HRSA
Health Resources & Services Administration

Documentation, Coding, and Billing for Behavioral Health Integration in Community Health

Session 3

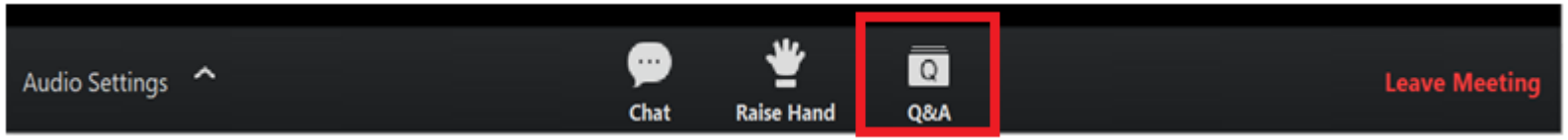
Monday, February 26, 2024

1:00 p.m. to 1:30 p.m. ET

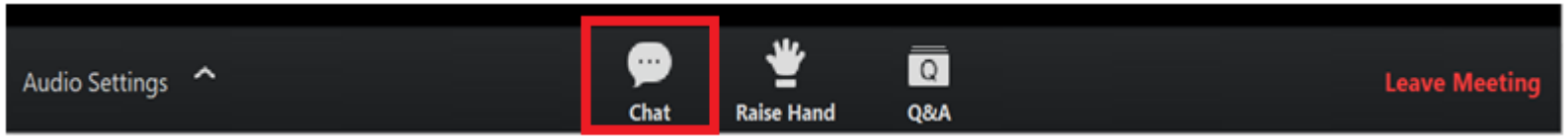
Vision: Healthy Communities, Healthy People

Submitting Questions and Comments

Submit questions by using the Q&A feature. To open your Q&A window, click the Q&A icon on the bottom center of your Zoom window.



If you experience any technical issues during the webinar, please message us through the chat feature or email healthcenter_BHTA@jbsinternational.com



Continuing Education (CE)

- We offer **behavioral health** Continuing Education units (CEUs) for participation in BHTA events.
- You must attend the event, then complete the online Health Center TA Satisfaction Assessment form (two-three minutes) at the end.
- Link with instructions is provided at the end of the session.

This course has been approved by JBS International, Inc. as a NAADAC Approved Education Provider, for educational credits. NAADAC Provider #86832, JBS international, Inc. is responsible for all aspects of their programming.

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Accessing Slides and Captioned Recordings

- The 508 compliant slides for this presentation are **available now** on the BHTA Portal in the section "Technical Assistance Resources."

- Captioned videos will be posted to the same location within two weeks.

https://bphc-ta.jbsinternational.com/technical-assistance-resources

Announcing! Two-Day In-Person Training

WHO Selected HRSA-funded Health Centers & PCAs

WHAT Primary and Behavioral Health Integration

WHEN Mon & Tues, July 22-23, 2024

Interested? Let us know!

https://bit.ly/PCBHITrainingInterestForm

WHERE HRSA Headquarters in Rockville, MD

WHY Practice Transformation

HOW Limited to 65
Travel, Lodging, and Registration Included

Upcoming Webinar

Workforce Retention and Resiliency within Integrated Care Setting

Date: Wednesday, March 6, 2024
Time: 1:00 – 2:00 PM ET
Duration: 60 minutes
Presenters: Philip H. Rainer, Senior Program Associate, Advocates for Human Potential (AHP); Katie Crowley, Program Associate, Advocates for Human Potential (AHP)
Description:
This webinar aims to provide key factors contributing to burnout, compassion fatigue, and employee turnover among primary and behavioral health providers; how these challenges have intensified due to the pandemic's impact; supervisory strategies that have been found to be effective in supporting employee engagement, resilience, and retention; and key organizational policies and practices that can enhance workforce retention and resilience. *Earn 1.0 Behavioral Health continuing education credits (CEUs) for attending this webinar.*

Registration Link:
https://us06web.zoom.us/webinar/register/WN_i1BHFMdvSUWgS38Jt1_cow

Registration QR Code:

HRSA Health Center Program

Presenter and Facilitator

GARY LUCAS, MSHI

Vice President of Research and Development
ArchPro Coding

AYLIN EDELMAN, M.D., RHIA, CCS

Technical Assistance Manager
JBS International

Today's Agenda

Deep Dive into Evaluation and Management (E/M) services

- E/M documentation guidelines
- Telehealth vs Virtual Communication Services
- Care Management Services

Principal/Chronic Care Management, Transitional Care Management, BHI, and Psychiatric Collaborative Care Mode

Objectives

Source: iStock

Participants of this webinar will be able to:

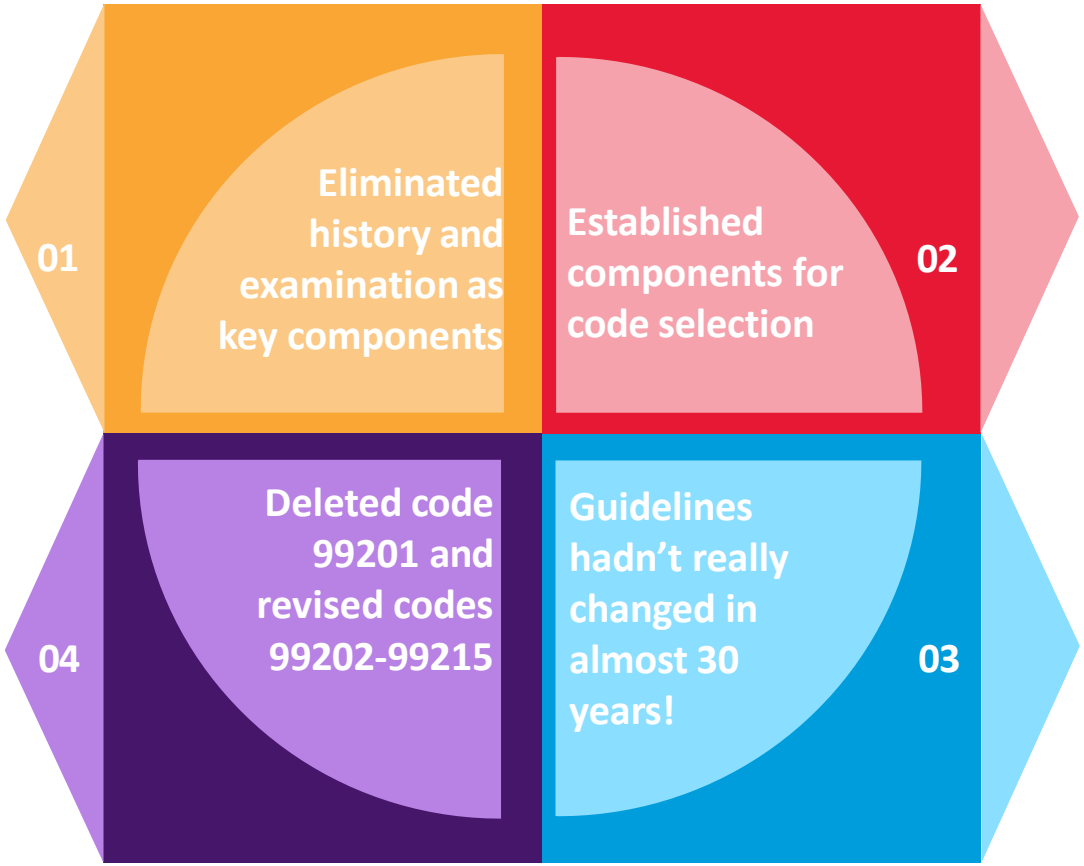
- Demonstrate the ability to apply E/M guidelines in different clinical scenarios.
- Differentiate between telehealth and virtual communication services in the context of E/M services.
- Evaluate the documentation requirements for each type of care management service.

Clinical provider's historical complaints with complicated documentation rules has been heard!

- In 2020, the **Patient's Over Paperwork** initiative "*CMS' internal process to evaluate and streamline regulations*" winds up and sweeping changes took effect January 2021 for office/outpatient E&M codes and in January 2023 for hospital, observation, nursing facility and home visits.
  - ✓ Reduce documentation burden for qualified providers **– check!**
  - ✓ Eliminate "note bloat" and need to "re-document" certain aspects of the record **– check!**
  - ✓ Reduce professional dissatisfaction and provider "burnout" **– hopefully!**
  - ✓ Encourage more time with patients and less time with unnecessary paperwork **– it is literally in the definition now!**
- 2024 brings slight updates to how much time impacts office visit codes 99202-99215 and nursing facility visit codes 99306/99308.

Summary of Major E/M Revisions from 2021-2024

AMA's CPT: Continue to provide a *"medically appropriate history **and/or** physical exam, when performed…(which) **is not** an element in selection of the level" of E/M codes."*

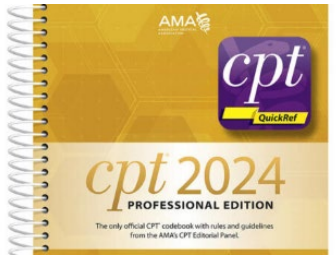


Use either **MDM** level or **Total Time** on the date of the encounter

99211 and Incident-to
This code is still only used for most non-Medicare nurse services that don't already have a code (e.g. vaccine admins)

Specific only to E/M office visits in 2021 but expanded to inpatient care (and beyond) in 2023.

Updated for 2024 - minimum times associated with Office/Outpatient E/M codes



New Patient 99202 15 minutes	**New Patient 99203** 30 minutes	**New Patient 99204** 45 minutes	**New Patient 99205** 60 minutes
Est. Patient 99212 10 minutes	**Est. Patient 99213** 20 minutes	**Est. Patient 99214** 30 minutes	**Est. Patient 99215** 40 minutes

Review pages 13-14 of the AMA's Professional Edition for details on what non-face-to-face time may be included when determining total time!

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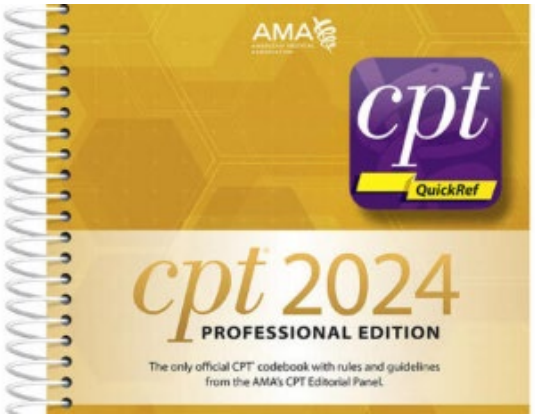
Time spent on the below items is counted if <u>on</u> the date of service



- preparing to see the patient (*e.g., review of tests*)
- obtaining and or reviewing separately obtained history
- performing a medically appropriate examination and/or evaluation
- counseling and educating the patient/family/caregiver
- ordering medications, tests, or procedures
- referring and communicating with other health care professionals (*when not separately reported*)
- **documenting clinical information in the electronic or other health record**
- independently interpreting results (*not separately reported*) and communicating results to the patient/family/caregiver
- care coordination (*not separately reported*)

See pg. 13-14 in the AMA's CPT Professional Edition for items NOT included in time calculations in 2024

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Updated AMA 2024 MDM Table

Level of Medical Decision Making (MDM) | **Revisions effective January 1, 2023 are noted in red text**

	Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed	Elements of Medical Decision Making: Amount and/or Complexity of Data to be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management
	N/A	N/A	N/A	N/A
99211 99202/9	**Straightforward**	**Minimal** • **1** self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**
9212 99203/9 9213	**Low**	**Low** • **2** or more self-limited or minor problems; **or** • **1** stable chronic illness; **or** • **1** acute, uncomplicated illness or injury or • 1 stable acute illness; or • acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	**Limited** *(Must meet the requirements of at least 1 of the 2 categories)* **Category 1: Tests and documents** • **Any combination of 2 from the following:** • Review of prior external note(s) from each unique source*; • review of the result(s) of each unique test*; • ordering of each unique test* **or** **Category 2: Assessment requiring an independent historian(s)** *(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)*	**Low risk of morbidity from additional diagnostic testing or treatment**
    99204/9 9214	**Moderate**	**Moderate** • **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment; **or** • **2** or more stable chronic illnesses; **or** • **1** undiagnosed new problem with uncertain prognosis; **or** • **1** acute illness with systemic symptoms; **or** • **1** acute complicated injury	**Moderate** *(Must meet the requirements of at least 1 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** • **Any combination of 3 from the following:** • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) **or** **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **or** **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported)	**Moderate risk of morbidity from additional diagnostic testing or treatment** *Examples only:* • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health
    99205/9 9215	**High**	**High** • **1** or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; **or** • **1** acute or chronic illness or injury that poses a threat to life or bodily function	**Extensive** *(Must meet the requirements of at least 2 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** • **Any combination of 3 from the following:** • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) **or** **Category 2: Independent interpretation of tests** • **Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);** **or** **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	**High risk of morbidity from additional diagnostic testing or treatment** *Examples only:* • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization or escalation of hospital-level of care • Decision not to resuscitate or to de-escalate care because of poor prognosis • Parenteral controlled substances

2024 Telehealth Updates from Medicare impacting RHC/FQHC

- Extended medical telehealth flexibilities using code G2025 through the end of 2024.
- Patients will have no geographic limitations and can essentially get telehealth from anywhere.
- Delays the proposed in-person visit requirement in order to begin billing for mental health telehealth visits through the end of 2024.
- Expands the list of telehealth to be provided by Mental Health Counselors and Marriage and Family Therapists.
- Adds the G0136 Social Determinants of Health Risk Assessment to Medicare's covered via telehealth list!
- Continues to allow the use of audio/visual telecommunications when supervising residents and "direct supervision" for incident-to services through the end of 2024.

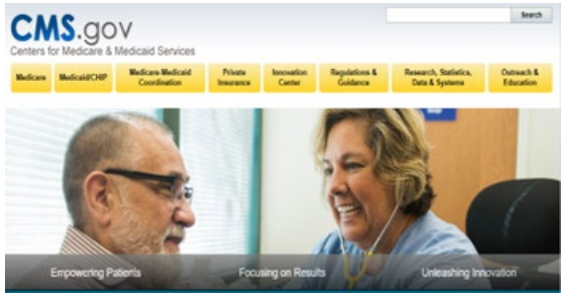
FQHC Telehealth
Key Thoughts for Billing

- **PRIVATE INSURANCE** – For non-Medicare carriers it is likely that the payer just wants the CPT/HCPCS-II code performed (99213 or 90832) plus a modifier -93/-95/-FQ/-FR and/or Place Of Service code 02 or 10 on the CMS1500 claim.

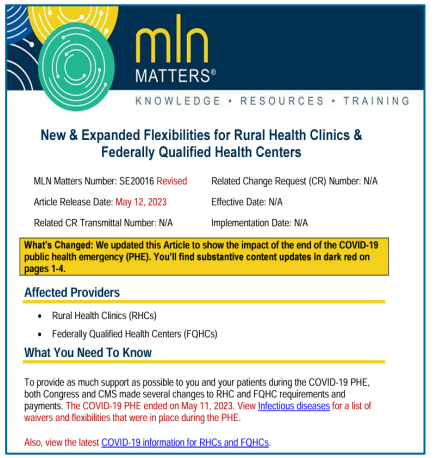
- **RHC/FQHC MEDICAL SERVICES** – For Medicare patients, RHC/FQHC are instructed to use code G2025 for in order to receive the flat fee of $95.37 (split 80/20%) if the code is on the CMS approved services list.

- **RHC/FQHC MENTAL HEALTH SERVICES** – For Medicare patients, RHC/FQHC are instructed to report a code on the CMS approved services list as if performed in-person and billing should add a modifier -93/-95 in order to receive your AIR/PPS payments.

CMS resources for RHC/FQHC Telehealth



- Get the CMS Med Learn Matters #SE20016 (*last updated 5-12-22?*) for updates, revenue code info, modifiers, and other great billing info.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New & Expanded Flexibilities for Rural Health Clinics & Federally Qualified Health Centers

MLN Matters Number: SE20016 Revised | Related Change Request (CR) Number: N/A
Article Release Date: May 12, 2023 | Effective Date: N/A
Related CR Transmittal Number: N/A | Implementation Date: N/A

What's Changed: We updated this Article to show the impact of the end of the COVID-19 public health emergency (PHE). You'll find substantive content updates in dark red on pages 1-4.

Affected Providers

- Rural Health Clinics (RHCs)
- Federally Qualified Health Centers (FQHCs)

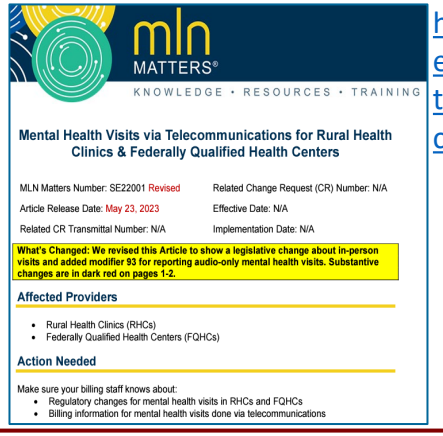
What You Need To Know

To provide as much support as possible to you and your patients during the COVID-19 PHE, both Congress and CMS made several changes to RHC and FQHC requirements and payments. The COVID-19 PHE ended on May 11, 2023. View Infectious diseases for a list of waivers and flexibilities that were in place during the PHE.

Also, view the latest COVID-19 information for RHCs and FQHCs.

https://www.cms.gov/files/document/se20016-new-expanded-flexibilities-rhcs-fqhcs-during-covid-19-phe.pdf

- For updates on reporting mental health telehealth in RHC/FQHC please refer to Med Learn Matters SE#22001 document *(updated 5-23-23?)*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Mental Health Visits via Telecommunications for Rural Health Clinics & Federally Qualified Health Centers

MLN Matters Number: SE22001 Revised | Related Change Request (CR) Number: N/A
Article Release Date: May 23, 2023 | Effective Date: N/A
Related CR Transmittal Number: N/A | Implementation Date: N/A

What's Changed: We revised this Article to show a legislative change about in-person visits and added modifier 93 for reporting audio-only mental health visits. Substantive changes are in dark red on pages 1-2.

Affected Providers

- Rural Health Clinics (RHCs)
- Federally Qualified Health Centers (FQHCs)

Action Needed

Make sure your billing staff knows about:

- Regulatory changes for mental health visits in RHCs and FQHCs
- Billing information for mental health visits done via telecommunications

https://www.cms.gov/files/document/se22001-mental-health-visits-telecommunications-rural-health-clinics-federally-qualified-health.pdf

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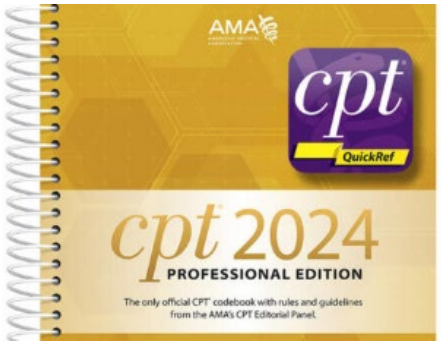
Documentation Basics of Transitional Care Management (TCM)



AMA CPT Guidelines

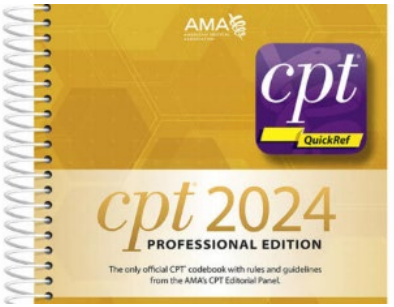
The goal of TCM is to lower preventable hospital readmissions by establishing the smooth transition from an inpatient stay between a patient's various care providers and their designated primary care manager.

Establish direct patient contact with the patient within 2 days of the discharge to determine what happened in the inpatient stay.

Based on those findings (i.e., med reconciliation and treatment referrals) schedule a face-to-face visit within either 7 (CPT 99495) or 14 days (CPT 99496).

If the patient is readmitted by anyone for that same condition in the 30 days following the discharges, TCM should likely not be paid/reported.

Care Management Documentation for Clinical Providers



- Info on the main Care Management services are located at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Care-Management

AMA CPT Guidelines

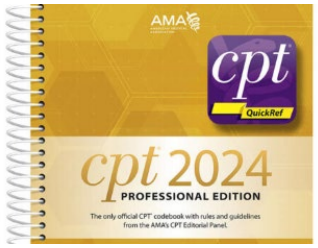
According to the CPT these are "management and support services provided by clinical staff, under the direction of a physician or other qualified health care professional….(that) include"

TIPS: Develop templates in your EHR, track monthly time, document care plan updates and *get credit for the clinical work you do in between patient visits*. Consider external care managers to help with the workload.

"Establishing, implementing, revising, or monitoring the care plan

Coordinating the care of other professionals and agencies

Educating the patient or caregiver about the patient's condition, care plan, and prognosis"



General Care Management Codes for Clinical Providers Managing Care Plans

Get patient verbal/written consent to be their ONLY care manager

For RHCs/FQHCs to bill Medicare patients it is necessary to get their approval of being their single care manager as well as **performing an "Initiating Visit" within 1 year prior** to first billing Care Management.

Chronic Care Management

99487-99491, +99439

+

Principal Care Management

99424-99427

Behavioral Health Integration (BHI) or Psychiatric Collaborative Care Model (Psych CoCM)

99484, 99492-99494

Monthly Chronic Pain Management

See G3002 and +G3003 for consideration with commercial and non-Medicare payers.

Many more related monthly Care Management options for RHC/FQHC were added by CMS effective 2024!

Key Themes
General BHI and Psych CoCM

Know your CPT!

Please review and study pages 47-49, 52-55, and 58 for full clinical documentation guidelines and coding standards (ex., having a documented care plan) that covers all payers and all patients.

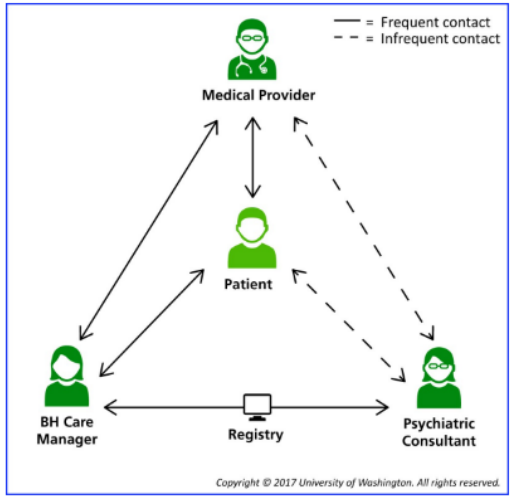
Billing will differ by payer.

AMA Coding Tip

Per AMA Professional Edition page 58:

If the QHP performs BHI activities and they *"are not used to meet the criteria for another reported code"* - use this time towards BHI or Psych CoCM

Psych CoCM is based on a University of Washington Model and can be researched via their website!



https://aims.uw.edu/collaborative-care/

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Additional CMS General BHI Info (May 2023)
Caution as it is NOT FQHC-specific for billing!

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Behavioral Health Integration Services

https://www.cms.gov/files/document/mln909432-behavioral-health-integration-services.pdf

Caution - this document does not contain FQHC-billing information!

Balance this information against CMS FQHC billing rules. Use it for great CMS definitions and billing options for non-FQHCs facilities

Tip: A Psychiatric Diagnostic Evaluation may constitute an "Initiating Visit" for G2023 should you use it for Medicaid or commercial payers.

BHI and Psych CoCM
Additional info for RHC/FQHC

When a **medical provider supervises and directs the care plan for patients with a mental, behavioral, or psychiatric conditions** (including substance use disorders).

- To distinguish general BHI services from the Psych CoCM please visit this link CMS Fact Sheet for Behavioral Health Integration Services for details on the CoCM model and how it differs from general BHI.

https://www.cms.gov/files/document/mln909432-behavioral-health-integration-services.pdf

- BHI ***optionally*** includes a Behavioral Heath Manager and a Psychiatric Consultant, whereas the Psych CoCM ***requires*** their active participation.

- Check out code **G0323** for *Care management services for behavioral health conditions, at least 20 minutes of clinical psychologist or clinical social worker time, per calendar month* for possible use with **non-Medicare payers**.
  - ***You may use G0511 to report this service to Medicare for MFT/MHC services as well.***

BHI and Psych CoCM
Key Issues for Discussion

According to the Agency for Healthcare Research and Quality integrated BH not only improves health and patient experiences but also reduces cost and delays in treatment. [1]

- Based on the growing evidence, CoCM is now regarded as one of the most established models of integrated BH care. The American College of Physicians recommends treating depression in primary care within the context of collaborative care. [2]

- Qualified clinical staff may have different meaning in the CPT versus state and payer rules. You will see the term ***"qualified health professional"*** especially related to the performance of your ***Behavioral Health Manager*** mentioned in several place for BHI and Psych CoCM.
  - Typically, this is someone with a masters/doctoral degree, ***BUT*** also appears to include someone with "*specialized training in behavioral health, with backgrounds in social work, psychology, or nursing*."

[1] Crowley, R. A., Kirschner, N., & Health and Public Policy Committee of the American College of Physicians (2015). The integration of care for mental health, substance abuse, and other behavioral health conditions into primary care: executive summary of an American College of Physicians position paper. *Annals of internal medicine*, *163*(4), 298–299. https://doi.org/10.7326/M15-0510

[2] Agency for Healthcare Research and Quality. What is Integrated Behavioral Health? https://integrationacademy.ahrq.gov/about/integrated-behavioral-health

Role of the BH Manager

Remember, Care Management is usually reported by the patient's primary care provider who received the consent to be their single care manager.

Their timed interactions with BH Managers and/or Psychiatric Consultants is key!

Typical services counted towards the monthly time requirement include:

- maintains an ongoing relationship with the patient,
- administers applicable validated rating scales,
- collaborates with patient/care team to develop the BH care plan,
- provides brief psychosocial interventions,
- collaborates with the treating physician,
- maintains the patient registry, and
- collaborates with the psychiatric consultant during weekly caseload reviews.

Role of the Psychiatric Consultant

Psychiatric Consultant are physicians with the full capability to manage prescriptions and provide all behavioral health services.

- Psych consultants do not necessarily need to be onsite; they can work remotely!
- They are not expected to have direct patient contact and often interact with patient registries to document care interactions and updated to treatment plans or to mark key milestones throughout treatment.
- **Typical services counted towards the monthly time requirement include:**
  - participates in the weekly caseload reviews to discuss patient clinical status and progress with the BH care manager,
  - makes treatment recommendations, and
  - facilitates referral for direct provision of psychiatric care when clinically indicated.

Care Management
Coding/Billing information for FQHC consideration

Medicare asks FQHCs to report the unique G0511 or G0512 codes that now encompass all general care management services including chronic/principal care management, chronic pain management, BHI, and the Psych CoCM

G0511 = **Rural Health Clinic or Federally Qualified Health Center only**, general care management (aka principal/chronic), 20 minutes or more of clinical staff time for chronic care **or chronic pain management** services **OR** behavioral health integration services directed by RHC or FQHC practitioner (MD, NP, PA, or CNM), **per calendar month**. Pays ~$77.94 split 80/20%

G0512 = **Rural Health Clinic or Federally Qualified Health Center only**, Psychiatric Collaborative Care Model, 60 minutes or more of clinical staff time for psychiatric CoCM services directed by a RHC/FQHC practitioner (physician, NP, PA, or CNM) and including services furnished by a behavioral health care manager and consultation with a psychiatric consultant, **per calendar month**. Pays ~$146.73 split 80/20%

Major Changes to Care Management Services (G0511)

- Adding in four new buckets of care management
  - Remote Physiologic Monitoring (RPM)
  - Remote Therapeutic Monitoring (RTM)
  - Community Health Integration (CHI)
  - Principal Illness Navigation (PIN)
- Allowing multiple G0511s per patient per month

Source: National Association of Rural Health Clinics 2024 Medicare Updates Webinar (12-11-23)

Per CMS Final Rule: "multiple times in a calendar month, as long as all of the requirements are met and resource costs are not counted more than once."

Care Management now has 20+ codes
Be aware of them all and read the CPT notes!

Physician Fee Schedule Code	Description
G0323	General Behavioral Health Integration (BHI)
99487	Complex CCM (over 60 minutes of care management per month)
99490	Basic CCM (20 minutes of care management)
99491	30 minutes or more of CCM furnished by a physician or other qualified health professional
99424	30 minutes or more of Principal Care Management furnished by physicians or non-physician practitioners
99426	30 minutes or more of PCM services furnished by clinical staff under the supervision of a physician or non-physician practitioner
G3002	Chronic pain management first 30 minutes
G3003	Chronic Pain Management (each additional 15 minutes)
99453	**Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment**
99454	**Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, ea**
99457	**Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes**
99458	**Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes**
99091	**Collection and interpretation of physiologic data (e.g. Blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days**
98975	**Remote therapeutic monitoring (eg, therapy adherence, therapy response); initial set-up and patient education on use of equipment**
98976	**Remote therapeutic monitoring (eg, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor respiratory system, each**
98977	**Remote therapeutic monitoring (eg, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system,**
98980	**Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; first 20 minutes**
98981	**Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the additional 20 minutes**
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 pe 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**
G0022	**Community health integration services, each additional 30 minutes per calendar month**
G0023	**Principal Illness Navigation services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a p per calendar month,**
G0024	**Principal Illness Navigation services, additional 30 minutes per calendar month**

General Care Management

Remote Physiologic Monitoring

Remote Treatment Management

Remote Therapeutic Monitoring

Community Health Integration

Principle Illness Navigation

Source: National Association of Rural Health Clinics 2024 Medicare Updates Webinar (12-11-23)

Codes designed to provide patient support
Community Health Integration (CHI)
Principal Illness Navigation (PIN)

New for 2024!

Community health integration and principal illness navigation services codes G0019-G0024 are the new codes that will allow providers to report time spent on Social Determinants of Health (SDOH) data collection.

G0019 and G0022

Community Health Integration services are to address unmet SDOH needs that affect the diagnosis and treatment of the patient's medical problems, 60 minutes per month and each additional 30 minutes.

G0023 and G0024

Principal Illness Navigation services are to help people with Medicare diagnosed with high-risk conditions (*ex., SUD/OUD, dementia, HIV/AIDS, and cancer*) identify and connect ***with patient navigators and peer support resources*** 60 minutes per month and each additional 30 minutes.

New for 2024!

For Medicare claims - billing staff will convert each general care management, some remote monitoring services, CHI, and PIN into a single code – G0511.

Polling Questions

Source: iStock

1a. Rate your knowledge of the topic area presented in this webinar:

- Not at all knowledgeable
- Slightly knowledgeable
- Moderately knowledgeable
- Very knowledgeable
- Extremely knowledgeable

1b. How confident are you in applying information about this webinar topic area in your work setting?

- Not at all confident
- Slightly confident
- Moderately confident
- Very confident
- Extremely confident

Q&A

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- All participants are asked to complete the TA Satisfaction Assessment Form.
- Two ways to access form - link posted in the chat box or in pop-up window that opens when session ends.
- We offer **behavioral health** Continuing Education Units (CEUs) to those who complete the online Health Center TA Satisfaction Assessment form.
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Thank you!

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