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Care Management: 2024 Health Equity Services

9/24/2024

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Objective

Today we'll discuss the new care management patient benefits that CMS added to Medicare for 2024.

Today's Presenter

- Provider Outreach and Education Consultant
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- Care Management Team
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  - Jennifer Lee
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Agenda

- 2024 Updates
- Caregiver Training Services
- Community Health Integration
- Principal Illness Navigation
- Social Determinants of Health Assessment

2024 Updates

Services Addressing Health Related Social Needs

- Coding will be provided
- Changes to payments to better account for resources involved in furnishing patient-centered care involving a multidisciplinary team of clinical staff and other auxiliary personnel
- Codes specifically designed to describe services involving community healthcare workers, care navigators, and peer support specialists

Community Health Integration Principal Illness Navigation

- Community Health Integration (CHI) services are to address unmet Social Determinants of Health (SDOH) needs that affect the diagnosis and treatment of the patient's medical problems
- Principal Illness Navigation (PIN) services are to help people with Medicare who are diagnosed with a high-risk condition (for example, mental health conditions, substance use disorder, and cancer) identify and connect with appropriate clinical and support resources

Caregiver Training Services

Caregiver Training Services

- Practitioners who train and involve caregivers to support patients with certain diseases or illnesses (e.g. dementia) in carrying out a treatment plan or therapy plan of care
- Services will be paid to a
  - Physician (all providers included in the CMS physician definition)
  - Nonphysician practitioner (NP, CNS, PA, CP) or therapist (PT, OT, SLP)

Individual Codes

Individual Codes	Description	Caregivers
97550	Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., 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)	One or more caregiver for a single patient
97551	Each additional 15 minutes	One or more caregiver for a single patient

Group Codes

Group Codes	Description	Caregivers
96202	CPT code 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	Multiple groups of caregivers (different patients)
96203	Each additional 15 minutes	Multiple groups of caregivers (different patients)
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	Multiple groups of caregivers (different patients)

Caregiver Training Services

- Caregiver Training Services (CTS) need to be congruent with the treatment plan
- May be paid for one or more caregivers
- Document the need and the patient's consent was given
  - Obtain consent early in cases of Alzheimers, dementia, etc.
- Patient should not be present as stated in the code description
  - Focus should be on training the caregiver
- 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
- Not available through telehealth

Community Health Integration

Community Health Integration

- HCPCS Code G0019
  - Community health integration (CHI) 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
- HCPCS Code G0022
  - CHI services, each additional 30 minutes per calendar month (List separately in addition to G0019)

Community Health Integration

- Requires an initiating visit where the practitioner would assess and identify SDOH needs that limit the practitioner's ability to diagnose or treat the patient's medical condition(s)
  - E/M visit (other than a low-level E/M) by the billing practitioner
    - Pre-requisite to bill for CHI services
  - Visit identifies presence of SDOH
    - Practitioner establishes an appropriate treatment plan
  - May be an E/M furnished as part of TCM
  - AWV can be used as an initiating visit, if "incident to" benefit is met
  - Only one practitioner will bill CHI and therefore there will only be one initiating visit
  - Inpatient/observation visits, ED visits, and SNF visits, would not typically serve as CHI initiating visit
  - CPT codes 90791 and 96156 may not be used as an initiating visit
  - Patient consent is required and must be documented

Community Health Integration

- Subsequent CHI visits
  - Services performed by certified or trained auxiliary personnel, which may include a CHW, incident to the professional services, and under the general supervision of the billing practitioner
  - Furnished monthly, as medically necessary
  - Direct contact with the patient
  - All auxiliary personnel must be certified/trained and authorized under state laws and regulations
- Focus of CHI services needs to be on addressing the particular SDOH need(s) that are interfering with, or presenting a barrier to, diagnosis or treatment of the patient's problem(s) addressed in the CHI initiating visit
  - CPT's examples of SDOH
    - Food insecurity, transportation insecurity, housing insecurity, and unreliable access to public utilities

Community Health Integration

- Medical documentation example
  - PCP discovers during a clinic visit after discharge from ED, patient has been able to reliably fill their prescriptions for diabetes medication, but frequently loses the medication (or access to it) while transitioning between homeless shelters and a local friend's home
  - Document SDOH need(s) of housing insecurity and transportation insecurity contributing to medication noncompliance, resulting in inadequate insulin control and a recent ED visit for hypoglycemia

Principal Illness Navigation

Principal Illness Navigation

- Services designed to help patients and their families navigate cancer treatment and treatment for other serious high-risk illnesses
  - Examples of a serious, high-risk condition/illness/disease may include
    - Cancer
    - Chronic obstructive pulmonary disease
    - Congestive heart failure
    - Dementia
    - HIV/AIDS
    - Severe mental illness
    - Substance use disorder
  - SDOH not required but may be applicable

Principal Illness Navigation Initial Visit

- Initiating E/M visit
  - E/M required prior to commencing principal illness navigation (PIN)
    - Required annually
  - May be an E/M furnished as part of TCM
  - Visit (other than a low-level E/M) or AWV by the billing practitioner
    - Practitioner establishes an appropriate treatment plan
    - Inpatient/observation visits, ED visits, and SNF visits, would not typically serve as a PIN initiating visit

Principal Illness Navigation Clinical Psychologist Initial Visit

- CPT code 90791 (Psychiatric diagnostic evaluation) and the Health Behavior Assessment and Intervention (HBAI) services described by CPT codes 96156, 96158, 96159, 96164, 96165, 96167, and 96168 may be used as an initiating visit
  - Most comparable to E/M codes that are utilized by clinical psychologists
  - Clinical psychologists have an incident to benefit

Principal Illness Navigation

- Initial visit must identify
  - One serious, high-risk condition expected to last at least three months
    - Significant risk of hospitalization, nursing home placement, acute exacerbation/decompensation, functional decline, or death
  - Condition requiring 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

Principal Illness Navigation

- Subsequent PIN visits
  - Auxiliary personnel incident to the services of the practitioner who billed the PIN initiating visit
  - May be provided by auxiliary personnel under contract with a third party
    - Must have sufficient clinical integration between the third party and billing practitioner
  - Auxiliary personnel must be certified/trained and be authorized to perform under state law/regulations
  - Peer support specialist, if no applicable State requirements exist, training must be consistent with the National Model Standards for Peer Support Certification published by SAMHSA
  - PIN peer support specialist (PIN-PS)
    - Must be a person who is in recovery from mental illness and/or substance use disorders, supervised by a mental health professional, and completes training that provides a basic set of competencies necessary to perform the peer support function, including demonstrating the ability to support the recovery of others from mental illness and/or substance use disorders and ongoing continual educational requirements

Principal Illness Navigation

- HCPCS Code G0023
  - PIN services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator; 60 minutes per calendar month
- HCPCS Code G0024
  - PIN services, additional 30 minutes per calendar month (list separately in addition to G0023)
- HCPCS Code G0140
  - PIN-PS services 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
- HCPCS Code G0146
  - PIN-PS services, additional 30 minutes per calendar month (list separately in addition to G0140)

Principal Illness Navigation

- Medical documentation
  - Beneficiary verbal or written consent
  - Activities performed by the auxiliary personnel and how they are related to the treatment plan
  - Practitioners are encouraged to record the associated ICD-10 Z-code (Z55-Z65) in the medical record and on the claim
  - Time spent
    - Time performing two different services may never be double counted
  - Document SDOH if applicable
- Frequency and duration limits do not apply
  - Utilization will be monitored
- PIN and PIN-PS should not be billed concurrently for the same serious, high-risk condition
- PIN services are “per condition”, therefore patients may receive PINs for more then one condition
- Services may be performed under general supervision
- Direct contact required (in-person or audio)

Social Determinants of Health Assessment

Community-Based Organizations

- Community health workers, care navigators, peer support specialists and other such auxiliary personnel may be employed by Community-Based Organizations (CBOs) as long as there is the required supervision by the billing practitioner for these services, similar to other care management services

Social Determinants of Health Risk Assessment

- Coding and payment will be provided to recognize when practitioners spend time and resources assessing SDOH that may be impacting their ability to treat the patient
- SDOH risk assessment will be added as an optional, additional element of the AWV
- Coding and payment will be provided for SDOH risk assessment furnished on the same day as an E/M

Social Determinants of Health

- Groups of SDOHs
  - Economic stability
    - Ability to afford healthy food, healthcare and safe housing
  - Education access and quality
    - Level of education, school performance, college unattainable
  - Healthcare access and quality
    - Access to healthcare, access to PCP, insurance coverage, and health knowledge
  - Neighborhood and built environment
    - Safety, access to parks, sidewalks, stores for food
  - Social and community context
    - Relationships and connections with family, friends, co-workers and community members

Social Determinants of Health

- HCPCS Code G0136
  - Administration of a standardized, evidence-based SDOH Risk Assessment, five to fifteen minutes, not more often than every six months
- May be provided
  - On the day of an E/M service (other than a low-level E/M)
  - On the day of an AWV provided by a physician/NP/PA
  - At a TCM visit
  - With a hospital discharge code (follow-up needs to be provided for unmet assessment needs)
  - On the same day as CPT codes 90791, 96156, 96158, 96159, 96164, 96165, 96167, and 96168
    - Performed by a clinical psychologist

Social Determinants of Health

- Online portal would not be acceptable
  - Considered an assessment based on evaluation of the patient's situation
    - Not a screening service
- SDOH risk assessment would require the appropriate follow-up
- Subject to copay and deductible
  - Unless done with an AWV
- Practitioners reporting G0136 are not required to have the capability to furnish CHI, PIN or other care management services

Social Determinants of Health

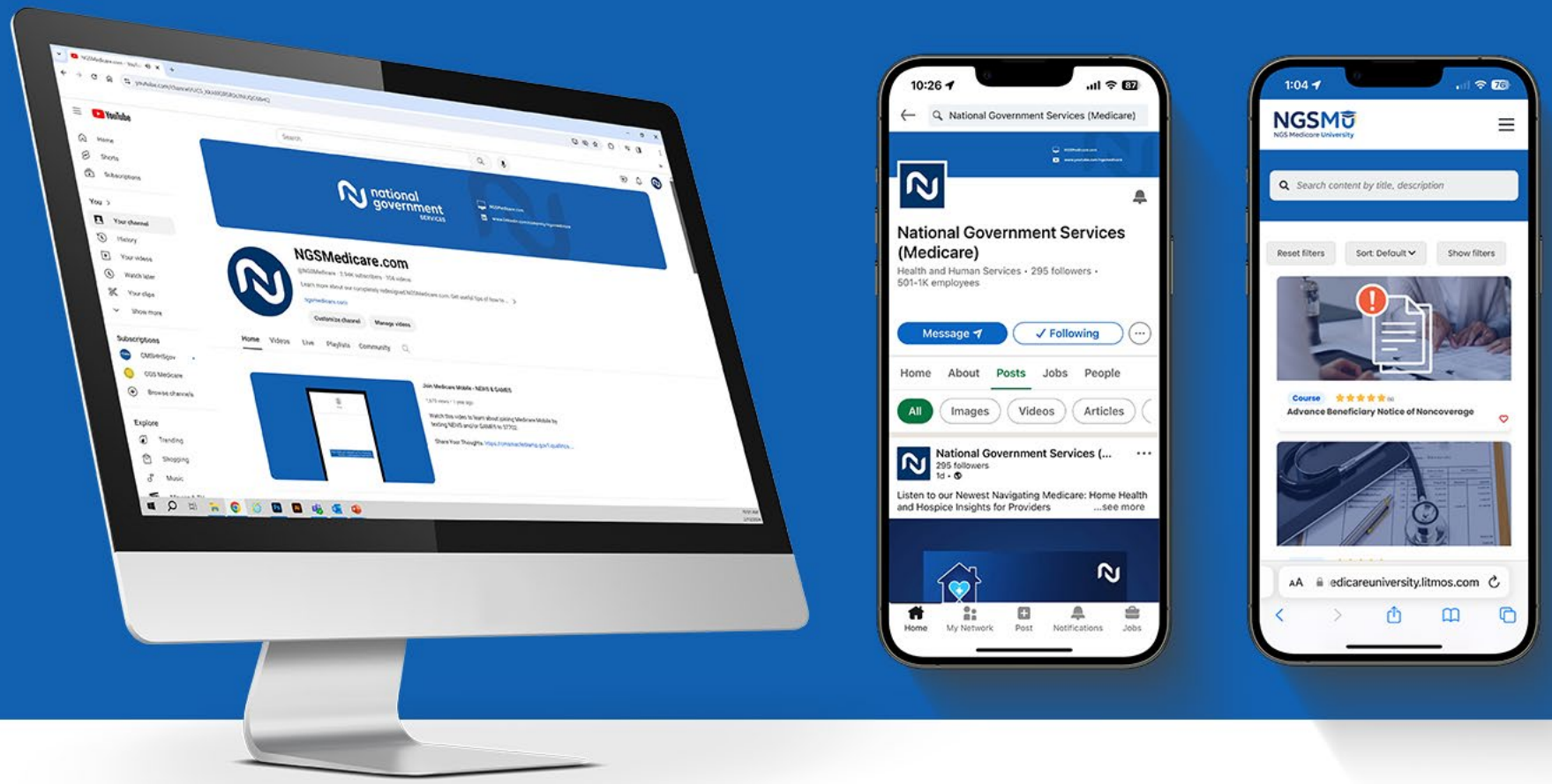
- Medical documentation
  - SDOHs needs identified during the assessment
  - Practitioners are encouraged to record the associated ICD-10 Z-code (Z55-Z65) in the medical record and on the claim
- The Accountable Health Communities Health-Related Social Needs Screening Tool
- PRAPARE

Resources

- MLN® Booklet: *Health Equity Services in the 2024 Physician Fee Schedule Final Rule*

Questions?

Thank you!



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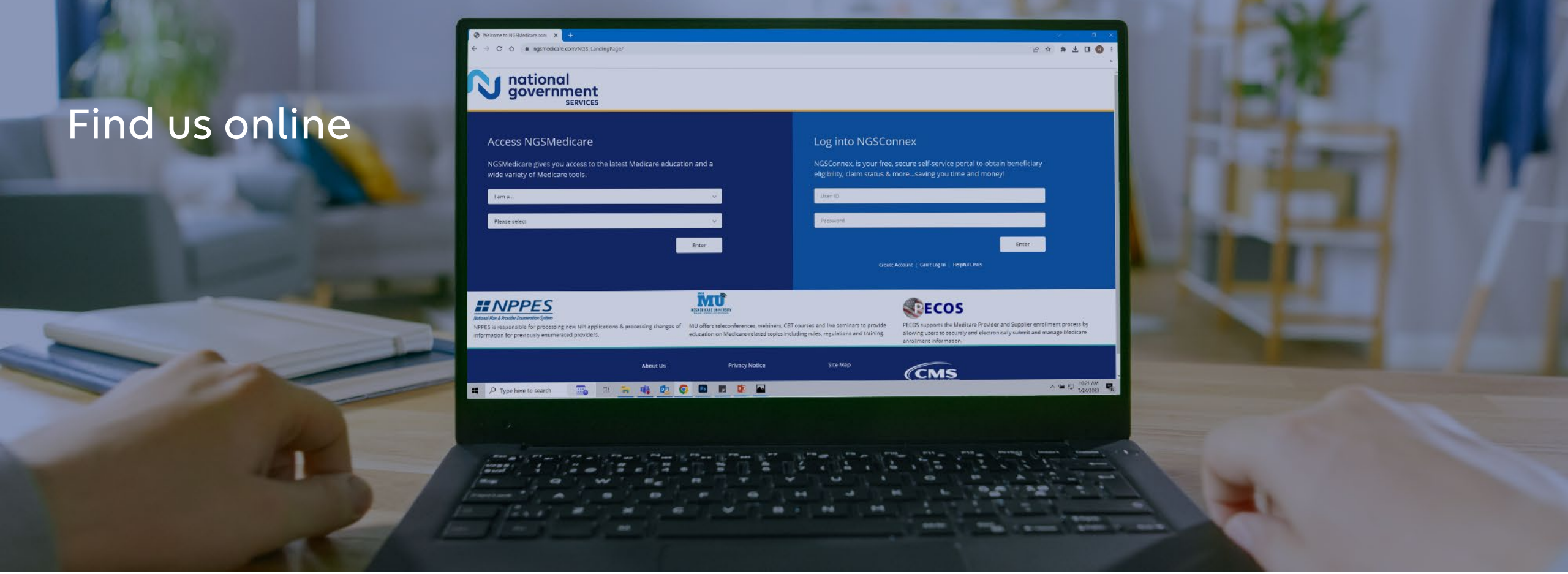

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