

Report on Medicare Compliance Volume 33, Number 22. June 17, 2024

For Payment, CMS Requires Physicians to Link SDOH to Treatment

By Nina Youngstrom

As CMS continues to bake health equity into Medicare reimbursement and pay-for-performance models, physicians and other practitioners should be aware of hoops they're required to jump through. For example, Medicare now pays for certain services to account for the social determinants of health (SDOH), but they must be tied to services provided to diagnose and treat an injury or illness. The SDOH services became reimbursable in the 2024 Medicare Physician Fee Schedule (MPFS) rule.

"CMS struggled with using funds to screen and address the social determinants of health," said Martie Ross, a principal with PYA, at a June 5 webinar sponsored by the firm. To find a way, CMS linked SDOH to medical necessity by saying Medicare pays for attending to SDOH if the billing practitioner has a reason to believe they interfere with diagnosing and treating the patient, she said. But now, "we need guidance from CMS on how we document reasons in the medical record."

Also, keep in mind that physicians and nonphysician practitioners (NPPs) may be reluctant to provide the new SDOH services, said Miriam Murray, a manager with PYA. "Providers' resistance is real," she said, along the lines of "I was trained to treat their medical conditions, not their social issues." But the reimbursement is there, and it's also embedded in inpatient quality reporting. "It's new for Medicare to take these services on," Murray noted. Hospitals and physician practices will need processes and policies to ensure they're responsive.

CMS in April 2022 released its health equity strategy, which has five priorities. They include building provider capacities to reduce health care disparities and expanding the collection, reporting and analysis of standardized data. The overarching goal is both to improve outcomes and access to care, but dollars factor in as well, Ross said. "It is disparities in access and outcomes that drive up costs in our health care system."

CMS has breathed life into its strategy in various ways in the past few years. For starters, two SDOH measures made their debut in the inpatient quality reporting (IQR) program in the 2023 inpatient prospective payment system (IPPS) rule. "It's a pay-for-reporting program," Ross noted. Hospitals that fail to submit the required information will have a negative payment adjustment two years later. The measures were voluntary in 2023, but they're mandatory this year.

Z Codes: 'It's Not Just About Housing'

The first measure is an attestation that the hospital answered questions about its commitment to health equity. They're yes or no answers, she explained, and "whether you answer yes or no doesn't affect payment." The second measure is whether the hospital screened patients for health-related social needs across five "domains"—transportation needs, housing instability, food insecurity, utility difficulties and interpersonal safety.

Although CMS uses the phrase health-related social needs for IQR, providers probably are more familiar with the term SDOH. Ross said there's no definitive list of the SDOH, but there's a "systemic way to report identified SDOH" in ICD-10 Z codes—Z 55 to Z 65. "That's far beyond the five categories of health-related social needs that

are part of screening IQR,” Ross said. “We are focusing on a broader universe of SDOH. It’s not something directly about your health. It’s something in your environment negatively impacting your health.” In addition to problems related to housing and economic insecurity (Z59), Z codes address a wider range of other challenges, such as problems related to education and literacy (Z55) and certain psychosocial circumstances (Z65).

Z codes are a way for CMS to promote the health equity priority of collecting data, Ross explained. They’ve become “critically important” in connection with CMS’s adjustment of MS-DRG payments for health-related social needs. Seven Z codes for variations of housing instability or inadequacy became a complication and comorbidity (CC) in the 2024 IPPS rule. MS-DRGs with a CC generate more reimbursement. For example, the MS-DRG for simple pneumonia without a CC (195) has a weight of .6256, but a weight of .8222 with a CC, Ross said. The reason for the higher weight is that caring for patients with a CC may require more resources because the hospital stay could be longer and require more comprehensive discharge planning, among other things.

“This becomes significantly more impactful when you get to more complex DRGs,” she noted. CMS said in the proposed 2025 IPPS rule it will continue to analyze claims data to identify when the presence of Z codes affects cost utilization. “It’s not just about housing,” Ross said. “It’s a broader incentive. They’re creating a regimented incentive structure for providers.”

SDOH Factor Into Proposed TEAM

Another incentive that would address health equity—the Transforming Episode Accountability Model (TEAM)—was proposed in the 2025 IPPS rule. If finalized, TEAM is mandatory for hospitals in the core-based statistical area (CBSA) selected for this episode-based bundled payment model, which is like the comprehensive joint replacement model but more comprehensive. “There are health equity-related provisions unique to the program,” Ross said.

For example, participating hospitals are required to complete SDOH screenings for people subject to bundled payments. “But what should really capture your attention is CMS will adjust target prices from episodes based on SDOH,” Ross said, and CMS will get that data from Z codes on claims. “Benchmarks are the game,” she said. “If you’re going to get paid, you have to beat the benchmarks.”

Connecting the SDOH Dots to Treatment

CMS also is reinforcing the incorporation of SDOH with Medicare reimbursement for four services that are now payable under the MPFS. But dots must be connected between SDOH and the medical necessity of the diagnosis and treatment.

For example, Medicare now covers the administration of an SDOH risk assessment (G0136). An SDOH risk assessment may be provided with an evaluation and management (E/M) visit, including hospital discharge planning or transitional care management services; behavioral health office visits; or annual wellness visits, according to a January MLN Booklet.^[1] The physician or NPP would assess a patient for housing insecurity, food insecurity, transportation needs and utility difficulty. An SDOH assessment may be performed by auxiliary personnel incident to the physician with direct supervision.

“The critical word here is assessment,” Ross said. “CMS makes it very clear this is not about routine screening,” like the information reported under IQR. “Instead, we administer this risk assessment when the billing practitioner has reason to believe there is an unmet SDOH that’s interfering with the ability to diagnose or treat the patient,” she said. “It’s critical to get your head around this concept and it’s because CMS has tied this requirement that the SDOH interferes with the ability to diagnose and treat because it ties back to medical necessity.” The reason it’s so important for providers to grasp this and document accordingly is that the Social

Security Act says Medicare doesn't pay for items or services unless they're "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

But CMS hasn't explained how practitioners should explain this in the medical records. "There are no magic words but at a minimum you want documentation of the determination by the physician that the reason for the service is to address what would interfere with the ability to diagnose and treat the patient," Ross said.

Same Requirement Applies for Other Services

The same reasoning applies to three other newly reimbursable SDOH services:

- Community Health Integration (CHI): These services, which are performed by auxiliary personnel under the general supervision of the billing practitioner, include person-centered planning, health system navigation and patient self-advocacy promotion, among other things, according to the MLN Booklet. CHI requires an initiating visit with the physician and is billed with codes G0019 and G0022.
- Principal Illness Navigation (PIN): These services are for patients diagnosed with one serious, high-risk disease like chronic obstructive pulmonary disease or dementia that's expected to last at least three months and puts them at risk of hospitalization or nursing home admission, said Katie Croswell, a manager with PYA. PIN services, which also are provided by auxiliary personnel under general supervision, are like CHI but they may be provided to a patient more than once per month under certain circumstances, she said. The services include person-centered planning and practitioner, home and community-based care coordination or communication. PIN requires an initiating visit with the physician, and it's billed with HCPCS codes G0023 and G0024. Auxiliary personnel who provide PIN must be state certified, and if there's no such thing in their states, they're required to be trained in certain core competences.
- PIN-Peer Support is for patients with high-risk behavioral health conditions. They're billed with HCPCS codes G0140 and G0146.

"Health equity is the new value-based care," Ross said. The premise of value-based care was that providing quality care ultimately saves money, but it could only go so far without addressing disparities. "You may reduce the individual cost of care, but if you want to reduce this on a societal level, you have to address who can't access health care because of inequities. Think of health equity as reducing the societal cost of care and it's the right thing to do."

Contact Ross at mross@pyapc.com, Croswell at kcroswell@pyapc.com and Murray at mmurray@pyapc.com.

¹ Centers for Medicare & Medicaid Services, "Health Equity Services in the 2024 Physician Fee Schedule Final Rule," MLN9201074, January 2024, <https://go.cms.gov/3yWLeUV>.

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