New Payment Opportunities: Is the Juice Worth the Squeeze?

Summary

The Centers for Medicare & Medicaid Services (CMS) included the following new codes in the Calendar Year (CY) 2024 Medicare Physician Fee Schedule (MPFS) final rule:[1]

- *Social Determinants of Health (SDOH) Assessment* code: to administer a standardized tool to identify each patient's SDOH needs.
- *Principal Illness Navigation (PIN)* codes: to recognize navigator services (like those used to support cancer patients) that are furnished by licensed or trained peer staff.
- *Community Health Integration (CHI)* codes: to recognize services that coordinate patient needs with community agencies that help with housing, food, and transportation.
- *Caregiver Training Services (CTS)* codes: to provide for training when caregivers are vital to the management and success of a patient's treatment plan.

CMS states, *"Medical practice has evolved to increasingly recognize the importance of these activities, and we believe practitioners are performing them more often. However, this work is not explicitly identified in current coding, so we believe it is underutilized and undervalued."*[2] As a result, the agency has released new codes and payments to address a range of services designed to improve patient health. In this paper, we summarize the codes, their use, payment rates, and some of the implementation questions Nimitt Consulting has received.

Background

A strong thread running throughout the final rule is the importance of making provision for services that can address SDOH that significantly impact a practitioner's ability to diagnose or treat a patient. With respect to the release of new codes and CMS' discussion of SDOH, the agency defines SDOH as economic and social condition(s) that influence the health of people and communities consistent with the American Medical Association's CPT® description of Evaluation and Management (E/M) guidelines.[3]

Many stakeholders have recommended that CMS explicitly make provision for these types of services, due to the growing evidence of their direct and quantifiable impact on patients' experiences and outcomes. To do so, CMS is required to determine whether such coverage is precluded by the Social Security Act's (SSA) implementing regulation, Section 1862(a)(1)(A), which imposes a "reasonable and necessary" qualification on services that are covered by Medicare.[4]

In the final rule, CMS demonstrates its willingness to define services as being "reasonable and necessary" where such evidence exists, particularly when the services can improve outcomes for patients with SDOH needs and other conditions. Such patients are likely to benefit from these services in order to facilitate adherence with their treatment plan—even when those services are not furnished directly to the patient.

The services outlined in this paper are important and applicable to patients with behavioral health conditions who may or may not be receiving intensive outpatient program (IOP) or partial hospitalization program (PHP) treatment. Since this article focuses on services for patients with cancer, sickle cell disease, and other chronic, serious non-behavioral health conditions, the behavioral health application of the codes are not discussed further.

Overview of New Codes

CMS acknowledges that some work associated with the services represented by the new codes it has released are provided as part of an E/M or another similar visit. However, CMS views these as separate services—as such, they need to be reported and paid separately. To that end, hospitals and clinicians have a new opportunity to separately report and be paid for several unique services, which are summarized below:

Social Determinants of Health Assessment

CMS finalized a code to separately identify and value a SDOH risk assessment that is furnished in conjunction with a qualifying E/M visit, including an annual wellness visit. It is important to understand that the SDOH risk assessment is not a screening; rather, it is an assessment using a standardized tool that is performed *after* the identification of at least one known or suspected SDOH need that demonstrates the patient is at-risk.

The SDOH risk assessment is considered to be "reasonable and necessary" per CMS' interpretation of the SSA when it is furnished by a treating practitioner to inform the patient's diagnosis and treatment plan. CMS expects that the assessment will typically happen on the same day as the visit where the treatment plan is updated to reflect results of the assessment, but that is not a requirement. This means that the assessment could be performed subsequent to a qualifying visit. Qualifying visits include the Annual Wellness Visit; Health Behavior Assessment Intervention; Transitional Care Management visit; hospital discharge; hospital observation; or post-acute care and other outpatient visits.

CMS requires the use of a standardized, evidence-based SDOH risk assessment tool that has been tested and validated through research; the assessment must include the domains of food insecurity, housing insecurity, transportation needs, and utility difficulties. Providers may include additional domains that are prevalent and/or culturally relevant to their patients. CMS discussed several potential evidence-based tools in the final rule, including the CMS Accountable Health Communities (AHC) tool; the Protocol for

Responding to & Assessing Patients' Assets, Risks & Experiences (PRAPARE) tool; and instruments identified for conducting a Medicare Advantage Special Needs Population Health Risk Assessment (HRA).[5]

By administering a SDOH risk assessment in conjunction with a qualifying visit, the practitioner can obtain more information about the patient's full social history and also determine the extent of SDOH issues that might impact the patient's care. CMS provided the example of a diabetes patient for whom a SDOH risk assessment informs the practitioner that the patient's living situation does not permit reliable access to electricity, impacting the ability to keep insulin refrigerated. With this information, the practitioner might prescribe insulin that remains stable at room temperature or consider the use of oral medication instead.

Key summary information for SDOH assessment

- Not a screening; rather, an assessment used when a practitioner has reason to believe unmet SDOH needs could interfere with the practitioner's diagnosis and treatment of a condition or illness.
- SDOH assessment is often provided on the same day as an E/M (other than a low-level visit), but can be subsequent to a qualifying visit.
- Any SDOH needs identified through the assessment must be documented in the medical record.
- Cannot be provided more frequently than once every six months.
- CMS does not require SDOH "Z codes" (Z55-Z65) for purposes of documentation but confirms that the use of Z codes is an appropriate form of documentation; CMS encourages this practice so the agency can collect consistent data from the codes being reported on claims.
- HCPCS code G0136 has been added to the telehealth list.

New HCPCS Code	Descriptor	OPPS SI	OPPS Payment	MPFS Facility POS Payment	MPFS Office POS Payment
G0136	Administration of Social Determinants of Health Risk Assessment risk assessment, 5–15 min, not more often than every 6 months	S	$27.34	$8.84	$18.66
SI: Status indicator; POS: Place of service; Payment rate for 2024					

Principal Illness Navigation (PIN)

CMS describes navigation as individualized support provided by licensed or trained staff (e.g., patient navigators, peer support specialists, other auxiliary personnel) for patients who have a principal illness. Navigation services benefit these patients, who require care coordination across different specialties or service-providers for different aspects of the diagnosis or treatment and, in some cases, related social services to access necessary care in a timely manner.

CMS defines "principal illness" as one serious, high-risk condition, illness, or disease that is expected to last at least three months and that puts the patient at significant risk of hospitalization, nursing home placement, acute exacerbation/decompensation, functional decline, or death. The patient's condition must also require developing, monitoring, or revising a disease-specific care plan. It may require frequent adjustment in medication or the patient's treatment regimen, or substantial assistance from a caregiver.

PIN services include *"items such as person-centered planning, promoting patient self-advocacy, and facilitating access to community-based resources to address unmet social needs and other factors that are relevant to the practitioner's diagnosis and treatment of the patient."* [6]

CMS describes that PIN services may include aspects of navigation that are involved with other services such chronic care management, but explains that those services typically focus heavily on the clinical aspects of care rather than the social aspects, which PIN may be more heavily focused on. CMS also explained that PIN services are intended to provide patients with access to assistance from a single, dedicated individual who has "lived experience" (meaning they have personally experienced the same illness or condition the patient is facing).[7]

The following are some examples given by CMS of patient conditions for which PIN services can be beneficial: cancer; chronic obstructive pulmonary disease (COPD); congestive heart failure (CHF); dementia; HIV/AIDS; chronic liver disease, chronic kidney disease; conditions that require stem cell transplantation; and severe mental illness.

A PIN service is initiated by a billing provider on the same date as a higher-level E/M visit; this E/M visit is a pre-requisite for billing PIN services. During that visit, the billing practitioner must identify the medical necessity of PIN services and incorporate them into the patient's treatment plan. CMS' expectation is that most PIN services will be delivered in-person by auxiliary staff, but a portion might be performed via two-way audio.

A billing practitioner may arrange for PIN to be provided by patient navigators and peer support personnel who are external to their office practice and under contract, as long as all of the "incident to" and other requirements and conditions for payment of PIN services are met or they can be ordered for hospital personnel to furnish. When provided by a billing practitioner in the hospital, or ordered by the billing practitioner for the hospital to provide, both the billing practitioner and the hospital bill. The hospital must then provide ongoing information back to the billing practitioner to update the treatment plan. Because peer support specialists may not have the same credentials as patient navigators, CMS created separate codes for peer PIN services.

Key summary information for PIN services

- Furnished under general supervision.
- Same practitioner to furnish and bill for both the PIN initiating visit and PIN services.
- An E/M (other than a low-level visit) is a pre-requisite for billing PIN services.
- An E/M visit is not required every month that PIN is billed; only before commencing PIN services and on an annual basis, to establish the treatment plan
- Inpatient/observation visits, ED visits, and SNF visits are not considered an initiating visit.
- Verbal or written patient consent must be documented in the medical record.
- Documentation of the time spent and a description of the activities provided must be in the medical record.
- Add-on codes enable billing time beyond 60 minutes per month, if medically necessary.
- Personnel who perform the services must meet service-specific training and certification requirements; they must be authorized to perform the service elements under applicable State laws and regulations.

New HCPCS Code	Descriptor	OPPS SI	OPPS Payment	MPFS Facility POS Payment	MPFS Office POS Payment
G0023	Principal Illness Navigation services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator or certified peer specialist; 60 minutes per calendar month, in the following activities: person-centered assessments; health education; self-advocacy skills; health navigation; care coordination; facilitating behavioral change; social/emotional support; and leveraging lived experience.	S	$84.93	$48.79	$79.24
G0024	Principal Illness Navigation services, additional 30 minutes per calendar month (List separately in addition to G0023).	N	0	$34.05	$49.44
G0140	Principal Illness Navigation, Peer Support by certified or training auxiliary personnel under the direction of a physician or other practitioner, including a certified peer specialist; 60 minutes pers calendar month, in the following activities: person-centered interview; identifying or referring to supportive services; care communication; health education; self-advocacy skills; social/emotional support; and leveraging lived experience.	S	$84.93	$48.79	$79.24
G0146	Principal Illness Navigation, Peer Support, additional 30 minutes per calendar month (List separately in addition to G0140).	N	0	$34.05	$49.44
SI: Status indicator; POS: Place of service; Payment rate for 2024					

Community Health Integration (CHI)

Similar to PIN, CMS notes that CHI services *"include person-centered planning, health system coordination, promoting patient self-advocacy, and facilitating access to community-based resources to address unmet social needs that interfere with the practitioner's diagnosis and treatment of the patient."*[8]

Auxiliary staff (including social workers, community health workers, registered nurses, and others) often engage in significant efforts to coordinate (e.g., integrate) the provision of patient services in the community to help beneficiaries who have identified SDOH needs. Through CHI services, beneficiaries are connected to vital health care and social services, which expand equitable access to care and improve patient outcomes. In order to satisfy the SSA "reasonable and necessary" test, CHI services should focus 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).

In the final rule, CMS describes the importance of CHI provided by certified or trained auxiliary personnel under the general supervision of the billing practitioner following an initiating E/M visit during which specific SDOH needs are identified. Auxiliary personnel who deliver CHI must be authorized to perform them under applicable State laws and regulations. In States that lack applicable licensure laws or other regulations relating to the service, auxiliary personnel must be certified or trained to perform all required service elements. For CHI, this training must include the competencies of patient and family communication; interpersonal and relationship-building; patient and family capacity-building; service coordination and system navigation; patient advocacy; facilitation; individual and community assessment; professionalism and ethical conduct; and the development of an appropriate knowledge base, including of local community-based resources.

CMS' expectation is that most CHI is delivered in-person, but a portion might be performed via two-way audio. A billing practitioner may arrange for CHI to be provided by personnel who are external to, and under contract with, the hospital or the physician's office—such as through a community-based organization that employs community health workers—if all of the "incident to" and other requirements and conditions for payment of CHI services are met. Alternatively, the treating practitioner can order hospital personnel to furnish. In this case, when CHI is provided by a billing practitioner in the hospital, both the billing practitioner and hospital bill the CHI codes. The hospital must then provide ongoing information back to the billing practitioner to update the treatment plan.

Key summary information for CHI services

- Furnished under general supervision.
- Same practitioner to furnish and bill for both the CHI initiating visit and CHI services.
- CHI must follow an initiating E/M visit; not required every month that CHI is billed; only before commencing CHI services, to establish the treatment plan, including specifying how addressing the unmet SDOH need(s) would help accomplish the plan.
- Inpatient/observation visits, ED visits, and SNF visits are not considered an initiating visit.
- Patient consent (either verbal or written) must be documented in the medical record.
- Staff time on activities provided must be documented in the medical record, including establishing the plan of care.
- Add-on code enables billing time beyond 60 minutes per month, if medically necessary.
- Personnel who perform the services must meet service-specific training and certification requirements; they must be authorized to perform the service elements under applicable State laws and regulations.

New HCPCS Code	Descriptor	OPPS SI	OPPS Payment	MPFS Facility POS Payment	MPFS Office POS Payment
G0019	Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner; 60 minutes per calendar month.	**S**	$84.93	$48.79	$79.24
G0022	Community health integration services, each additional 30 minutes per calendar month. (List separately in addition to G0019).	N	0	$34.05	$49.44
SI: Status indicator; POS: Place of service; Payment rate for 2024					

Caregiver Training Services (CTS)

CMS considers CTS to be "reasonable and necessary" per the SSA since they are intended to assist certain patients to carry out a treatment plan that has been established by the treating practitioner—even though CTS is not directly provided to the patient as an individual.

CMS provided examples of conditions that may require caregivers' involvement, including: cancer, stroke, traumatic brain injury (TBI), dementia, autism spectrum disorders, intellectual or cognitive disabilities, End-Stage Renal Disease (ESRD), and lymphedema. CMS noted that patients who have physical mobility limitations, use assisted devices or mobility aids, and are undergoing cell therapy or stem cell transplants also benefit from caregiver involvement.

Part of the caregiver's training should include development of skills that enable the patient to safely complete activities of daily living; solve problems to reduce the negative impacts of the patient's diagnosis; adapt to the environment; use equipment or assistive devices; and/or engage in interventions that focus on motor, process, and communication skills.

CMS finalized a revised definition of "caregiver" based on extensive comments received from the public. The agency's definition is: "*an adult family member or other individual who has a significant relationship with, and who provides a broad range of assistance to, an individual with a chronic or other health condition, disability, or functional limitation" and "a family member, friend, or neighbor who provides unpaid assistance to a person with a chronic illness or disabling condition."*[9]

CMS' discussion of who could bill for CTS codes was a little muddled in the final hospital outpatient prospective payment system (OPPS) rule, and seemed to imply that only therapists could provide these services for behavioral health patients. CMS did not include cancer patients or other seriously ill patients in its explanation of outpatient hospital care.

When questioned during the November 2023 hospital Open Door Forum call, CMS representatives said that hospitals can bill for CTS services for all conditions. Due

Key summary information for CTS services

- CTS must be integral to the patient's overall treatment and furnished after the treatment plan (or therapy plan of care) is established.
- The patient's (or their representative's) consent for the caregiver to receive CTS must be documented in the patient's medical record.
- Documentation must include that the CTS was ordered based on the treating practitioner's assessment and clinical rationale that a caregiver's involvement is necessary to ensure successful patient outcomes.
- The physician or NPP must perform the CTS face-to-face.
- The patient may not be present during CTS.
- There is no limit on the number of CTS sessions that can be furnished to caregivers by the same practitioner and for the same patient, so long as the medical necessity is based on the treatment plan or changes in the patient condition or diagnosis that are documented in the patient's medical record.

to the questions stakeholders raised, CMS further clarified this in Transmittal 12372, which states that CTS services can be billed and paid when furnished by a physician or a non-physician practitioner (NPP)—such as a nurse practitioner, physician assistant, clinical nurse specialist, certified nurse-midwife, clinical psychologist, or a therapist (e.g., physical therapist, occupational therapist, or speech language pathologist)—under an individualized treatment plan or therapy plan of care.[10]

In other words, CTS is expected to be furnished by a non-physician practitioner or therapist. When a hospital bills for these services on outpatient hospital claims, it means the hospital employs the therapist or non-physician practitioner and there will not be a professional claim submitted; payment to the hospital is not made under OPPS, but under the Medicare Physician Fee Schedule (MPFS) instead.

New HCPCS Code	Descriptor	OPPS SI	OPPS Payment	MPFS Facility POS Payment	MPFS Office POS Payment
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.	A	*	$44.53	$52.06
97551	Caregiver training each additional 15 minutes (List separately in addition to code for primary service) (Use 97551 in conjunction with 97550).	A	*	$23.90	$25.87
97552	Group 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 with multiple sets of caregivers).	A	*	$10.48	$21.94
SI: Status indicator; POS: Place of service; Payment rate for 2024; * Paid under a different fee schedule					

Unresolved Questions: Is the Juice Worth the Squeeze?

Why Does Using These Codes Matter (What is the "Juice")?

Many tertiary care hospitals are likely already performing these types of services as part of other services for chronically and seriously ill patients. They have not, however, been able to report the services with codes on claims and receive separate payment or credit (i.e., visibility in the data) for having done so. An organization that is focused narrowly on compliance may consider the use of these codes to be required in order to ensure billing accuracy; the

organization may also question whether the implementation effort (i.e., new workflows) and payment amounts are otherwise worth the "squeeze."

Nimitt Consulting's view is that the benefits of using these new codes go far beyond compliance and net income. Two years from now, when claims data are available, CMS and other stakeholders will be able to see which facilities provided and billed for these services, for what patient conditions. Specifically, we will have visibility into whether patients who have serious illnesses or who live in health care disparity areas are receiving comprehensive care. These data will enable stakeholders to track, measure, and benchmark the provision of these services—and possibly begin to correlate the services' impact on patient outcomes.

In addition to the encouraging possibilities this presents for patient outcomes, we also believe that providing (and being able to track) these services will, in time, become a hallmark of a "gold standard" provider. It is also important to acknowledge and formally report the services of these well-trained and important members of the healthcare team who have not previously been recognized in this manner for the care they deliver.

Who Can Provide and Get Paid for the Services (Is There Even Juice to be "Squeezed")?

Some of CMS' communication has been confusing and, at times, appears to contradict the new codes' goals. The confusion over eligibility to provide (and bill for) these services led to CMS receiving many questions and comments in response to the proposed rule.

The agency did not help matters by stating, in the CY 2024 MPFS final rule: *"As proposed, these services can only be furnished and billed by physicians and practitioners who can bill for services performed by auxiliary personnel incident to their professional services."*[11] In CMS parlance, the agency is stating that the services can *only* be billed by clinicians in non-facility settings (like offices and freestanding clinics). Yet, CMS has also touted that the services were, in part, designed to help treat cancer patients—and much of cancer care is furnished by facility-based clinicians. Hence, the final rule statement created concern and confusion.

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In both the November Hospital and MPFS Open Door Forum calls, CMS clearly stated and clarified that these services are billable by hospitals when their staff furnish them pursuant to a clinician's order. CMS also clarified that the services are also billable by the clinician who orders the service in the hospital setting, as well as by office-based clinicians. This was an important clarification, since it confirms that most of these services are billable on both UB and 1500 claims for hospital patients.

When Will CMS Release Additional Guidance (Why Won't CMS Give the "Juice" Recipe)?

During the November 2023 MPFS Open Door Forum call, CMS representatives stated that the agency would be releasing additional guidance. As of February 5, 2024, the only clear information we have seen is in Transmittal 12372. This document clarifies that CTS services can be provided for any/all conditions and can be provided by physicians, NPPs, or therapists.

CMS has not provided additional information for hospitals. What has been published must be carefully parsed and appears in the technical programming specifications of the January 2024 Integrated Outpatient Code Editor (IOCE) Transmittal and in new section 6.12 of the complete IOCE specifications effective January 1, 2024. The IOCE Transmittal and specifications seem to support what CMS verbalized during the Open Door Forum calls: that hospitals will be able to receive payment for most of these new services.

It would have been more useful, however, for CMS to provide clear and explicit guidance in its January OPPS transmittal, in plain English, spelling out exactly what is allowable for hospitals and practitioners—particularly since clarification is needed to qualify CMS' "incident to" language in the final MPFS rule.

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Nimitt Consulting's recommendation is that providers should continue to inbound CMS with questions and request clearer information and explicit examples (similar to those that the agency has released for other types of new services in the past). A good tip is that CMS staffs' names and emails are provided in the MPFS Transmittal 12372 for each of the services.

What Additional Patient Liability is There (Could Patients Also Feel the "Squeeze")?

As noted, many providers have been furnishing these services despite the lack of specific codes. Now that there are unique codes to bill for the services, providers have questions about how new charges for these services will be perceived by their patients and about the potential impact on patient liability.

Regarding new charges for services, since these services' expense have likely been included in charges for visits and other related services, providers now have the opportunity to reduce the charges for those visits and other services and offset the separate charges for these new codes. This will not eliminate patient liability entirely, but will go a long way toward mitigating the perception that providers are increasing the costs of care.

Regarding patient liability, the short answer is that patients *will* be responsible for their 20 percent co-payment for each of these services. It is important to note, however, that more

than 85 percent of Medicare beneficiaries also have Medigap or another secondary insurance—few patients will actually pay out-of-pocket. The remaining approximately 15 percent of patients will likely qualify for financial assistance and have their co-pay either waived or covered by the hospital.

Providers should run the numbers for their facility's Medicare Fee-For-Service (FFS) outpatients who participate in programs for cancer and other serious illnesses—these are the patients and families for whom the newly covered services could be a game-changer. Once providers have assessed the proportion of patients eligible to receive these services that also have no secondary co-payment coverage or financial assistance, they are likely to see that these numbers are surprisingly low.

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How to Create Workflows to Support Compliant Billing (How do we Deal With the Inevitable "Squeeze")?

For hospital providers, all services furnished to patients must be ordered by treating clinicians. For this reason, the most important workflow update will be to create specific orders for these services and then add them to the appropriate order sets. Additionally, new staff who have not previously received orders (such as peer support specialists) may need to be added to the type of staff to whom orders route.

After orders route to the appropriate staff to perform the ordered service, it is optimal for the electronic medical record (EMR) system to open up flowsheets and other documentation templates to guide staff in documenting required and important components of the service.

Since many of the new services are timed, templates should enable staff to enter the time they spent. The services are also billable for a month, so staff will need to document blocks of time by date (as they periodically interact both with the patient and with others on behalf of the patient) and then sum the time to report per the code descriptions. Finally, the staff's work must be summarized and reported back to the ordering clinician; the clinician must incorporate the findings/issues into the patient's treatment plan, including updating orders for these and other services.

Again, it is likely that this work is already happening in the facility. But, because it was not separately billable, these common workflows have likely not been built out completely. Doing so will require clinical informatics time.

Another task is to assess current service-specific training and certification requirements and compare them to CMS' requirements. This includes assessing whether the staff have need for additional training and/or certification, and ensuring that applicable State laws and

regulations are researched, updated and adhered to. New types of staff may need to be added to the hospital's credentialling procedures.

> It is likely that this work is already happening in the facility. But, because it was not separately billable, these common workflows have likely not been built out completely.

One suggestion is to start with the most simple, straightforward service and complete the work from start to finish before moving to another service type. For example, if the facility decides to begin with the SDOH risk assessment, it will need to create a project team. This team will select the standardized assessment tool and a practitioner team may also need to be created. Then the project team will develop the order, determine the practitioners who have access to the order, determine which order sets to add the assessment order or whether to leave it as a stand-alone order, and create the documentation templates by type of performing staff, etc. Once completed, the team can determine how the risk assessment results route to the ordering clinician, how clinicians are to acknowledge the results, and how the results will be incorporated into the treatment plan and additional orders. These are subsequent topics ripe for the practitioner team to consider. The SDOH effort is likely to identify the issues to be considered for orders and documentation templates for all of the other new services: PIN, CHI, and CTS.

Once the work has been done for the first code (i.e., SDOH), the facility can replicate the process, and may use the same project team, perhaps augmented with other performing staff or clinicians, to implement the other new codes.

Conclusion

Despite some currently unanswered questions, and the effort required to implement these services, Nimitt Consulting believes that, yes: the juice *is* worth the squeeze! It will, however, take time for providers to roll-out these services and effectively update orders and workflows to enable compliant billing. We recommend starting slowly and taking on one or two of the new codes at a time, then adding the other new codes, as appropriate. Squeeze one citrus at a time, if you will.

It is crucial to begin by assessing what, who, and how these services are currently furnished in the facility compared to the new code and CMS requirements. Of course, this raises questions about whether commercial and other governmental payers will cover and pay for the services—we know the answer to this question will take time once Medicare has set the standards.

Because of the multi-stakeholder and informatics resources necessary for effective implementation, having an executive champion enthused to implement and report these services may also be necessary, particularly given the number of competing priorities that organizations have.

Stay tuned for more information on this at Nimitt's Linked-In page: www.linkedin.com/company/nimittconsulting/ and provide your comments. Doing so will help other stakeholders benefit from your thoughts about these services, your workflows, and any tips/tricks that have served your organization well in getting these services up and running.

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References

[1] Department of Health & Human Services, Centers for Medicare & Medicaid Services (CMS), "Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program," *Federal Register*, 88: November 16, 2023, pages 78818-80047.

[2] CMS, "Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies," page 78920.

[3] CMS, "Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies," page 78921.

[4] U.S. Congress. *United States Code: Social Security Act, 42 U.S.C. §§ 301- 1940*. 1940. Periodical. https://www.loc.gov/item/uscode1940-003042007/. See Section 1862(a)(1)(A).

[5] CMS, "Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies," page78933.

[6] Department of Health & Human Services, Centers for Medicare & Medicaid Services (CMS), *CMS Manual System Publication 100-04 Medicare Claims Processing - Transmittal 12372 (Change Request 13452)*, Baltimore (MD): CMS, November 22, 2023.

[7] CMS, "Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies," page 78937.

[8] CMS, *CMS Manual System Publication 100-04 Medicare Claims Processing - Transmittal 12372*.

[9] CMS, "Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies," page 78917.

[10] CMS, *CMS Manual System Publication 100-04 Medicare Claims Processing - Transmittal 12372*.

[11] CMS, "Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies," page 78922.