Providing and Billing Medicare for SDOH-Related Services

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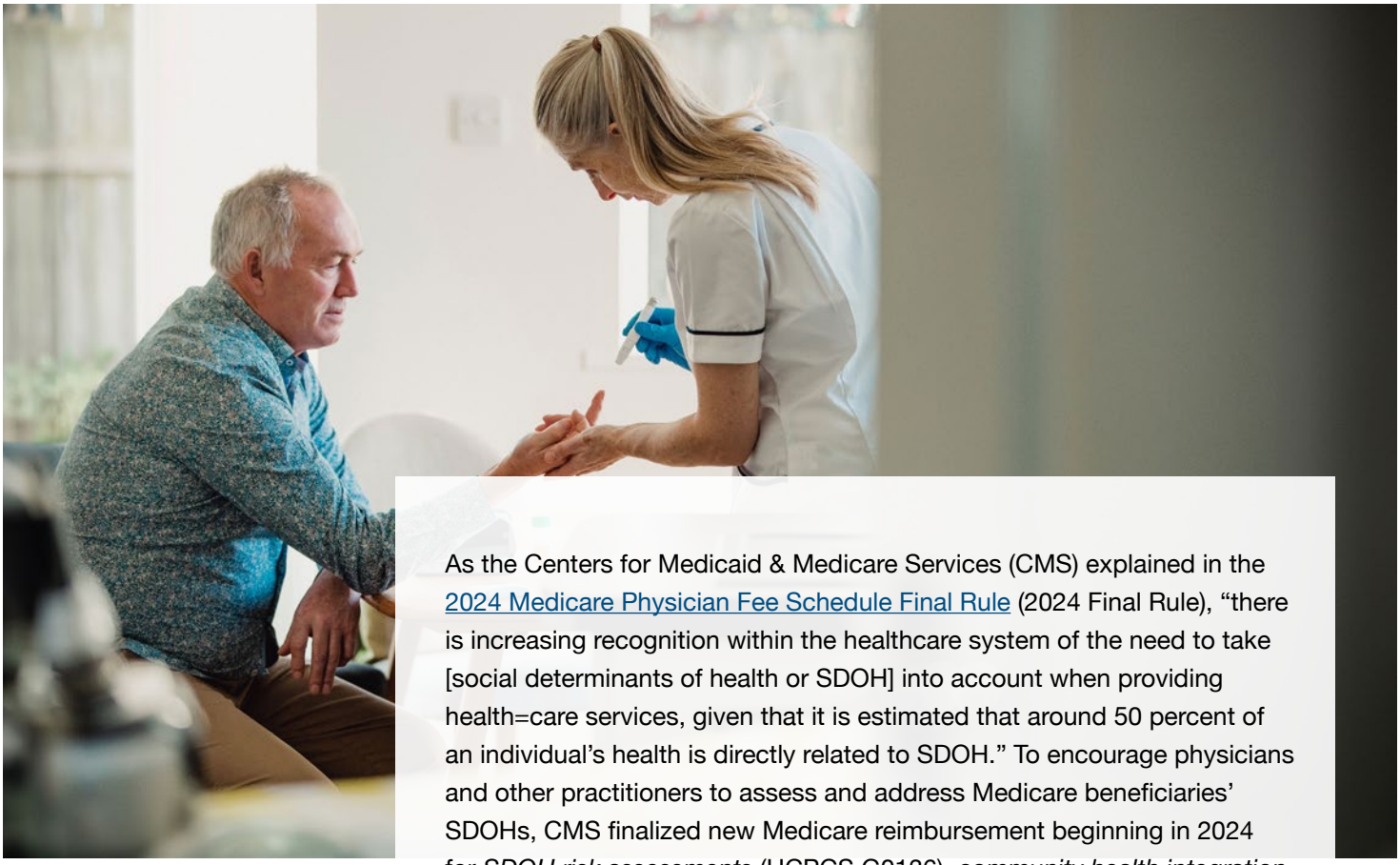

As the Centers for Medicaid & Medicare Services (CMS) explained in the 2024 Medicare Physician Fee Schedule Final Rule (2024 Final Rule), "there is increasing recognition within the healthcare system of the need to take [social determinants of health or SDOH] into account when providing health=care services, given that it is estimated that around 50 percent of an individual's health is directly related to SDOH." To encourage physicians and other practitioners to assess and address Medicare beneficiaries' SDOHs, CMS finalized new Medicare reimbursement beginning in 2024 for *SDOH risk assessments* (HCPCS G0136), *community health integration services* (HCPCS G0019, G0022), and *principal illness navigation services* (HCPCS G0023, G0024, G0140, G0146).

In its January 2024 Medicare Learning Network booklet, Health Equity Services in the 2024 Physician Fee Schedule Final Rule, CMS highlighted how these services promote its health equity priorities:

1. Expand the collection, reporting, and analysis of standardized data
2. Assess causes of disparities within its programs and address inequities in policies and operations to close gaps
3. Build capacity of healthcare organizations and the workforce to reduce health and healthcare disparities
4. Advance language access, health literacy, and the provision of culturally tailored services
5. Increase all forms of accessibility to healthcare services and coverage

The following Q&As provide a detailed explanation of CMS' billing rules for these services as defined in the 2024 Final Rule and the 2025 Medicare Physician Fee Schedule Final Rule (2025 Final Rule) and clarified in CMS' March 2024 Health-Related Social Needs FAQs.

SDOH Risk Assessment – HCPCS G0136

What is the SDOH risk assessment?

The SDOH risk assessment involves a review of a beneficiary's SDOH or identified social risk factors that influence the diagnosis and treatment of medical conditions. Rather than a routine screening to be used with all patients, the assessment is performed when a practitioner has reason to believe unmet SDOH needs exist that could interfere with the practitioner's diagnosis and treatment of a condition or illness. The assessment should require five to 15 minutes to complete.

How is the SDOH risk assessment performed?

The assessment must involve the administration of a standardized, evidence-based SDOH risk assessment tool that has been tested and validated through research. The tool must address the domains of food insecurity, housing insecurity, transportation needs, and utility difficulties. A billing practitioner may choose to assess for additional domains if other prevalent or culturally salient social determinants are present in the community where the practitioner practices.

Possible evidence-based tools include the CMS Accountable Health Communities (AHC) tool, the Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences (PREPARE), and instruments identified for Medicare Advantage Special Needs Population Health Risk Assessment. A practitioner may combine questions from multiple standardized, validated tools (and should maintain a record of the origin of each question in a customized tool).

The SDOH risk assessment may be performed by auxiliary personnel under the general supervision of the billing practitioner incident to their professional services.

CMS has included SDOH risk assessments on the Medicare Telehealth Services List. CMS requires a real-time audio/visual connection between the beneficiary and the billing practitioner or auxiliary personnel performing the assessment; an audio-only interaction is not sufficient.

When performing these assessments, practitioners should ensure all communication with the beneficiary is appropriate for the beneficiary's educational, developmental, and health literacy levels and is culturally and linguistically appropriate.

With what types of visits may the SDOH risk assessment be performed?	The SDOH risk assessment may be performed in conjunction with (1) hospital discharge visits, (2) transitional care management services, (3) outpatient evaluation and management (E/M) visits (other than a Level 1 visit performed by clinical staff), (4) annual wellness visits, (5) psychiatric diagnostic evaluation services (CPT 90791), and (6) health behavioral assessment and intervention services (CPTs 96156, 96158-59, 96164-68). Only practitioners who can bill for these services can bill for SDOH risk assessments. CMS does not require the SDOH risk assessment to be performed on the same day as one of these services but notes there are limited scenarios in which a practitioner would know ahead of a visit that the risk assessment would be appropriate, i.e., that the practitioner would have reason to believe unmet SDOH needs exist that may interfere with the practitioner's diagnosis and treatment of the patient.
What medical record documentation is required to support a claim for the SDOH risk assessment?	The beneficiary's SDOH needs identified through the completion of the risk assessment must be documented in the medical record. CMS encourages (but does not require) the use of Z-codes in reporting SDOH needs to facilitate high-quality communication between providers.
To bill for SDOH risk assessment, must a practitioner have the capacity to provide care management services and/or have a partnership with community-based organizations (CBOs) to address identified SDOH needs?	CMS does not require the practitioner who furnishes the SDOH risk assessment have the capacity to furnish care management services or have partnerships with CBOs. While recognizing practitioners may not be ideally suited to solve long-standing SDOH concerns, CMS noted follow-up or referral after an SDOH risk assessment is an important element to addressing the issues that impact a patient's health and can help the beneficiary connect with services and individuals who can address more of the beneficiary's SDOH needs. Thus, CMS expects the billing practitioner to refer the beneficiary to relevant resources and consider the assessment results in their medical decision-making or diagnosis and treatment plan. CMS stated it intends to monitor use of SDOH risk assessments and left open the opportunity to reevaluate this decision in later rulemaking.
How frequently may SDOH risk assessments be performed?	Medicare reimbursement for SDOH risk assessments is limited to once every six months per practitioner per beneficiary. CMS has not specifically addressed whether more than one practitioner can bill for SDOH risk assessments for the same beneficiary in a given six-month period.
Must a beneficiary consent to the SDOH risk assessment?	CMS does not require the billing practitioner to obtain beneficiary consent to the SDOH risk assessment but encourages practitioners to notify the beneficiary that Part B cost sharing will apply as it does for other physician services under the Medicare program. As best practice, such notification should be documented in the medical record.

What place of service should be listed on a claim for SDOH risk assessment?

The place of service (POS) for a completed SDOH risk assessment is the location at which the risk assessment is performed. If the assessment is performed via telehealth, the place of service will be POS 02 (beneficiary at a location other than home) or POS 10 (beneficiary is at home).

What is the Medicare reimbursement for SDOH risk assessments?

CMS has established the following 2025 national payment rates under the Medicare Physician Fee Schedule for SDOH risk assessments:

Service	Non-Facility	Facility
HCPCS G0136	$18.44	$8.73

Additionally, if the SDOH risk assessment is furnished in a physician practice operated as a hospital outpatient department, the hospital may receive additional reimbursement under the Medicare Hospital Outpatient Prospective Payment System (OPPS). CMS has assigned HCPCS G0136 to Ambulatory Payment Classification (APC) 5821, with a 2025 payment rate of $29.79 (not adjusted for labor costs). This amount is in addition to the amount paid under the Medicare Physician Fee Schedule. HCPCS G0136 has been assigned to status indicator "S," which means it is a procedure or service paid under OPPS with a separate APC payment and that no multiple procedure discount is applied.

How are rural health clinics (RHCs) and Federally Qualified Health Centers (FQHCs) reimbursed for SDOH risk assessments?

CMS did not add SDOH risk assessments to the list of general care management services for which RHCs and FQHCs may be reimbursed. Thus, RHCs and FQHCs do not receive any additional reimbursement from Medicare for performing SDOH risk assessments.

Do any payers other than Medicare pay for SDOH risk assessments?

A Medicare Advantage (MA) plan must offer its enrollees at least traditional Medicare benefits, which now include SDOH risk assessments. PYA anticipates many MA plans will pay for these assessments in the same manner as they now pay for other physician services. Some MA plans, however, may refuse to pay for SDOH risk assessments on the basis that the plan, itself, is performing these assessments. Commercial plan coverage and payment for SDOH risk assessments vary. State Medicaid programs have adopted different approaches to address SDOHs.

Community Health Integration Services – HCPCS G0019, G0022

What are community health integration (CHI) services?

CHI services are performed by certified or trained auxiliary personnel incident to the professional services and under the general supervision of the billing practitioner.

They address one or more SDOH needs identified by the billing practitioner during an initiating visit that significantly limit the billing practitioner's ability to diagnose or treat the beneficiary's medical condition and establish an appropriate treatment plan.

With one exception discussed below, these services can be billed only by physicians and non-physician practitioners who can bill for services performed by auxiliary personnel incident to their professional services. CHI services are billed on a monthly basis based on the amount of time spent by auxiliary personnel performing the services during that month (60- and 30-minute increments).

In the 2025 Final Rule, CMS clarified that a clinical social worker (CSW) enrolled as a Medicare participating provider can bill under their own provider number for CHI services personally performed by the CSW (but not for services performed by auxiliary personnel). CSWs also qualify as auxiliary personnel for purposes of CHI services furnished under the general supervision of and billed by a physician or non-physician practitioner.

Is the provision of CHI services limited to underserved communities?

No, CMS has not imposed any requirements specific to the beneficiary's community.

How are CHI services initiated?

As a prerequisite to furnishing and billing for CHI services, the billing practitioner must have an initiating visit with the beneficiary during which the billing practitioner identifies one or more SDOH needs that significantly limit the billing practitioner's ability to diagnose or treat the beneficiary's medical condition and establish an appropriate treatment plan. An initiating visit is not required each month CHI services are performed.

The initiating visit must be an E/M visit other than low-level E/M visits that can be performed by clinical staff. Inpatient/observation visits, emergency department visits, and skilled nursing facility visits would not typically serve as CHI initiating visits because the practitioners furnishing E/M services in these settings would not typically be the ones to provide continuing care for the beneficiary or to follow the beneficiary longitudinally in the community.

Transitional care management services (CPT 99495 and 99496) and annual wellness visits (except those performed by a professional who does not have an "incident to" benefit for their services under the Medicare program, e.g., health educator, registered dietician) may serve as CHI initiating visits.

CHI services must be billed by the same practitioner who bills for the initiating visit. CMS has not addressed whether CHI services may be billed by a practitioner in the same group practice in the same specialty or sub-specialty as the practitioner who billed for the initiating visit.

What documentation is required to demonstrate medical necessity for CHI services?

The documentation in the beneficiary's medical record from the initiating visit should specify (1) the beneficiary's unmet SDOH need or needs that significantly limit the billing practitioner's ability to diagnose or treat the patient's medical condition and establish an appropriate treatment plan and (2) how addressing the unmet need or needs will help accomplish the billing practitioner's treatment plan for the beneficiary.

Because Medicare coverage is generally limited to items and services that are reasonable and necessary for the diagnosis or treatment of injury or illness, the focus of CHI services must be addressing the particular SDOH need(s) that interfere with or present a barrier to diagnosis or treatment of the beneficiary's problems addressed in the initiating visit (as opposed to any SDOH need the beneficiary may have).

Must the beneficiary consent to receiving CHI services?

A beneficiary must consent to receiving CHI services prior to the initiation of the services. The person securing the beneficiary's consent must explain to the beneficiary that cost sharing will apply, that the beneficiary may discontinue services, and only one practitioner per month can bill for CHI services.

Consent may be obtained orally from the beneficiary, provided it is documented in the beneficiary's medical record. (For auditing purposes, the medical record documentation should specifically include that the patient understands the financial responsibility and other consenting criteria.) Consent may be obtained by auxiliary personnel. Once obtained, a beneficiary's consent remains effective until revoked or until the beneficiary chooses to have a different practitioner provide CHI services. It is not necessary to secure a new consent on an annual basis.

Who can perform CHI services?

CHI services are performed by certified or trained auxiliary personnel (not necessarily clinical staff) under the general supervision of the billing practitioner. Auxiliary personnel must meet any applicable state law requirements, such as certification or licensure, to provide CHI services.

In states with no such requirements, auxiliary personnel must receive appropriate training to provide CHI services. Such training must include the competencies of patient and family communication, interpersonal and relationship-building skills, patient and family capacity-building, service coordination and systems navigation, patient advocacy, facilitation, individual and community assessment, professionalism and ethical conduct, and the development of an appropriate knowledge base, including knowledge of local community-based resources. CMS does not require or recommend a minimum number of hours of training nor does the agency require or recommend specific content or the use of a specific curriculum.

While codes G0019 and G0022 were specifically designed to capture services usually performed by community health workers, clinical staff (e.g., nurses, social workers) also can perform CHI services, provided they have completed appropriate training.

What is required for general supervision of auxiliary personnel?

General supervision means the service is furnished under the billing practitioner's overall direction and control, but the practitioner's presence is not required during the performance of the service. (By contrast, direct supervision requires the billing practitioner to be physically present in the same suite of offices and immediately available to assist during the performance of the service.) The billing practitioner is responsible for determining auxiliary personnel have the appropriate training and experience to provide CHI services; although, the practitioner is not required to provide such training.

Auxiliary personnel providing CHI services do not have to be employed by the billing practitioner. Instead, a billing practitioner may contract with a community-based organization (CBO) (e.g., area agency on aging, aging and disability resource centers) to secure the services of qualified auxiliary personnel. (The billing practitioner should require the CBO to verify any staff person providing CHI services is properly certified or has received the required training.) The billing practitioner, however, must provide general supervision of CBO staff providing CHI services and maintain active participation in and management of the course of treatment for beneficiaries receiving CHI services from CBO staff.

Auxiliary staff must not have been excluded from Medicare, Medicaid, or other federally funded healthcare programs by the Office of Inspector General or had their Medicare enrollment revoked.

CMS expects auxiliary personnel providing CHI services to communicate regularly with the billing practitioner to ensure the services are approximately documented in the beneficiary's medical record and to continue to involve the billing practitioner in evaluating the continuing need for the services.

Can auxiliary personnel providing CHI services identify and address a beneficiary's additional unmet SDOH needs, or is another initiating visit with the billing practitioner required?

The scope of practice for auxiliary personnel does not include determining whether a given SDOH need is impacting the ability of the billing practitioner to diagnose or treat problems addressed in the initiating visit. While auxiliary personnel should report all such findings to the billing practitioner, it is up to the billing practitioner to determine whether CHI services to address subsequently identified unmet SDOH need(s) are medically necessary. While another initiating visit is not required, the billing practitioner must make this determination before auxiliary personnel can provide CHI services to address the newly identified need.

What types of activities qualify as CHI services?

CMS has identified the following activities in defining CHI services:

- 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
  - 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).
  - 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 caregiver (if applicable).
  - Communication with practitioners, home- and community-based service providers, hospitals, and skilled nursing facilities (or other healthcare 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 healthcare 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 healthcare 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 healthcare 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.
- Healthcare access/health system navigation coordination
  - 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.

This is not a list of mandatory monthly elements. CMS, however, expects those service elements that are reasonable and necessary based on the beneficiary's specific needs would generally be performed during the month.

Do CHI services have to be performed face-to-face with the beneficiary?

CMS believes that most of the elements of CHI services will involve direct contact between the auxiliary personnel and the beneficiary and that a substantial portion will be in-person. CMS, however, recognizes that a portion might be performed virtually (via audio-video or audio only). CMS does not require a minimum number of in-person interactions between auxiliary personnel and the beneficiary (e.g., monthly face-to-face meetings).

CMS did not add CHI services to the Medicare Telehealth Services List, explaining that CHI services would not be considered Medicare telehealth services under section 1834(m) of the Social Security Act because the services may not typically require face-to-face interaction. CMS noted the possible use of asynchronous communication technology to support the provision of CHI services, which suggests CMS' policies for other communication-based technology services should apply instead.

What are the documentation requirements for CHI services?

CHI services must be documented in the beneficiary's medical record maintained by the billing practitioner. The documentation should include the name and credential (if any) of auxiliary personnel providing the service, the activities they performed with or on behalf of the patient in relation to the practitioner's plan of care for the patient, and the time spent providing the service.

Auxiliary personnel may but are not required to enter this information themselves in the beneficiary's medical record. Documentation, in the end, is the responsibility of the billing practitioner, who must show that she or he is interacting with the CHI care team enough to support general supervision requirements; one way to do this is to review and verify (sign and date) auxiliary personnel documentation.

What are the rules for counting time spent by auxiliary personnel?

To bill for HCPCS G0019, auxiliary personnel must provide 60 minutes of CHI services in a calendar month. For each additional 30 minutes of auxiliary personnel time during the same calendar month, the billing practitioner may bill one unit of the add-on code, HCPCS G0022. There is no limit on the number of units of HCPCS G0022 that may be billed in a calendar month.

Based on CMS' guidance relating to other care management services, the following rules should be applied in counting time:

- Time spent providing services on different days or by different auxiliary personnel in the same calendar month may be aggregated to total 60 (or 30) minutes.
- If two auxiliary personnel are furnishing services at the same time, only the time spent by one individual may be counted.
- Time of fewer than 60 (or 30) minutes during a calendar month cannot be rounded up to meet the time requirements, nor may time be carried over from a prior month.
- If time spent by auxiliary personnel benefits more than one beneficiary receiving CHI services, that time can be counted toward total time for only one beneficiary.
- Document the total amount of time spent in a given month working with or on behalf of a beneficiary in the beneficiary's medical record. Recording of start-stop times is the preferred method for tracking time totals.

May CHI services be furnished to a group of beneficiaries with similar challenges?	According to CMS, "CHI services are highly individualized and focused on a 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 and subsequently by the [community health worker] and/or auxiliary personnel in the community." Based on this explanation, CMS "did not propose a code describing services delivered to a group of patients."
May more than one practitioner bill for CHI services furnished to the same beneficiary during the same month?	No, only one practitioner may bill for CHI services in a given month, as CMS is concerned that CHI services would be too fragmented if the beneficiary has more than one individual address their unmet SDOH need(s).
What are the circumstances in which a practitioner cannot bill CHI services for a specific beneficiary?	According to CMS, CHI services cannot be billed while the beneficiary is under a Medicare Part B home health plan of care because of the significant overlap between services furnished under a home health plan of care and CHI services. ***A beneficiary may receive CHI services and other care management services (e.g., chronic care management, principal care management, remote physiologic monitoring) concurrently if time and effort are not counted more than once, requirements to bill the other care management services are met, and the services are medically reasonable and necessary.*** A beneficiary may receive CHI services and other care management services (e.g., chronic care management, principal care management, remote physiologic monitoring) at the same time, provided they are distinct services, and no time is double counted.
Is a beneficiary ineligible for CHI services if he or she is receiving community health worker services under a state Medicaid program?	According to CMS, "[t]he CHI services are meant to resolve those specific concerns to facilitate the patient's medical care, which would distinguish CHI from other social services and programs that may be available through Medicaid State plans or other State or community programs."
What diagnosis codes should be used on claims for CHI services?	While CMS requires the beneficiary's SDOH needs to be documented in the medical record, it only encourages (versus requires) practitioners to record the associated ICD-10 Z-Code (Z55-Z65) in the medical record and on the claim.
What place of service should be listed on a claim for CHI services?	The place of service would be the location at which the billing practitioner would ordinarily provide in-person, face-to-face care to the beneficiary. Thus, a practitioner who practices in a hospital outpatient department would list "22" as the place of service on the claim form, triggering payment at the facility rate.

What is the Medicare reimbursement for CHI services?

CMS has established the following 2025 national payment rates under the Medicare Physician Fee Schedule for CHI services:

Service	Non-Facility	Facility
G0019	$77.96	$47.55
G0022	$48.52	$33.32

Additionally, if CHI services are furnished in a physician practice operated as a hospital outpatient department, the hospital may receive additional reimbursement under the Medicare Hospital Outpatient Prospective Payment System (OPPS). CMS has assigned HCPCS G0019 to APC 5822, with a 2025 payment rate of $92.50 (not adjusted for labor costs). This amount is in addition to the amount paid under the Medicare Physician Fee Schedule. HCPCS G0019 has been assigned to status indicator "S," which means it is a procedure or service paid under OPPS with a separate APC payment and that no multiple procedure discount is applied. CMS has not assigned any APC to HCPCS G0022.

How are rural health clinics (RHCs) and Federally Qualified Health Centers (FQHCs) reimbursed for CHI services?

Effective January 1, 2025, RHCs and FQHCs may bill for CHI services by including the appropriate HCPCS code on the claim form (as opposed to the general care management code, HCPCS G0511). An RHC or FQHC will be reimbursed at the national non-facility payment rates listed above for CHI services, not the RHC all-inclusive rate or the FQHC prospective payment system rate. RHCs and FQHCs may continue to use HCPCS G0511 until June 30, 2025, but the reimbursement rate has been reduced to $54.67. As of July 1, 2025, RHCs and FQHCs no longer can bill for CHI services (or any general care management services) under HCPCS G0511.

Do any payers other than Medicare pay for CHI services?

A Medicare Advantage plan must offer its enrollees at least traditional Medicare benefits, which now include CHI services. PYA anticipates many MA plans will pay for CHI services in the same manner as they now pay for other physician services. Some MA plans, however, may refuse to pay for CHI services, on the premise the plan, itself, is providing these directly to beneficiaries. Commercial plan coverage and payment for CHI services vary. As noted previously, many state Medicaid programs include coverage for community health worker services but not in the same manner as CHI services.

Is Medicare reimbursement for CHI services adequate to support a practice employing a community health worker?

Based on data from the Bureau of Labor Statistics, one can assume the salary and benefits for a community health worker would be approximately $5,000 per month. To cover this expense, a practice would have to bill and collect for CHI services furnished to about 70 traditional Medicare beneficiaries each month (assuming one hour of service per beneficiary).

Principal Illness Navigation Services – HCPCS G0023, G0024

What are principal illness navigation (PIN) services?

PIN services are furnished by certified or trained auxiliary personnel, which may include a patient navigator or certified peer specialist, under the direction of a billing practitioner. Such personnel are involved in the beneficiary's healthcare navigation as part of the billing practitioner's treatment plan for the beneficiary's serious, high- risk disease expected to last at least three months; that places the beneficiary at significant risk of hospitalization or nursing home placement, acute exacerbation/decompensation, functional decline, or death; and that 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, e.g., cancer, chronic obstructive pulmonary disease, congestive heart failure, dementia, HIV/AIDS, severe mental illness (SMI), substance use disorder (SUD). In response to comments regarding PIN services for beneficiaries who have suffered fractures, CMS clarified in the 2025 Final Rule that there are circumstances in which osteoporosis may be considered a serious, high-risk disease for which PIN service may be appropriate.

With one exception noted below, PIN services can only be billed by physicians and non-physician practitioners who can bill for services performed by auxiliary personnel incident to their professional services. These services are billed on a monthly basis based on the amount of time spent by auxiliary personnel performing the services during that month (60- and 30-minute increments).

In the 2025 Final Rule, CMS clarified that a clinical social worker (CSW) enrolled as a Medicare participating provider can bill under their own provider number for PIN services personally performed by the CSW (but not for services performed by auxiliary personnel). CSWs also qualify as auxiliary personnel for purposes of PIN services furnished under the general supervision of and billed by a physician or non-physician practitioner.

How are PIN services initiated?

As a prerequisite to furnishing and billing for PIN services, the billing practitioner must have an initiating visit with the beneficiary during which the practitioner identifies the medical necessity of PIN services and establishes an appropriate treatment plan. An initiating visit is not required each month PIN services are performed. While there is no limit on the length of time during which PIN services may be provided, an initiating visit must be performed annually.

The initiating visit must be an E/M visit other than low-level E/M visits that can be performed by clinical staff. Inpatient/observation visits, emergency department visits, and skilled nursing facility visits would not typically serve as PIN initiating visits because the practitioners furnishing E/M services in these settings would not typically be the ones to provide continuing care for the beneficiary or to follow the beneficiary longitudinally in the community.

Transitional care management services (CPT 99495 and 99496) and annual wellness visits (except those performed by a professional who does not have an "incident to" benefit for their services under the Medicare program, e.g., health educator, registered dietician) may serve as PIN initiating visits.

Recognizing that clinical psychologists may be the practitioner type who primarily interfaces with beneficiaries with SMI or SUD, CMS has also included psychiatric diagnostic evaluation services (CPT 90791) and health behavioral assessment and intervention services (CPT 96156, 96158-59, 96164-68) as PIN initiating visits.

PIN services must be billed by the same practitioner who bills for the initiating visit. CMS has not addressed whether PIN services may be billed by a practitioner in the same group practice in the same specialty or sub-specialty as the practitioner who billed for the initiating visit.

May more than one practitioner bill for PIN services furnished to the same beneficiary during the same month?

More than one practitioner may bill for PIN services furnished to the same beneficiary during the same month if the beneficiary has been diagnosed with more than one serious, high-risk condition requiring condition-specific PIN services (as defined above).

Must the beneficiary consent to receiving PIN services?	Yes, a beneficiary must consent to receiving PIN services prior to the initiation of the services. As part of the consent process, the person securing consent must explain to the beneficiary that cost sharing will apply to PIN services and that the beneficiary may discontinue services. Consent may be obtained orally from the beneficiary, provided it is documented in the beneficiary's medical record. (For auditing purposes, the medical record documentation should specifically include that the patient understands the financial responsibility and other consenting criteria.) Consent may be obtained by auxiliary personnel. A beneficiary's consent for PIN services remains effective for one year; if services extend beyond a year, a new consent must be secured from the beneficiary in connection with the annual initiating visit.
Who can perform PIN services?	PIN services are performed by certified or trained auxiliary personnel under the general supervision of the billing practitioner. Auxiliary personnel must meet any applicable state law requirements to provide PIN services, such as certification or licensure. In those states with no such requirements, auxiliary personnel providing PIN services must be trained to provide all service elements. Such training must include the competencies of patient and family communication, interpersonal and relationship-building, patient and family capacity building, service coordination and systems navigation, patient advocacy, facilitation, individual and community assessment, professionalism and ethical conduct, and the development of an appropriate knowledge base, including specific certification or training on the serious, high-risk condition, illness, or disease addressed in the initiating visit. CMS does not require or recommend a minimum number of hours of training, nor does the agency require or recommend specific content or the use of a specific curriculum.
What is required for general supervision of auxiliary personnel?	Refer to the earlier discussion of CHI services, as CMS applies the same rules to PIN services.
Do PIN services have to be performed face-to-face with the beneficiary?	Refer to the earlier discussion of CHI services, as CMS applies the same rules to PIN services.

What types of activities qualify as PIN services?

CMS has identified the following activities in defining PIN services:

- Person-centered assessment, performed to better understand the individual context of the serious, high-risk condition
  - Conducting a person-centered assessment to understand the beneficiary'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).
  - Facilitating beneficiary-driven goal setting and establishing an action plan.
  - Providing tailored support as needed to accomplish the practitioner's treatment plan.
- Identifying or referring beneficiary (and caregiver or family, if applicable) to appropriate supportive services.
- Practitioner, Home, and Community-Based Care Coordination
  - Coordinating receipt of needed services from healthcare practitioners, providers, and facilities; home- and community-based service providers; and caregiver (if applicable).
  - Communication with practitioners, home-, and community-based service providers, hospitals, and skilled nursing facilities (or other healthcare facilities) regarding the beneficiary's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors.
  - Coordination of care transitions between and among healthcare 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 healthcare facilities.
  - Facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) as needed to address SDOH need(s).
- Health education—Helping the beneficiary contextualize health education provided by the beneficiary's treatment team with the beneficiary's individual needs, goals, preferences, and SDOH need(s), and educating the beneficiary (and caregiver if applicable) on how to best participate in medical decision-making.
- Building beneficiary self-advocacy skills, so that the beneficiary can interact with members of the healthcare team and related community-based services (as needed), in ways that are more likely to promote personalized and effective treatment of their condition.
- Healthcare access/health system navigation
  - Helping the beneficiary access healthcare, including identifying appropriate practitioners or providers for clinical care, and helping secure appointments with them.
  - Providing the beneficiary with information/resources to consider participation in clinical trials or clinical research as applicable.
- Facilitating behavioral change as necessary for meeting diagnosis and treatment goals, including promoting beneficiary motivation to participate in care and reach person-centered diagnosis or treatment goals.
- Facilitating and providing social and emotional support to help the beneficiary cope with the condition, SDOH need(s), and adjust daily routines to better meet diagnosis and treatment goals.
- Leverage knowledge of the serious, high-risk condition and/or lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals.

This is not a list of mandatory monthly elements. CMS, however, expects those service elements that are reasonable and necessary based on the beneficiary's specific needs would generally be performed during the month.

What are the documentation requirements for PIN services?	PIN services must be documented in the beneficiary's medical record maintained by the billing practitioner. The documentation should include the name and credential (if any) of auxiliary personnel providing the service, the time spent providing the service, and a description of the activities performed by the auxiliary personnel and how they are related to the treatment plan for the serious, high-risk condition. Any identified SDOH need(s) should be recorded in the medical record. CMS encourages (but does not require) practitioners to record the associated Z-code(s) in the medical record and on the claim. CMS does not require all auxiliary personnel performing PIN services to document the services in the beneficiary's medical record themselves. Rather, the billing practitioner is responsible for ensuring appropriate documentation of the PIN services provided to the patient is included in the medical record. Documentation, in the end, is the responsibility of the billing practitioner, who must show she or he is interacting with auxiliary personnel enough to support general supervision requirements; one way to do this is to review and verify (sign and date) auxiliary personnel documentation.
What are the rules for counting time spent by auxiliary personnel?	To bill for HCPCS G0023, auxiliary personnel must provide 60 minutes of PIN services in a calendar month. For each additional 30 minutes of auxiliary personnel time during the same calendar month, the billing practitioner may bill one unit of the add-on code, HCPCS G0024. There is no limit on the number of units of HCPCS G0024 that may be billed in a calendar month. Refer to the earlier discussion of the rules for counting auxiliary personnel time with regard to CHI services, as the same would apply to PIN services.
What are the circumstances in which a practitioner cannot bill PIN services for a specific beneficiary?	CMS has not identified any circumstance in which a patient receiving a certain service would be ineligible for PIN services due to a significant overlap between the services. A beneficiary may receive PIN services and other care management services (e.g., chronic care management, principal care management, remote physiologic monitoring) concurrently, if time and effort are not counted more than once, all requirements to bill the other care management services are met, and the services are medically reasonable and necessary.
What place of service should be listed on a claim for PIN services?	Refer to the earlier discussion of this subject with regard to CHI services, as the same would apply to PIN services.

What is the Medicare reimbursement for PIN services?

CMS has established the following 2025 national payment rates under the Medicare Physician Fee Schedule for PIN services:

Service	Non-Facility	Facility
G0023	$77.96	$47.55
G0024	$48.52	$33.32

Additionally, if PIN services are furnished in a physician practice operated as a hospital outpatient department, the hospital may receive additional reimbursement under the OPPS. CMS has assigned HCPCS G0023 to APC 5822, with a 2025 payment rate of $92.50 (not adjusted for labor costs). This amount is in addition to the amount paid under the Medicare Physician Fee Schedule. HCPCS G0023 has been assigned to status indicator "S," which means it is a procedure or service paid under (OPPS) with a separate APC payment and that no multiple procedure discount is applied. CMS has not assigned any APC to HCPCS G0024.

How are RHCs and FQHCs reimbursed for PIN services?

Effective January 1, 2025, RHCs and FQHCs may bill for PIN services by including the appropriate HCPCS code on the claim form (as opposed to the general care management code, HCPCS G0511). An RHC or FQHC will be reimbursed at the national non-facility payment rates listed above for PIN services, not the RHC all-inclusive rate or the FQHC prospective payment system rate. RHCs and FQHCs may continue to use HCPCS G0511 until June 30, 2025, but the reimbursement rate has been reduced to $54.67. As of July 1, 2025, RHCs and FQHCs no longer can bill for PIN services (or any general care management services) under HCPCS G0511.

Do any payers other than Medicare pay for PIN services?

Refer to the earlier discussion of payment for CHI services, as the same would apply to PIN services.

PIN Services - Peer Support Specialists (HCPCS G0140, G0146)

Why did CMS create separate reimbursement for PIN services furnished by peer support specialists?

In commenting on CMS' proposal to reimburse PIN services, the peer support community noted certain activities included in the scope of PIN services are outside the scope of practice for peer support specialists, such as care coordination activities. Recognizing the value peer support specialists can provide to beneficiaries with severe mental illness (SMI) and substance use disorder (SUD), CMS created separate reimbursement for PIN services furnished by peer support specialists, excluding from the scope of services those activities outside their scope of practice (PIN-PS services).

The billing rules and reimbursement for PIN-PS services are the same as those for PIN services except (1) the modification to the scope of activities to be consistent with peer support specialists' scope of practice and (2) the limitation of PIN-PS services to beneficiaries with SMI and SUD. Also, a beneficiary cannot receive both PIN services and PIN-PS services at the same time.

A peer support specialist providing PIN-PS must satisfy any applicable state certification requirements. If no applicable state requirements exist, the specialist must have completed training consistent with the National Model Standards for Peer Support Certification published by the Substance Abuse and Mental Health Services Administration.

For more information about providing and billing Medicare for SDOH-related and care management services, contact

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