December 11, 2023 | Volume 37, Issue 47

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In this issue

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Compliance

New compliance guidance makes it easier for practices to think small

The HHS Office of Inspector General (OIG) is making good on its April 24 announcement that it will modernize its compliance programs. The agency published the General Compliance Program Guidance (GCPG) on Nov. 6, 15 years after the OIG's last model compliance plan, a supplemental guideline for nursing facilities.

The OIG emphasized that its new and existing compliance guidance documents remain voluntary and are not binding. Providers can continue to use classic compliance guidelines, such as the OIG Compliance Program for Individual and Small Group Physician Practices, which the OIG published Oct. 5, 2000.

Take note of 3 new features

The OIG used some information from the classic compliance guidelines, but it isn't the same information in a different document. There are several new features in the new guidelines, including the following:

1. **Reader-friendly format.** Say goodbye to the three columns and tiny font of the classic CPGs. The format of the new CPGs is easier to read and includes call-outs with helpful tips and a table of contents that allows for quick navigation through the document.
2. **More regulatory information.** You'll find guidance on well-known health care compliance laws such as the anti-kickback statute, the Stark physician self-referral rule and the False Claims Act. But the new CPG also contains

information on topics such as HIPAA compliance, information blocking and patient safety.

3. **A new method to encourage compliance.** The OIG takes a "carrots, not sticks" approach to compliance that recommends the promise of rewards rather than the threat of punishment to prevent compliance slip-ups, writes Melissa Wong, partner, Holland & Knight, Boston, in a Nov. 10 alert about the new guidance. "This new concept advocates for the use of creative ways to incentivize, for example, an achievement of compliance goals or actions that reduce compliance risk, or to reward performance of compliance activities outside of the individual's job function, such as mentoring colleagues on compliant conduct or serving as a compliance representative within their department or team," she explained.

Use customized guidelines for small organizations

Turn to section V(A) of the document for tips on how to create or improve a compliance program for a small practice.

"OIG has always acknowledged the ability to 'right-size' a compliance program based on the size and type of the healthcare organization. However, the GCPG provides much more specific and detailed guidance on which features could be traded off or not when implementing a customized compliance program," Wong explained in the Nov. 10 alert. For example, a small practice that doesn't have the staff, or funding, for a dedicated compliance officer might assign the role of "compliance contact" to a staff member who will be responsible for the organization's compliance activities.

If an anonymous compliance tipline isn't in your budget, the OIG suggests an open-door policy that encourages staff to come forward with compliance concerns, Wong noted. And a drop box where staff can anonymously leave concerns or suggestions is still an option for your organization. Just make sure that someone monitors the box and follows up on any tips.

The OIG also suggests various ways small groups can train staff, including with free materials that the OIG has created. You can use materials you find on the internet, but the OIG cautioned readers to carefully review materials and modify them for the practice or specific staff members.

You should be especially wary of materials that are several years old, particularly when they concern coding, materials that don't provide links to official rules or policies and materials that offer ways to get around compliance rules.

Another small group modification concerns checking exclusion lists, Wong observed in the alert. "Another interesting observation is that though OIG references the importance of monthly exclusion and debarment checks in other sections of the GCPG, here OIG does not specifically mention monthly screenings — a frequent pain point for smaller organizations," she explained.

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ISSN 0893-8121. pbncustomer@decisionhealth.com Price: $699/year.

The OIG instead calls for routine monitoring of various exclusion lists, she wrote.

3 elements for effective scaled-down compliance programs

The OIG gives small practices a wide range of suggestions for implementing a compliance program. But in response to a question from *Part B News* Wong identified three elements that a solo or small practice should include in its compliance plan:

1. Designate a compliance contact "so that employees know who to go for with compliance questions and concerns," she says.
2. Put someone in charge of follow up. "Practices must also ensure that someone is accountable for corrective action when things go wrong, whether that is the compliance contact or another leader in the organization," Wong adds.
3. Check the exclusion lists. "Another key item that the OIG specifically calls out is the need to ensure a solid process that checks for OIG and SAM exclusions and debarment and to ensure that all licenses remain in good standing," she further explains. "An excluded employee or an employee with a lapsed license can have a significant impact on a small entity."

The OIG will release more compliance guidance in the coming year. In the meantime, the agency has created a dedicated email address where you can submit feedback for the GCPG or future compliance guidelines at compliance@oig.hhs.gov. — *Julia Kyles, CPC* (jkyles@decisionhealth.com) ■

RESOURCES

- HHS OIG General Compliance Program Guidance: https://oig.hhs.gov/compliance/general-compliance-program-guidance/
- HHS OIG Compliance Program for Individual and Small Group Physician Practices: https://oig.hhs.gov/documents/compliance-guidance/801/physician.pdf
- A Roadmap for New Physicians https://oig.hhs.gov/compliance/physician-education/
- HEAT provider compliance training: https://oig.hhs.gov/compliance/provider-compliance-training/
- Holland & Knight Alert – OIG Releases New Compliance Program Guidance for All Healthcare Stakeholders: https://www.hklaw.com/en/insights/publications/2023/11/oig-releases-new-compliance-program-guidance-for-all-healthcare

Compliance

Thwart abuse: Consider opt-out, training in chaperone policy

Some notable recent cases in which providers have been accused of sexual assaults on patients in exam rooms present an occasion to reconsider medical chaperone policies that can help defend against such incidents.

In August, the Queens, N.Y. District Attorney brought charges against Zhi Alan Cheng of "sexually abusing three patients at New York-Presbyterian Queens hospital" in addition to raping three other women in his Queens home. In October, George Tyndall, M.D., then on trial for multiple charges of sexual misconduct allegedly committed when he worked at a campus clinic at the University of Southern California at Los Angeles, was found dead in his home.

Along with strict policies on appropriate behavior in sensitive examinations — generally defined as genital, rectal, pelvic and breast exams — use of medical chaperones would seem to offer a strong line of defense against both incidents and accusations of abuse (*PBN 3/7/16, 1/17/22*). But their use is neither universal nor always appropriately conducted.

Many states don't require it

Some states have board requirements regarding chaperones. In Oregon, for example, they must not only be offered for sensitive exams, but also have "an active Oregon license to practice a health care profession" or have completed "a course for medical chaperones reviewed by the Oregon Medical Board," among other requirements.

But many states have no such requirements, and Elizabeth L. Jeglic, professor of psychology at John Jay College of Criminal Justice in New York City, notes that while the AMA Code of Medical Ethics recommends providers "adopt a policy that patients are free to request a chaperone and ensure that the policy is communicated to patients" and "always honor a patient's request to have a chaperone," they don't mandate it.

Also, there are often institutional, emotional and social barriers to fully effective use of chaperones.

"Some facilities have an opt-in policy as opposed to an opt-out policy, which puts the onus on the patient

to request a chaperone" Jeglic says. "Some individuals may feel pressured or uncomfortable saying they want a chaperone. It could also be influenced by age, gender and culture — for example if the doctor is an older male and the patient is a younger patient that may feel that they must not question a doctor's integrity or judgment."

3 chaperone musts

Train chaperones. Jeglic cites a 2017 study of provider-patient incidents in the journal Sexual Abuse that found among the reported cases of sodomy assault 19% "occurred with a chaperone, parent, nurse, or other individual in the room with the patient-victim and physician." But this number went down to 6% "in academic medical settings, where it is common to have residents involved in care and medical students actively observing."

This suggests it's not enough to just have an untrained third person of an appropriate gender in the room. "Chaperones need to be trained on what to look for," Jeglic says. For example, the chaperone "may not be fully aware of what constitutes a boundary violation for an intimate exam — thus they should be trained on what to report and how to report."

Also, their attention has to be trained. "One of the issues is that they are doing other things while in the room — like paperwork — and not watching what the doctor is doing," Jeglic says.

Train providers, too. The health care professionals who work with them should know at least as much as the chaperones about what is and isn't appropriate.

Jonathan Rosenfeld, founder and managing attorney of Rosenfeld Injury Lawyers in Chicago, stresses the need for "ongoing programs that address appropriate conduct, boundaries and communication skills" for providers, including "scenarios related to patient encounters, highlighting the significance of recognizing and responding to red flags. By fostering a culture of accountability and awareness, health care providers are better equipped to identify and address potential issues before they escalate."

Rich Cahill, vice president and associate general counsel of The Doctors Company in Napa, Calif., recommends "written protocols that are periodically reviewed, audited and updated as necessary" that not only reenforce the above learnings but also lay out the reporting, investigating and sanctioning that comes with a related accusation.

Opt-out gets informed consent. If you make chaperones opt-out, patients who decline the service "should be required to read about the exam, what should happen and sign that they have agreed to opt out," Jeglic says. Rosenfeld stresses that the refusal should be documented in the patient's medical record "as a protective measure, acknowledging that the offer was made and declined." — *Roy Edroso* (roy.edroso@hcpro.com) ■

RESOURCES

- Queens (N.Y.) District Attorney, "Doctor charged with sexually assaulting patients in hospital, raping acquaintances at his home," Aug. 7, 2023: https://queensda.org/doctor-charged-with-sexually-assaulting-patients-in-hospital-raping-acquaintances-at-his-home/
- AMA Code of Medical Ethic Opinion 1.2.4, "Use of Chaperones," https://code-medical-ethics.ama-assn.org/ethics-opinions/use-chaperones
- Oregon Medical Board, "Offering a Medical Chaperone": www.oregon.gov/omb/topics-of-interest/pages/chaperone.aspx
- James M. DuBois et alia, "Sexual Violation of Patients by Physicians: A Mixed-Methods, Exploratory Analysis of 101 Cases," Sexual Abuse, June 19, 2017: https://journals.sagepub.com/doi/full/10.1177/1079063217712217?rfr_dat=cr_pub++0pubmed&url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org

Coding

CMS will cover caregiver training for behavioral and functional care

Medicare finalized coverage of five caregiver training codes, effective Jan. 1, 2024. The decision paves the way for reimbursement when a provider such as a physical therapist, physician or physician assistant trains a patient's friend or family member to provide behavior management or modification **(96202-96203)** or to improve a patient's ability to perform activities of daily living (ADL) **(97550-97552)** when the patient is not present.

(**Note:** Check out the chart online, which provides the codes and national, non-facility payment rates for the five caregiver training service (CTS) codes that Medicare will cover.)

The new policy should benefit Medicare patients and the friends and family who help care for them, says Gretchen Jacobson, vice president for Medicare for the Commonwealth Fund. "In a survey of family caregivers,

(continued on p. 6)

Benchmark of the week

PFS pain for 2024 selected codes is spread out, but still hurts

With a 3.4% conversion factor (CF) cut looming in 2024 and Congress looking less likely by the day to deliver timely relief, providers who routinely bill services from CMS' "selected codes" chart can at least take comfort that none of the 23 non-facility codes are taking too big a loss (*PBN 11/13/23*).

As part of the yearly physician fee schedule (PFS) updates, CMS provides fee changes for the same set of selected codes every year to give providers an idea of how the CF changes will affect how they will get paid for some popular procedures and services.

In recent years, many if not most of the non-facility codes on the chart have sustained some deep cuts. In the 2021 PFS, for example, seven of the 23 codes had double-digit drops, including a 20% gouge out of **93000** (Electrocardiogram complete), and all but four codes lost at least 5% of value (*PBN 12/21/20*). Things calmed down in 2022, with most of the codes settling in the 3%-4% loss range (*PBN 11/22/21*). But in 2023 losses rose again; while only **99348** (Home visit est pt) and **90471** (Immunization admin) hit negative double digits, seven codes lost at least 5% (*PBN 12/5/22*).

But this year things look better – at least for these codes. Eight are flat, and only two – **43239** (Egd biopsy single/multiple) and **93307** (Tte w/o doppler complete) lose as much as 2%. Two codes, 90471 and **93015** (Cardiovascular stress test), actually get a boost of 2%, the former perhaps reflecting CMS' recent push to pay better for shots (*PBN 1/16/23*). And it has to be good news that the high-utilization E/M codes **99203, 99213** and **99214** lose next to nothing. It remains to be seen if Congress can do anything about the rest of them. – *Roy Edroso* (roy.edroso@hcpro.com)

Impact on CY 2024 payment for selected procedures

Code	Mod	Short descriptor	CY 2023*	CY 2024**	% Change	Utilization rank, 2022 claims
11721		Debride nail 6 or more	$43.64	$43.88	1%	155
17000		Destruct premalg lesion	$66.45	$66.80	1%	153
43239		Egd biopsy single/multiple	$374.91	$369.35	-2%	399
66821		After cataract laser surgery	$326.97	$326.79	0%	577
67210		Treatment of retinal lesion	$502.85	$502.30	0%	2,267
77427		Radiation tx management x5	$188.12	$186.64	-1%	560
88305	26	Tissue exam by pathologist	$35.71	$35.36	-1%	56
90471		Immunization admin	$19.84	$20.30	2%	651
92012		Eye exam establish patient	$88.27	$87.43	-1%	216
92014		Eye exam&tx estab pt 1/>vst	$123.98	$123.45	0%	100
93000		Electrocardiogram complete	$14.22	$14.08	-1%	93
93010		Electrocardiogram report	$7.93	$7.86	-1%	63
93015		Cardiovascular stress test	$69.43	$70.73	2%	571
93307	26	Tte w/o doppler complete	$42.32	$41.59	-2%	2801
93458	26	L hrt artery/ventricle angio	$282.67	$281.27	0%	873
98941		Chiropract manj 3-4 regions	$39.01	$38.64	-1%	77
99203		Office o/p new low 30-44 min	$110.09	$109.69	0%	94
99213		Office o/p est low 20-29 min	$88.60	$89.39	1%	13
99214		Office o/p est mod 30-39 min	$125.30	$126.07	1%	6
99291		Critical care first hour	$268.78	$267.85	0%	154
99292		Critical care addl 30 min	$117.37	$117.22	0%	738
99348		Home/res vst est low mdm 30	$74.39	$74.66	0%	752
99350		Home/res vst est high mdm 60	$181.83	$180.75	-1%	761

*Payments based on the 2023 CF of 33.0607 (after expiration of CY 2023 Consolidated Appropriations Act provision)

**Payments based on the 2024 CF of 32.7442, which includes the budget neutrality adjustment.

Source: CMS-1784-F_Impact of Final Rule on CY 2023 Payment for Selected Procedures: www.cms.gov/medicare/medicare-fee-service-payment/physicianfeesched/pfs-federal-regulation-notices/cms-1784-f

(continued from p. 4)

three out of five said more training and more involvement in care planning would help them," Jacobson says. "We know that caregiving responsibilities take a toll on caregivers' finances as well as mental and physical health, and any help for caregivers is likely to also greatly benefit the Medicare beneficiaries they care for."

Make sure staff understand CMS' core definitions and requirements before your practice adds CTS to its menu of services.

Select appropriate patients, document need

Providers who offer CTS should consider each patient's condition and document how CTS will contribute to the patient's treatment plan.

Examples of conditions and circumstances that could support the medical necessity of CTS include "stroke, traumatic brain injury (TBI), various forms of dementia, autism spectrum disorders, other intellectual or cognitive disabilities, physical mobility limitations, or necessary use of assisted devices or mobility aids," according to CMS.

CMS did not issue strict limits on the number and frequency of CTS. But the services should be based on documented factors, including the original treatment plan and changes in the patient's condition, treatment plan or the people who provide care for the patient.

Understand who is a caregiver

According to CMS' final definition, a caregiver 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."

Review requirements for the sessions

Providers use verbal instructions, video and live demonstrations and feedback during CTS sessions, according to the 2024 CPT manual. Behavior management/modification CTS involves group sessions that show caregivers how to use different skills and strategies "to address behaviors impacting the patient's mental or physical health diagnosis." CTS aimed at patient functionality is designed to train caregivers on strategies and techniques that facilitate functional performance and safety in the home, according to guidelines in the 2024 CPT manual.

Share additional coding and billing information

Remind staff that they will report one unit of service for group CTS sessions **(96202-96203** and **97752)** not one unit of service for each caregiver in the group, CMS explains in the final rule. Practices should use the group CTS codes whenever the provider trains more than one caregiver at the same time.

In addition, CMS designated codes 97550, 97551 and 97552 as "sometimes therapy" services. When a physical therapist, occupational therapist or speech-language pathologist performs CTS, the service must be under a therapy plan of care. However, when a physician or non-physician practitioner provides the service outside of a therapy plan of care, they can perform the services under a treatment plan, CMS clarifies in the final rule. — *Julia Kyles, CPC* (jkyles@decisionhealth.com) ■

Patient encounters

Before dismissing intoxicated patient, try to see beyond to root cause

You may occasionally encounter a patient who, in the provider's opinion, is intoxicated, either by drugs or alcohol. Given informed consent issues, you may be inclined to refuse treatment — but be careful that you're not missing a chance to throw the patient a lifeline.

The subject comes up in medical literature; in a 2023 paper on "Refusal of Care" available on StatPearls, emergency medicine specialists Benjamin D. Pirotte, M.D., and Scarlet Benson, M.D., both of Aventura Hospital and Medical Center in Aventura, Fla., make the point that "patients under the influence of alcohol or drugs may lack the capacity to make their own medical decisions," though unlike, for example, patients disoriented by dementia, these patients are "expected to recover from their ingestion relatively quickly."

If the situation is emergent, however, the authors say, "the decision making usually falls on the healthcare professional in charge." They note that in extreme cases most state laws allow "for temporary involuntary hospitalization and treatment until the patient is no

longer intoxicated, and any medical illnesses affecting capacity have resolved."

Adhere to stepwise process

You should follow a clear protocol, advises Stephanie Nichols, Pharm.D., associate professor of pharmacy practice and psychiatry at the University of New England, and member of the substance use disorder faculty at Maine Medical Center, both in Portland.

"First, the patient's safety must be assessed including respiratory, neurologic and cardiac functions," Nichols says. "If a patient is experiencing an opioid overdose including being unresponsive to painful stimuli and stopped or shallow breathing, naloxone should be administered. If a patient is on stimulants, there is an elevated risk of a heart attack and stroke. It is also important to identify if an intoxicated patient plans to drive home and to intervene."

Even if there's no obvious emergency, the provider should attempt to engage the patient to find out what's going on, counsels Gerda Maissel, M.D., CEO of My MD Advisor in New York City.

"If the patient is stable, consider whether there is an opportunity to discuss what is going on," Maissel says. "When a patient discloses a substance use disorder or expresses a desire for help, the physician should engage in a supportive conversation and explore options. Depending on the situation, the physician may choose to refer the patient to a substance abuse specialist or treatment program."

Maissel further counsels thorough documentation of their presentation and the provider's basis for judging them intoxicated.

See, or send away?

As Maissel suggests, while it's possible the patient has just made an unwise decision as to how much recreational drug intake is suitable prep for a doctor's visit, there's a very good chance that the patient has a more serious issue that, whatever the ostensible reason for the visit, calls for the provider's attention — particularly if they've been self-medicating or over-using prescribed medications for pain.

Elisha Peterson, M.D., an anesthesiologist and chronic pain specialist in Washington, D.C., says she has seen patients in clinic who were "acutely intoxicated." Sometimes, when in hospital, Peterson has walked these patients to the emergency room; other times "we have asked patients if they have someone who can pick him or her up from their appointment if the patient came alone."

"Ideally the front desk should reroute these patients to reschedule when he/she is of sound mind to engage in the appointment appropriately," Peterson says. She "would not discuss consent with any patient who appears intoxicated, whether or not the patient denies he/she is."

But Georgiy Brusovanik, M.D., of Miami Back & Neck Specialists in Florida, who offers minimally invasive treatments for pain sufferers, says patients sometimes come in on significant amounts of pain drugs because they are in severe pain, and to refuse them treatment on that basis would be to "deny patients who are on narcotics proper care."

"As a revision specialist, I'm the last resort for patients who've had bad outcomes after surgery," Brusovanik says. "Denying these patients care while they're on narcotics is essentially condemning them to having pain forever."

Brusovanik stresses that pain and its treatment (or maltreatment) can lead to increased tolerance and dependence. "One of my old orthopedic attendings had an ankle fracture," he says. "This person knew the side effects of opioids, and yet this person ended up stealing narcotics from patients and then committing suicide. I'm not in a position to tell [my patients] to go home and sleep it off."

Whatever course you take, always thoroughly document your reasoning so you can defend it if problems arise after the fact. — *Roy Edroso* (roy.edroso@hcpro.com)

RESOURCE

- "Refusal of Care," Benjamin D. Pirotte, M.D., and Scarlet Benson, M.D., StatPearls, www.ncbi.nlm.nih.gov/books/NBK560886/

Have a question? Ask PBN

Do you have a conundrum, a challenge or a question you can't find a clear-cut answer for? Send your query to the *Part B News* editorial team, and we'll get to work for you. Email askpbn@decisionhealth.com with your coding, compliance, billing, legal or other hard-to-crack questions and we'll provide an answer. Plus, your Q&A may appear in the pages of the publication.

Ask Part B News

Social determinants of health assessment tools must cover 4 core domains

Question: *I am looking for more specific information on code* ***G0136*** *(Administration of a standardized, evidence-based Social Determinants of Health [SDOH] Risk Assessment tool, 5-15 minutes, not more often than every 6 months).*

1. *Where can we find examples of the standardized tools we can use?*
2. *Are there specific questions we should ask the patients?*
3. *Can the provider just document the patient's answers or should they document their response?*

Answer: Selecting the appropriate assessment tool is key to performing and reporting this service.

In the final 2024 Medicare physician fee schedule, CMS stated that providers must use a standardized, evidence-based risk assessment tool that has been tested and validated through research.

In addition, the tool must include questions that address the following four domains:

1. Food insecurity.
2. Housing insecurity.
3. Transportation needs.
4. Utility difficulties.

The provider who administers the assessment "may choose to add other domains if prevalent or culturally salient to their patient population," CMS writes in IOM 100-04, Change Request 13452.

Here are four tools that meet Medicare's requirements:

1. Accountable Health Communities Health-Related Social Needs Screening Tool — 10 core questions and 16 optional questions: www.cms.gov/priorities/innovation/files/worksheets/ahcm-screeningtool.pdf.
2. Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (PRAPARE) — 17 questions and four optional questions: https://prapare.org/prapare-toolkit/.
3. WellRx – 11 questions: www.jabfm.org/content/29/3/414.
4. Your Current Life Situation Survey — nine questions with additional questions the provider can add based on patient need: https://sirenetwork.ucsf.edu/tools-resources/resources/your-current-life-situation-survey.

Providers should select the assessment tool or tools based on patient need. They can use different tools for different patients. You should also make sure that providers use the most current version of a tool, that updated versions of the tool contain the four domains and watch out for changes to the code's requirements. In addition, you should make sure that your coding and care teams know that even though some questionnaires are described as screening tools, G0136 is not a screening or preventive service.

Complete documentation for the service begins before the provider administers the questionnaire. The provider should document why they believed the patient had one or more unmet SDOH needs that interferes with their ability to diagnose or treat the patient.

If the provider determines the patient has a relevant, unmet SDOH, the provider should also document what they did in response to that information.

CMS included the following example in the final fee schedule:

"For example, through administration of the SDOH risk assessment for a patient presenting for diabetes management, a practitioner might discover that a patient's living situation does not permit reliable access to electricity, impacting the patient's ability to keep insulin refrigerated. The practitioner may then prescribe a type of insulin that remains stable at room temperature or consider oral medication instead. In this example, the practitioner could furnish an SDOH risk assessment in conjunction with the E/M visit to gain a more thorough understanding of the patient's full social history and to determine whether other SDOH needs are also impacting medically necessary care."

If the patient has trouble paying their power bill the provider might refer the patient to a program that helps people pay their utility bills. — *Julia Kyles, CPC* (jkyles@decisionhealth.com)

RESOURCES

- The U.S. playbook to address social determinants of health: www.whitehouse.gov/wp-content/uploads/2023/11/SDOH-Playbook-3.pdf
- Final 2024 Medicare physician fee schedule: www.federalregister.gov/d/2023-24184/p-1151
- IOM 100-04, Change Request 13452: www.cms.gov/files/document/r12372cp.pdf