Roundtable: Codes & Value-sets for the SDOH Screening and Referral Metric

June 18, 2024

Social Determinants of Health (SDOH): Social Needs Screening & Referral Measure Technical Assistance (TA)

Oregon Health Authority

ORPRN
Oregon Rural Practice-Based Research Network

OHSU

Welcome & Introductions

In the Zoom chat, please introduce yourself with the following:

- Your name & pronouns
- CCO affiliation
- Something brand new you learned from Friday's session or something you are hoping to learn today

★ **Please include your CCO in your Zoom name**

★ **We encourage you to have your cameras on, if possible, especially in the breakout groups**

Roundtable Learning Objectives

- Learn about new Medicare HCPCS codes for social needs screening and referral
- Learn how other CCOs are planning to work with clinical providers to improve and/or increase engagement in metric data capture via codes
- Discuss what TA would support CCO efforts to increase or improve the use of claims data for the metric

New SDOH HCPCS Codes

CMS 2024 Physician Fee Schedule- New HCPCS codes for SDOH risk assessment

SDOH Assessment Code:

- **G0136: Administration of standardized, evidence-based SDOH assessment** 5-15 minutes, up to 1x every 6 months
  - Housing, food, transportation, utilities screening
  - Provided by a licensed providers such as physician, NP, PA, certified nurse specialist
  - In person or telehealth
  - Can be stand-alone or provided with an evaluation and management visit, behavioral health office visit, or annual wellness visit

This code could be coupled with a Z code to indicate a positive screen

This code is currently open for encounter data submission to OHA

https://www.cms.gov/files/document/mln9201074-health-equity-services-2024-physician-fee-schedule-final-rule.pdf-0

CMS 2024 Physician Fee Schedule- New HCPCS codes for SDOH risk assessment

Community Health Integration Codes:

- **G0019- Community health integration services** up to 60 minutes per calendar month
  - Includes person-centered assessment, understanding personal and cultural needs, facilitating patient-driven goal-setting, and providing tailored support
  - Includes coordinating receipt of services including social services
  - Provided by auxiliary personnel, **including licensed CHWs** under the direction of a physician or other practitioner

- **G0022- Community health integration services** additional 30 minutes (no limit)

This code is currently open for encounter data submission to OHA

This code could be coupled with a Z code to indicate navigation occurred

https://www.cms.gov/files/document/mln9201074-health-equity-services-2024-physician-fee-schedule-final-rule.pdf-0

CMS 2024 Physician Fee Schedule- New HCPCS codes for SDOH risk assessment

Principal Illness Navigation Codes:

For patients with high-risk physical and/or behavioral health condition

- **G0023: Principal illness navigation services** up to 60 minutes per calendar month
  - Includes person-centered assessment, including understanding SDOH needs
  - Includes coordinating access to and receipt of social services
  - Facilitating and providing social and emotional support to help patient cope with the condition, SDOH needs, and adjust daily routines to better meet diagnosis and treatment goals
  - Provided by auxiliary personnel, **including licensed patient navigators**, under the direction of a physician or other practitioner
- **G0024: Principal illness navigation services** additional 30 minutes per calendar month

This code is currently open for encounter data submission to OHA

This code could be coupled with a Z code to indicate navigation occurred

https://www.cms.gov/files/document/mln9201074-health-equity-services-2024-physician-fee-schedule-final-rule.pdf-0

CMS 2024 Physician Fee Schedule- New HCPCS codes for SDOH risk assessment

Principal Illness Navigation Codes:

For patients with high-risk physical and/or behavioral health condition

- **G0140: Principal illness navigation services** up to 60 minutes per calendar month
  - Includes person-centered assessment, including understanding SDOH needs
  - Includes coordinating access to and receipt of social services
  - Facilitating and providing social and emotional support to help patient cope with the condition, SDOH needs, and adjust daily routines to better meet diagnosis and treatment goals
  - Leveraging knowledge of the serious, high-risk condition and/or lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals
  - Provided by auxiliary personnel, **including licensed peers**, under the direction of a physician or other practitioner
- **G0146: Principal illness navigation services** additional 30 minutes per calendar month

This code is currently open for encounter data submission to OHA

This code could be coupled with a Z code to indicate navigation occurred

https://www.cms.gov/files/document/mln9201074-health-equity-services-2024-physician-fee-schedule-final-rule.pdf-0

North Carolina Pilot Coding Approach

HCPCS Code	Z Code
G9919- screening conducted and positive OR G0136- Risk Assessment Social Determinants of Health	Z59.41- food
	Z59.00- housing
	Z59.89- non-medical transportation

HCPCS Code	Z Code
G9920- screening conducted and negative OR G0136- Risk Assessment Social Determinants of Health	Z59.41- food
	Z59.00- housing
	Z59.89- non-medical transportation

Hypothetical Approach

HCPCS Code	Z Code	Modifier
G9919- screening conducted and positive OR G0136- Risk Assessment Social Determinants of Health	Z59.41- food	11- referral made 12- no referral made 13- member declined referral
	Z59.00- housing	11- referral made 12- no referral made 13- member declined referral
	Z59.89- non-medical transportation	11- referral made 12- no referral made 13- member declined referral
HCPCS Code	**Z Code**	**Modifier**
G9920- screening conducted and negative OR G0136- Risk Assessment Social Determinants of Health	Z59.41- food	
	Z59.00- housing	
	Z59.89- non-medical transportation	

Providers Responsibilities and Needs

What do you think are clinical providers concerns regarding submitting codes for this metric?

-please raise your hand or respond in the chat-

Breakout Discussion

You will be randomly assigned to a breakout room. In your breakout rooms, you will have 25 minutes to discuss:

1. **What are the facilitators and barriers to adoption of coding for the metric in your network?**
2. **What other approaches will you employ to ensure that community organizations which do not engage in medical coding can participate in data collection for the metric?**
3. **What technical assistance from OHA or ORPRN would you like to have around coding or engaging providers in coding for the metric?**

Please designate one colleague from your breakout group to take notes & share with the large group when we reconvene.

Share-Out & Group Discussion

Next Steps

★ **Check out the 2024 CCO Learning Collaborative Playbook!**

Homework...

- Reach out to TA providers with questions
- Connect with each other

Measure Contacts

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