specifically identified.
Documentation Considerations	A physician or other qualified health care professional administers an assessment of an individual's social determinants of health (SDOH) or identified social risk factors that may influence the diagnosis and treatment of medical conditions. SDOH can limit the provider's ability to diagnose or treat a condition and the patient's ability to follow the prescribed treatment plan. This service is reported in addition to an E/M service or the annual wellness visit (AWV). This service may only be reported once every six months. This service is approved by Medicare as a telehealth service and may be performed by staff under incident-to guidelines. This is **not a screening** but an assessment, and it is to be used when the practitioner believes that the patient has unmet SDOH needs that are interfering with the diagnosis or treatment of an illness. CMS is also allowing G0316 to be furnished on the same day as 90791 (psychiatric diagnostic evaluation) and with Health Behavior Assessment and Intervention codes 96156, 96158, 96159,96164, 96165, 96167, and 96168. **G0136 may also be done in conjunction with the AWV for primary care.** The specific tools used to assess these issues should be identified as well as the total time involved in this activity. The ICD 10 code when no SDoH found would be the ICD 10 for the visit, when positive the appropriate Z code for the SDoh. This is not to be done more often than every 6 months." The risk assessment is in relation to the patient's social risk factors that influence the diagnosis and treatment of medical conditions. This is a service that can be performed in outpatient settings, with the exception of discharge visits/planning.

Things to consider:

- When the SDoH is positive there should be a plan in place to support these issues with identified referrals and/or other considerations.
- This assessment will tie into other new coding process in 2024 for treatment planning for care, training and support.

The Code	Definition
G0019 $75.38 G0022 $47.28	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 For each additional 30 minutes during the identified month.
Who can use the code	This service can be provided incident to an MD, DO, APN, PA by trained staff. The initial provider would have performed the G0136 and identified a plan of care which the support person then follows. This most likely would be a primary care provider but is not limited to primary care alone based on the role of the consulting provider or specialist.
ICD 10 Considerations	The identified ICD 10 codes for primary medical issues as well as the Z codes for the SDoH and related issues.
Documentation Considerations	Certified or trained auxiliary personnel provide community health integration services to address social determinants of health (SDOH) with a patient under the direction of a physician or other qualified health care professional. SDOH can limit the provider's ability to diagnose or treat a condition and the patient's ability to follow the prescribed treatment plan. The provider performs a person-centered assessment to identify the SDOH needs and the problems that need to be addressed in an initiating E/M service. This service may include information about the patient such as their life story, strengths, goals, preferences, and cultural and linguistic factors. After setting goals with the patient and developing an action plan, support is provided to the patient to continue the desired treatment plan. The provider also coordinates care with other health care professionals, facilities, and caregivers as necessary, including referrals to specialists or follow-up visits after care in a facility such as an emergency room or skilled nursing facility. The patient may require community-based social services specific to their SDOH needs (e.g., food assistance, transportation). Additional services may be necessary to support the patient in accomplishing the treatment goals. Report G0019 for the first 60 minutes of community health integration services per calendar month and G0022 for each additional 30 minutes per calendar month.

Things to consider:

- A formal plan needs to be part of the medical record identifying the specific issues being addressed; the participating individuals including informed consent for the intervention.
- Specific goals for the patient for these issues would be identified taking into account the patient's life story, ethnicity, strengths, weaknesses, support system and short and long-term needs.
- A log of services, supports and contacts provided with the specific time identified. (example coordination with housing/placement search; referrals for ABC). Services would be both in person, over the phone, utilizing audio/video support as needed.
- This service is billed monthly under the supervising provider who performed the assessment and is the patient's primary provider in the setting.

The Code G2211 $15.66	Definition Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)
Who can use the code	Any medical provider – MD, DO, APN, PA that is providing continual and ongoing support and care. This would not be used for episodic care unless that care involved continual (Longitudinal) issues.
ICD 10 Considerations	The diagnoses would identify a chronic condition with issues or concerns.
Documentation Considerations	This add-on code represents the additional time and resources associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a serious or complex condition for a new or established patient. The relationship between the provider and the patient must be ongoing to provide consistency and continuity for the patient's acute or chronic health conditions over a long period of time. Medical conditions managed by the single provider may span a broad spectrum of diagnoses and organ systems. The provider's continued responsibility for the patient's health care needs increases the complexity of the evaluation and management service. Report this code in addition to an office or outpatient evaluation and management (E/M) code.

Things to consider:

- **Can only be coded with office based services not any facility CPT codes or POS**
- This add on cannot be coded with any other procedures codes (joint injections, debridement, etc.)
- E/M visit complexity add-on reflects the time, intensity, and PE resources involved when practitioners furnish the kinds of O/O E/M office visit services that enable them to build longitudinal relationships with all patients (that is, not only those patients who have a chronic condition or single high-risk disease) and to address the majority of patients' health care needs with consistency and continuity over longer periods of time. In response to comments, we also made further refinements to the HCPCS code descriptor to clarify that the code applies to a serious condition rather than any single condition
- The assessment and plan should be specific as to why the visit and condition was complex in nature and the needs of the patient and care provided that supported this (there are no assumptions by diagnoses or type of provider that this would be appropriate).
- The assessment should include a follow up care plan as part of this process that is specific in timing, plan and care needs (not PRN).

The Code	Definition
96202 $22.47	96202 Multiple-family group behavior management/modification training for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parent(s)/guardian(s)/caregiver(s); initial **60** minutes Face-to-face training with multiple sets of parent(s)/guardian(s)/caregiver(s) of a patient with a mental or physical health condition.
96203 $5.42	Each additional 15 minutes
Who can use the code	MD, DO, APN, PA – not incident to
ICD 10 Considerations	The specific ICD 10 code would be specific to the condition for training with the identified Z codes or specific physical condition ICD 10 codes.
Documentation Considerations	The physician or other qualified health care professional provides face-to-face behavior management or modification training to multiple sets of parents, guardians, or caregivers for the patient (who is not present). The physician trains guardians and caregivers with evidence-based strategies and procedures targeted toward the patient's mental or physical health diagnosis and adverse behaviors. The training is intended to equip guardians and caregivers with skills and methods to utilize with the patient with a goal of eliciting more positive behaviors and improved health and well-being. Behavior modification focuses on changing behavioral patterns over the long-term using different motivational methods. Report **96202** for the initial **60** minutes of face-to-face time and **96203** for each additional **15** minutes. This requires a specific plan of action, training goals and objectives in the group setting.

Things to consider:

- Support for caregivers who are assisting a relative/friend requiring palliative care may incorporate practical, educational, psychological, spiritual, financial, or social strategies — based on unmet needs and a desire by the caregiver(s) for assistance — with the intention of enhancing the caregiver's capacity to undertake their role, respond to its challenges, and maintain their own health (during and after their relative/friend's death).
- The training should be directly relevant to the person-centered treatment plan for the patient in order for the services to be considered reasonable and necessary under the Medicare program. Each behavior should be clearly identified and documented in the treatment plan, and the caregiver should be trained in positive behavior management strategies. In terms of frequency, CMS identified "In other words, the medical necessity of CTS for the patient should determine the volume and frequency of the training." .There may be instances in which the patient has a new caregiver who needs the training. The volume and frequency for the same patient may be based on the treatment plan, changes in the patient's condition, the diagnosis or the caregivers.
- A treatment plan is required detailing the services provide included informed consent by patient with identified caregiver - the treatment plan would include:
    - Identify the issues the patient has that the caregiver is managing
    - Identify the specific goals for the caregiver with the patient and what steps are needed to achieve these goals

- What is the timeframe for this process
- Topics for training may include" behavior, identifying triggers, reinforcers, strategies, specific skills, functional communication, self help, attention and tasks
- What are the barriers for the patient (transportation, illness, family issues) to achieve these goals with the caregiver
- What resources and support will be provided
- For each encounter documentation of care and time involved

The Code	Definition
97550 $50.46 97551 $25.18 97552 $20.70	97550 Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face; initial **30** minutes Each additional 15 minutes 97552 Group caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face with multiple sets of caregivers
Who can use the code	MD, DO, APN, PA , OT, PT and SLP Not provided incident to
ICD 10 Considerations	Specific ICD 10 coding that reflects the severity of the condition with functional issues specifically coded.
Documentation Considerations	Caregiver training is provided without the patient present to teach the caregiver how to facilitate a patient's functional performance in the home or community. The face-to-face training is a structured educational process aimed at equipping the caregiver with the knowledge and skills necessary to support and enhance the independent daily functioning of individuals requiring care. This training encompasses a range of practical strategies and techniques tailored to the specific needs and challenges of the patient, enabling the caregiver to create a safe, conducive, and empowering environment that promotes the patient's well-being, autonomy, and successful engagement in various activities of daily living. Report **97550** for the first **30** minutes of training. Report **97551** for each additional **15** minutes.

Things to consider:

- Caregiver training is direct, skilled intervention for the caregiver(s) to provide strategies and techniques to equip caregiver(s) with knowledge and skills to assist patients living with functional deficits. Codes 97550, 97551 are used to report the total duration of face-to-face time spent by the qualified health care professional providing training to the caregiver(s) of an individual patient without the patient present. Code 97552 is used to report group caregiver training provided to multiple sets of caregivers for multiple patients with similar conditions or therapeutic needs without the patient present.
- A therapy plan is in place with specific goals, objectives, with time idenditifed.

- During a skilled intervention, the caregiver(s) is trained using verbal instructions, video and live demonstrations, and feedback from the qualified health care professional on the use of strategies and techniques to facilitate functional performance and safety in the home or community without the patient present. Skilled training supports a caregiver's understanding of the patient's treatment plan, ability to engage in activities with the patient in between treatment sessions, and knowledge of external resources to assist in areas such as activities of daily living (ADLs), transfers, mobility, safety practices, problem solving, and communication
- 97550-97552 are sometimes therapy codes also provided by MD, DO, APN as well as PT, OT, SLP.

Principle Illness Navigation Services with both CPT and HCPCs Codes

	CPT PCM 99424	CPT PCM 99426	HCPCS PIN G0023	HCPCS PIN G0140
Type of staff	Physician or other Qualified Health Care Professional (APN/PA)	Clinical support staff	Patient navigator/ certified peer specialist	Peer specialist
Patient condition	1 Complex	1 Complex	1 Serious	Behavioral Health
Reporting time interval	30 minutes, for each additional 30 minutes 99425	30 minutes, for each additional 30 minutes 99427	60 minutes, for each additional 30 minutes G0024	60 minutes, for each additional 30 minutes G0146
Billed	Per calendar month	Per calendar month		

The Code	Definition
99424 $ 78.64 99425 $56.89	99424 Principal care management services, for a single high-risk disease, with the following required elements: one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death, the condition requires development, monitoring, or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities, ongoing communication and care coordination between relevant practitioners furnishing care; first **30** minutes provided personally by a physician or other qualified health care professional, per calendar month.
Who can use the code	This code is used for the physician (MD/DO), APN, CNS, or PA personally providing the care
ICD 10 Considerations	Diagnoses must be significant (not unspecified)
Documentation Considerations	Time spent by a clinician coordinating an individual's care plan with other health care professionals including medication adjustments and ongoing communication, for patient with complex chronic condition. This is per month so there would be a log or ongoing running document with time totaled at the end of the month Principal care management services are provided to patients for a single high-risk disease. There is one complex condition that is chronic and expected to last a minimum of three months that puts the patient at substantial risk of exacerbation, functional decline, hospitalization, or death. The disease-specific care plan related to this condition requires on-going development, monitoring, or revising. Frequent adjustments to the medication regimen are required, or patient comorbidities increase the complexity of the condition's management. Communication and care coordination between those furnishing care is required on an ongoing basis. Report **99424** once per calendar month for the first **30** minutes of care provided personally by a physician or other qualified health care professional (QHP); report **99425** for each additional **30** minutes.

Things to consider:

- Diagnoses must be significant and informed consent must be part of this process.
- There would be a detailed treatment plan for services provided with a summary of the services and time involved.

The Code	Definition
99426 $58.72 99427 $44.63	99426 Principal care management services, for a single high-risk disease, with the following required elements: one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death, the condition requires development, monitoring, or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities, ongoing communication and care coordination between relevant practitioners furnishing care; first **30** minutes of clinical staff time directed by physician or other qualified health care professional, per calendar month.
Who can use the code	Clinical staff (RN, LPN, MA with specific are coordination training) billed under the physician/QHP originating the plan of care.
ICD 10 Considerations	Significant diagnoses
Documentation Considerations	Principal care management services are provided to patients for a single high-risk disease. There is one complex condition that is chronic and expected to last a minimum of three months that puts the patient at substantial risk of exacerbation, functional decline, hospitalization, or death. The disease-specific care plan related to this condition requires on-going development, monitoring, or revising. Frequent adjustments to the medication regimen are required, or patient comorbidities increase the complexity of the condition's management. Communication and care coordination between those furnishing care is required on an ongoing basis. Report **99425** for each additional **30** minutes. Report **99426** once per calendar month for the first **30** minutes of clinical staff time when directed by a physician or other QHP; for each additional 3**0** minutes, report **99427**.

Things to consider:

- The care plan by the physician or QHP must be detailed in terms of the management provided by the support staff in a treatment plan process with informed consent by the patient/caregiver.
- The management of the services is under the direction of the provider that must be reflected within the notes and treatment plan.
- Billed monthly based on total time in contact (face to face, phone and by other activities)

The Code	Definition
G0023 $ 75.38 G0024 $47.28	G0023 Principal illness navigation 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: G0024 for each additional 30 minutes
Who can use the code	Support staff under the direction of a physician or QHP
ICD 10 Considerations	Specific diagnoses for care provided
Documentation Considerations	Principal Illness Navigation (PIN) services are performed by certified or trained auxiliary personnel under the direction of a physician or other practitioner. PIN services are provided to Medicare patients with high-risk conditions who receive a patient-centered assessment to better identify their needs and connect them to clinical and support resources. High-risk conditions for which PIN services are provided include, but are not limited to, congestive heart failure (CHF), chronic kidney disease (CKD), dementia, cancer, HIV/AIDS, organ failure, substance use disorder (SUD), and mental health conditions. PIN services are provided during an initial visit and in subsequent visits to establish ongoing support and direction as the patient connects to disease-specific resources related to their high-risk condition. Examples of PIN services include establishing a comprehensive record of the patient's health history along with their cultural and linguistic identities, aligning care coordination, targeting illness-specific health education, providing health-care system navigation, building patient self-advocacy skills, and enabling access to services that address unmet social determinations of health (SDOH) needs. Report G0023 for the first 60 minutes of PIN services provided per calendar month. Report G0024 for each additional 30 minutes of PIN services provided per calendar month; list separately in addition to G0023.

Things to consider:

- The primary issue for this coordination of care is medical in nature.
- The care plan by the physician or QHP must be detailed in terms of the management provided by the support staff in a treatment plan process with informed consent by the patient/caregiver.
- The management of the services is under the direction of the provider that must be reflected within the notes and treatment plan.
- Billed monthly based on total time in contact (face to face, phone and by other activities) under the supervising provider (MD, DO, APN, PA_

The Code	Definition
G0140 $ 75.38 G0146 $47.28	Principal illness navigation-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: G0146 for each additional 30 minutes
Who can use the code	Support staff under the direction of a physician or QHP
ICD 10 Considerations	Specific diagnoses for care provided that is mental health/SUD in nature
Documentation Considerations	Principal Illness Navigation (PIN) services are performed with peer support (PIN-PS) from certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a certified peer specialist. Peer support specialists may include individuals who have experience with the patient's shared high-risk illness. Principles of peer support specialists include empathy and shared personal experience, focus on individual patient strengths, and provision of support to patients as they work toward recovery and/or management of their illness within their plan of care. PIN services are provided to Medicare patients with high-risk conditions who receive a patient-centered assessment to better identify their needs and connect them to clinical and support resources. High-risk conditions for which PIN-PS services are given include behavioral health conditions that otherwise satisfy the definition of a high-risk condition(s). PIN-PS services are provided during an initial visit and in subsequent visits to establish ongoing support and direction as the patient connects to disease-specific resources related to their high-risk condition. Examples of PIN services include establishing a comprehensive record of the patient's health history along with their cultural and linguistic identities, aligning care coordination, targeting illness-specific health education, providing health-care system navigation, building patient self-advocacy skills, and enabling access to services that address unmet social determinations of health (SDOH) needs. Report G0140 for the first 60 minutes of PIN-PS services provided per calendar month. Report G0146 for each additional 30 minutes of PIN-PS services provided per calendar month; list separately in addition to G0140..

Things to consider:

- This set of codes is used specifically for mental health/SUD conditions when they are primary to other conditions or concerns.
- The care plan by the physician or QHP must be detailed in terms of the management provided by the support staff in a treatment plan process with informed consent by the patient/caregiver.
- The management of the services is under the direction of the provider that must be reflected within the notes and treatment plan.
- Billed monthly based on total time in contact (face to face, phone and by other activities) under the supervising provider (MD, DO, APN, PA_

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