Reimbursement Tips:
Community Health Integration (CHI)

Overview

Community Health Integration (CHI) are personalized and supportive services provided to patients with unmet social drivers of health (SDOH) needs that interfere with, or present a barrier to, the diagnosis, treatment, and self-management of illnesses, diseases, or conditions.

Effective January 1, 2024, CMS implemented CHI services and began reimbursing FQHCs separately from the Medicare Prospective Payment System (PPS) encounter rate for CHI services. CHI services are part of the suite of care management services billable by FQHCs (see NACHC resource: Summary of Medicare Care Management Services). This Tip Sheet provides FQHCs with simplified, easy-to-understand instructions for providing and billing Medicare for CHI services. Also see NACHC resource: Medicare Billing Lingo, Defined! for definitions of terms used throughout this document.

Initiating Visit Requirements

The initiating visit, which is a separately billable and reimbursable service from CHI services, may be any one of the following:

- Evaluation and Management (E/M visit (CPT 99212-99215)
- Annual Wellness Visit (AWV) (CPT G0438, G0439)
- Transitional Care Management (TCM) (CPT 99495-99496)

Note: Initial Preventive Physical Exam (IPPE) is NOT an accepted initiating visit for CHI services

The initiating visit must:

- ✔ Precede the start of CHI services
- ✔ Be performed by the same billing provider who will also furnish and bill for subsequent CHI services, regardless of whether the initiating visit is an E/M, AWV, or TCM encounter
- ✔ Identify the unmet SDOH needs which "significantly limit" the practitioner's ability to diagnose or treat health conditions and thus, the patient's ability to receive treatment and self-manage such health conditions
- ✔ Establish a patient-centered treatment plan that specifies how addressing unmet SDOH need(s) would remove barriers to diagnosis and treatment
- ✔ If it is an AWV, the practitioner identifies and documents that an unmet SDOH need prevents or inhibits the AWV personalized prevention plan (see AWV Reimbursement Tips) from being carried out
- ✔ Establish the CHI services as incidental to the practitioner's Medicare Part B services and explain to the patient that auxiliary personnel may perform subsequent CHI services

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Eligible Patients

- ✔ Medicare Part B beneficiaries
- ✔ Provide consent for services
- ✔ Have unmet SDOH need(s) that interfere with, or present a barrier to, the diagnosis and treatment of the problems identified during an initiating visit
- ✔ Have been seen for an initiating visit prior to the start of services

SDOH include economic and social condition(s) that affect the health of people and communities. Examples of unmet SDOH needs may include:

- Food insecurity
- Housing insecurity
- Transportation insecurity
- Unreliable access to public utilities (i.e., heat, water, electricity)

See NACHC SDOH Action Guide for more information on social drivers of health.

Authorized Billing Providers

Who they are:

- Physicians (MD,DO)
- Nurse Practitioners (NP)
- Physician Assistants (PA)
- Certified Nurse Midwives (CNM)

Note: Must be qualified by education, licensure, scope of practice, and training to perform E/M and TCM level services or the specified AWV service.

What they do:

- ✔ Perform the initiating visit (before the start of CHI services)
- ✔ Determine medical necessity of CHI and order services
- ✔ Obtain patient consent for services (verbal or written). If not obtained by billing provider, consent may also be obtained by auxiliary personnel under general supervision
- ✔ Furnish services personally and/or via general supervision of auxiliary personnel as indicated by the service CPT code
- ✔ Reviews any unmet SDOH identified by auxiliary personnel during their delivery of CHI services to determine if they should be included as part of the treatment plan

Note: During the consent process, the patient must be informed that coinsurance applies and that only one provider per month can deliver and bill for CHI services. Consent must be obtained again if there is a change in the billing provider.

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Auxiliary Personnel

Who they are (examples):

- Community Health Workers
- Nurses (nurse care manager, Clinical Nurse Specialist (CNS), Registered Nurse (RN), Licensed Practical Nurse (LPN))
- Social Workers

Note: CMS has recognized Community Health Workers (CHWs) as auxiliary personnel who are members of the interdisciplinary team involved in the treatment of Medicare beneficiaries for both medical and behavioral health care. The U.S. Department of Labor finalized, in September 2023, the duties of Community Health Workers (CHWs) (Occupational Outlook Handbook). CMS acknowledges that while CHI services codes were created to capture the services of CHWs, these codes are not limited to just these types of auxiliary personnel.

CMS specifically requires that in states where requirements for auxiliary personnel do not exist, they must be certified and trained in these areas:

- Applicable knowledge of services, including community-based resources
- Communication (family and patient) and relationship-building skills
- Patient advocacy and facilitation
- Professionalism and ethical conduct
- Care coordination and health care/community systems navigation and assessment
- Patient advocacy and its facilitation
- Individual patient and community assessment
- Develop and strengthen the skills and abilities of the patient and family to improve access to health care and community services

What they may do (under general supervision, and after the initiating visit has taken place):

- ✔ Obtain patient consent for services (verbal or written)
- ✔ Provide CHI services
- ✔ Document CHI service activities and time spent on such activities in the medical record
- ✔ Communicate any newly identified SDOH concerns to the billing practitioner for review

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Service Elements, Coding & Billing

CODE	*Service Elements*	*Service Provider*	*FQHC Medicare Billing Code & Rate*
G0019	CHI services may be billed once per calendar month after at least 60 minutes of services performed by certified or trained auxiliary personnel under the direction of a physician or other practitioner. CHI activities address unmet SDOH needs that are significantly limiting the ability to diagnose or treat problems(s) identified in an initiating visit: Patient-centered assessment • Coordination with home- and community-based resources • Health education • Developing self-advocacy skills • Patient behavioral change facilitation • Facilitate and provide social and emotional patient support	Auxiliary personnel under general supervision, or the billing provider may choose to personally deliver these services.	G0019: $77.95 OR G0511: $54.67 (only valid through July 1, 2025, for FQHCs transitioning to individual codes)
G0022	CHI services, each addtl' 30 minutes per calendar month.		G0022: $48.52 OR G0511: $54.67 (only valid through July 1, 2025, for FQHCs transitioning to individual codes)

• The reimbursement rate is based on the 2025 Medicare Physician Fee Schedule (PFS); no Geographical Adjustment Factor (GAF) or Geographic Practice Cost Index (GPCI) has been applied. FQHCs can expect the payment to be slightly higher or lower depending on the GAF/GPCI. Code descriptions taken from the AAPC's HCPCS Level II 2025 Manual.

For CY 2025, FQHCs must report individual services codes for general care management services, including any add-on codes, starting January 1, 2025. FQHCs requiring additional time to configure their systems may continue reporting G0511 until July 1, 2025, at which point compliance with individual service codes is mandatory.

CHI services primarily consist of non-face-to-face interactions with the patient and care management tasks performed on behalf of the patient. As chronic care management activities do not include a face-to-face service (see Medicare Billing Lingo, Defined!), CMS does not include the services in the Medicare telehealth services list. Non-face-to-face interactions with the patient may include communication methods such as secure electronic messaging, phone calls, or other remote tools. Non-face-to-face care management tasks involve activities such as reviewing medical records, coordinating care with other providers, or connecting patients with community-based resources. While these services are primarily delivered remotely, the patient, auxiliary personnel, or provider may determine that in-person care management services are beneficial on an as-needed basis. Such in-person interactions remain part of the overall CHI service and are not required to occur monthly.

CHI services are reported by calendar month and the date of service may be set for the date when billing requirements have been met, or any date after that, as long as it is on or before the last day of the calendar month.

Health centers may include a billable CMS PPS encounter and a care management service on the same Medicare claim. When billing for both a care management service and a PPS encounter on a single claim, the payment will consist of the lesser of the PPS service's charges or its fully adjusted PPS rate for the billable visit, plus 80% of the charges for the care management service.

Patients pay 20% coinsurance based upon the lesser of the submitted charges or the local payment rate for the individual care management service codes or G0511. Coinsurance may be covered in part or in full by secondary coverage (i.e., Medigap, private, or Medicaid). Coinsurance may be "slid" commensurate with the sliding fee discount program (SFDP) policy of the health center (see Sliding Coinsurance for CMS/Medicare Care Management for more information).

It is important to note that due to the overlapping social services CMS believes are already accounted for under a home health care plan, CHI services may not be billed by FQHC practitioners while the beneficiary is receiving home health services.

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CMS has a goal of improving the collection of SDOH data through the use of ICD-10-CM Z Codes which are represented in the Z55-Z65 code range. SDOH data can be collected before, during, or after a health care encounter through the various health risk assessments and screening tools available to providers, such as PRAPARE. A new SDOH Risk Assessment code, G0136 was created by CMS to capture the administration of the risk assessment tool. The SDOH Risk Assessment is not a qualifying FQHC visit under the FQHC Prospective Payment System and is considered to be included in the overall FQHC PPS encounter rate when provided as part of a qualifying FQHC visit. For more information on SDOH coding, see the NACHC SDOH Coding Infographic.

Documentation

Be sure to capture the following documentation elements when billing for CHI services:

- ✔ The unmet SDOH needs (i.e., ICD-10 Z-codes) that are significantly limiting the ability to diagnose or treat problem(s)
- ✔ The date and practitioner who furnished the initiating visit
- ✔ Patient consent
- ✔ Details of patient-centered assessment, action plan, patient goals, and support plan needed to accomplish treatment plan
- ✔ Communication and care coordination between care team and community-based services, including caregivers at home
- ✔ Plans to support the patient in accessing community based social services (e.g., housing, utilities, transportation, food assistance) to address SDOH needs
- ✔ Patient education contextualized for the patient's SDOH and treatment plan needs and on how to best participate in medical decision-making
- ✔ Methods used to build patient self-advocacy skills
- ✔ Activities designed to aid the patient in accessing healthcare providers, including appointment schedulin
- ✔ Activities to facilitate any needed behavioral changes to meet diagnosis and treatment goals
- ✔ Activities to facilitate and provide social and emotional support to the patient
- ✔ Time spent on each CHI activity and who performed them

The billing practitioner is ultimately responsible for documentation, including that of any contracted community-based organizations (CBOs) or other contracted personnel who furnish CHI services under the clinical care and treatment of this same billing practitioner.

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Co-Occurring Care Management Services

Each care management program offers unique services, although there may be some overlap in the patient populations eligible for each. In certain cases, it may be appropriate to deliver more than one service within a given month. Service codes from different programs can be billed for the same patient in the same month if advance consent for both services is obtained and all other reporting requirements are fulfilled, ensuring that time and effort are not double-counted. Billing providers should be aware that cost-sharing and advance consent must be handled separately for each service, and only one practitioner may be designated for each service per month. Provided all reporting criteria are met, more than one service may be billed. Possible co-occurring care management services for CPM may include: Chronic Care Management (CCM, CCCM, PCM), Transitional care management (TCM), Principal illness navigation (PIN, PIN-PS), Behavioral Health Integration (BHI), Psychiatric collaborative care management (Psych CoCM), Remote physiologic monitoring (RPM), Remote therapeutic monitoring (RTM), and Advanced primary care management (APCM).

See NACHC resource: Summary of Medicare Care Management Services for more information on Medicare Care Management Services.

References

- AMA. 2025 CPT Codebook
- AAPC. 2025 HCPCS Level II Codebook
- CMS CY 2025 Physician Fee Schedule Medicare Final Rule. https://www.federalregister.gov/public-inspection/2024-25382/medicare-and-medicaid-programs-calendar-year-2025-payment-policies-under-the-physician-fee-schedule
- CMS. CY 2024 Physician Fee Schedule Final Rule. 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#h-255
- U.S. Bureau of Labor Statistics. Community Health Workers

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