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How to Use (and Not Use) New Code G0136 for SDOH

The code isn't for SDOH "screening" but "assessment." Here's what that means, and what else you need to know.

The Centers for Medicare & Medicaid Services (CMS) approved a new code earlier this year related to patients' social determinants of health (SDOH).[1] HCPCS code G0136 is designed to pay clinicians for the time it takes to assess a patient's SDOH, which the care team may then address either directly or through referral.[2] As with many things in life, the implementation of G0136 has differed somewhat from the intent, but here's what we know so far about how to use the new code.

FREQUENTLY ASKED QUESTIONS

Q: What is the code?

A: HCPCS code G0136 is for "Administration of a standardized, evidence-based SDOH assessment, 5-15 minutes, not more often than every six months."[1]

Q: What does that mean?

A: It means you can now get paid for the work associated with assessing a patient's SDOH needs[3] and developing a treatment plan

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accordingly, but there are some caveats, so keep reading.

Q: How do I do the SDOH assessment?

A: You must use an evidence-based, standardized tool to ask the patient about their health-related social needs. You can't just ask a few random questions about SDOH; you have to use a validated tool. CMS doesn't specify what tool to use, but they give some examples (see "Examples of SDOH assessments" on page 10.) The agency's final rule also states that the assessment must include the following SDOH categories, or "domains:" food insecurity, housing insecurity, transportation needs, and utility difficulties.[2] Clinicians may choose to assess patients for other SDOH categories as well, but those four are required.

Q: When can I do the SDOH assessment?

A: You can provide it as an add-on service to your patients during an evaluation and management (E/M) visit (including outpatient/office visits, hospital discharges, or even transitional care management visits), a behavioral health office visit, or an annual wellness visit (AWV).

Q: Can I do this for every patient?

A: This is where things get tricky. The definition of this code includes the word "assessment," not "screening." Just as a cancer screening is done on someone without symptoms, an SDOH "screening" would imply no symptoms are necessary. However, CMS is clear that this is not their intent for G0136. Here are the exact words from the final rule:[2] "We reiterate that the SDOH risk assessment code, HCPCS code G0136, when performed in conjunction with an E/M or behavioral health visit is not designed to be a screening, but rather tied to one or more known or suspected SDOH needs that may interfere with the practitioners' diagnosis or treatment of the patient."

In other words, you should either know or suspect your patient has an SDOH need before you do the assessment. One example CMS gives is a patient who requests a refill of a refrigerated medication that has gone bad because the electricity in their home was shut off.[1] In this instance, you have reason to believe the patient has an SDOH need (utility difficulties), and it would be appropriate to do the assessment.

Q: If my patient has no known or suspected SDOH needs interfering with care, then I shouldn't do this assessment?

A: Correct. But you should still be on the lookout for any SDOH needs your patient might have that are interfering with your ability to diagnose or treat the patient. You should even proactively ask the patient about it. But you can't bill G0136 for screening purposes, only for assessment purposes.

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Q: How will I know whether my patient has an SDOH need if I don't assess them for it?

A: In my opinion, this is the biggest flaw with the new code. It's designed with the good intention of helping clinicians learn about and address non-medical barriers to care. But the approach it takes is reactive, rather than proactive. Contrast this SDOH assessment process with current protocols for depression screening in older adults.[4] We screen them to proactively identify any mood disorders, rather than wait for complications to develop. But this is not the case with G0136. With the code's current rules, we essentially have to work backwards: identify complications potentially caused by SDOH (e.g., spoiled medication because the electricity went out) and then do an assessment to confirm the SDOH need. In many primary care settings, it's hard to conceive of a patient who *doesn't* have at least one need. Perhaps CMS will change the criteria for this code in the future, but for now you should only use

KEY POINTS

- HCPCS code G0136 allows clinicians to bill Medicare for performing a validated assessment of social needs that may interfere with the clinician's diagnosis or treatment of the patient.
- The code,valued at 0.18 work RVUs, is not intended for SDOH screening but for assessing a patient's known or suspected social needs.
- While payment for SDOH assessment has been long-awaited, the new code may have limited use given its narrow definition.

this code for patients you know or suspect have SDOH needs based on information you receive or something you observe prior to the assessment.

Q: I did the assessment. Now what?

A: After you perform the validated SDOH assessment on your patient, your treatment plan should be informed by the identified needs. After all, "An SDOH risk assessment without appropriate follow-up for identified needs would serve little purpose."[2]

> Your treatment plan should be informed by the patient's identified SDOH needs.

While we as physicians cannot personally solve every SDOH problem, our care teams may be able to connect patients with local resources for their individual needs. For example, if a patient can't fill their prescription because they are struggling to buy groceries, you might connect them to a local food pantry, or the local Meals on Wheels program for seniors.[5] Another option would be to review the cost of medications and look for less-expensive options or discount programs. Or maybe you have a social worker in your practice to whom you could refer the patient.

There are a number of online directories available to help with this (see "Resources for addressing patients' social needs").

Q: How much is the payment for G0136?

A: As of the time of publication, the national reimbursement rate is $18.97 (check with your local Medicare administrative contractor for rates specific to your locale), and the code has 0.18 work relative value units (wRVUs) attached to it.[6]

Q: Can I bill this every six months?

A: Technically, yes, but there are some nuances. Remember that the assessment must be based on you knowing or suspecting that the patient has an SDOH need that will affect your diagnosis or treatment. If you did an assessment six months ago (and adjusted your treatment plan accordingly), something in the patient's life situation would have to change significantly to justify doing it again.

Q: Should I bill the patient for this?

A: If you perform this SDOH assessment outside of an AWV, then the patient will bear some of the cost (generally 20% of the Medicare allowed amount for traditional Medicare patients, once they've met their Part B deductible). If you perform it during an AWV, CMS waives the patient's cost sharing. You should bill G0136 with modifier 33 (preventive services) in this instance. Interestingly, you can do this over several days. For example, a patient might complete the SDOH assessment on a Monday and then come to the office the next day for their AWV. You would then bill code G0136 on Tuesday (the day of the AWV) even though you did the SDOH assessment on Monday.[7] The multi-day rule also applies to G0136 billed with an E/M visit or behavioral health visit, but CMS advises that "in most cases" the patient would not complete the assessment before an E/M or behavioral health visit because it's not a screening.[8]

Q: What documentation does CMS require?

A: CMS doesn't offer much guidance besides requiring documentation of the patient's SDOH needs.[8] Include an ICD-10 Z-code (Z55-Z65)[9] if an applicable one is available. There is a time element (5-15

EXAMPLES OF SDOH ASSESSMENTS

SDOH assessment tools referenced in the Centers for Medicare & Medicaid Services final rule:

- The Accountable Health Communities Health-Related Social Needs Screening Tool (Center for Medicare and Medicaid Innovation): https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf
- Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (National Association of Community Health Centers): https://prapare.org/wp-content/uploads/2023/01/PRAPARE-English.pdf

Other validated SDOH assessment tools:

- HealthBegins Upstream Risks Screening Tool & Guide (Association of American Medical Colleges): https://www.aamc.org/system/files/c/2/442878-chahandout1.pdf
- Your Current Life Situation Survey (Kaiser Permanente): https://sirenetwork.ucsf.edu/tools-resources/resources/your-current-life-situation-survey
- Social Needs Screening Tool (American Academy of Family Physicians): https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/hops19-physician-form-sdoh.pdf

minutes) in the code description, so you should document the amount of time you personally spent on the SDOH assessment. If you bill G0136 in conjunction with an AWV or E/M visit over multiple days as outlined above, CMS also instructs that your documentation reflect that you began the service one day and completed it on another.[7]

Though CMS does not explicitly require it, you may also want to document that the patient had an SDOH assessment due to known or suspected SDOH needs that might interfere with the treatment plan. CMS encourages documentation of the assessment. It's a good idea to note that you used a validated tool. Putting a copy of the completed assessment in the chart is even better. Finally, you should include some documentation of how the assessment informed the treatment plan you developed.

Q: Are all insurance companies paying for G0136?

A: No. The code is new, the implementation is new, and the coverage is spotty. You should work directly with your private payers and your Medicare administrative contractor to see exactly what their coverage is. They will also have more guidance on documentation requirements.

BOTTOM LINE: IS THIS WORTH IT?

Identifying and addressing our patients' social needs as best we can is worthwhile, whether or not we're billing for G0136. Data show how our patients' health outcomes are a function of not only the care we deliver but also "underlying genetics, health behaviors, social and environmental factors."[10] Therefore, helping our patients with these factors when and where we can is important. Sometimes we can offer a lot of help. Other times our assistance is limited to empathy, but that still builds the sort of doctor-patient relationship that leads to better health outcomes.

This particular code, G0136, may have somewhat limited application right now. It's a good tool when you can use it, but even when you can't, don't lose sight of the big picture: Addressing SDOH needs will improve the health of your patients. FPM

Send comments to **fpmedit@aafp.org,** or add your comments to the article online.

RESOURCES FOR ADDRESSING PATIENTS' SOCIAL NEEDS

- AAFP Neighborhood Navigator: https://www.aafp.org/family-physician/patient-care/the-everyone-project/neighborhood-navigator.html
- Findhelp.org (formerly Aunt Bertha): https://www.findhelp.org
- Meals on Wheels America: https://www.mealsonwheelsamerica.org/find-meals
- United Way's Your Local 211: https://www.211.org/about-us/your-local-211

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2. 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*. Nov. 16, 2023. Accessed July 23, 2024. https://www.federalregister.gov/documents/2023/11/16/2023-24184/medicare-and-medicaid-programs-cy-2024-payment-policies-under-the-physician-fee-schedule-and-other

3. Healthy People 2030: social determinants of health. U.S. Department of Health and Human Services. Accessed July 23, 2024. https://health.gov/healthypeople/priority-areas/social-determinants-health

4. Depression and suicide risk in adults: screening. U.S. Preventive Services Task Force. June 20, 2023. Accessed July 24, 2024. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/screening-depression-suicide-risk-adults

5. Find a Meals on Wheels provider near you. Meals on Wheels America. Accessed July 24, 2024. https://www.mealsonwheelsamerica.org/find-meals

6. Physician fee schedule. Centers for Medicare & Medicaid Services (CMS). Modified July 12, 2024. Accessed July 24, 2024. https://www.cms.gov/medicare/payment/fee-schedules/physician

7. CMS Manual System: Pub 100-04 Medicare Claims Processing. CMS. May 2, 2024. Accessed July 24, 2024. https://www.cms.gov/files/document/r12599cp.pdf

8. Health-related social needs FAQ. CMS. Accessed Aug. 1, 2024. https://www.cms.gov/files/document/health-related-social-needs-faq.pdf

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