



# TRAUMA CENTER

Association of America

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August 8, 2023

Ms. Chiquita Brooks-  
LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244

RE: CMS-1784-P Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies

Dear Ms. Brooks-LaSure,

### *Services Addressing Health-Related Social Needs and Caregiver Behavior Management Training*

TCAA is appreciative of CMS' proposals to recognize the resources required to address complex health-related social needs of patients and we are particularly interested in how these services can not only support patients suffering from traumatic injuries, but also prevent traumatic injuries. The TCAA offers the following suggestions and comments concerning the various proposed codes and guidelines. Overall, we ask that CMS accept questions for various use cases and then publish and update guidance on use cases to enable clinicians to report and receive appropriate separate payment without onerous documentation and other compliance requirements.

### Principal Illness Navigation

Principal Illness Navigation (PIN) services are well-known for cancer patients and TCAA supports separate codes and billing for navigator services (placeholder HCPCS codes GXXX3 and GXXX4). We also understand that PIN services are expected to be initiated with an E/M service, but that continuing PIN services would not require an E/M visit be billed. However, TCAA asks whether the proposed definition of a principal illness as one serious, high-risk condition 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 would extend to an injury.

TCAA supports separate billing and payment for PIN services, and we have the following questions and considerations:

- CMS lists several diagnoses including cancer. CMS did not list any conditions that are created from traumatic injuries such as brain injury, orthopedic issues, etc. Would these conditions qualify for PIN services? Would the PIN services qualify for coverage and payment when patient healing can take months to complete with best expectations and longer should setbacks occur?

- If a patient is determined to not have any SDOH identified with “Z codes” (Z55-Z65), does this make the PIN services not billable or non-covered? What if the assessment identifies other issues, but not any that fall within this Z code range?
- Can PIN services be initiated without having performed and billed an SDOH assessment?
- When PIN services are ordered by the clinician, does the order need to identify the issue(s) that interfere with, or present a barrier to, diagnosis or treatment of the serious, high-risk condition or can the auxiliary staff who perform the PIN services document that?
- Does CMS expect PIN services to be delineated in the plan of care like other diagnostic tests and therapeutic services?
- Can communication via patient portals be counted in the time performing PIN services like in-person and telephone and audio-visual communication time will be counted?

### **Social Determinants of Health (SDOH) Risk Assessment**

TCAA supports separate billing and payment for administering a standardized SDOH assessment tool. Billing and payment for SDOH risk assessment (placeholder HCPCS code GXXX1) would be allowed when furnished on the same day as an E/M visit and not more frequently than once every six months. TCAA is concerned that CMS does not expect this service to be furnished by emergency department and clinicians in the hospital like trauma surgeons. Patients with repeated emergency department visits, such as those with a history of falls (Z91.81) are likely to need a SDOH assessment and CHI services (discussed further below). Such services would help prevent future falls and perhaps prevent a traumatic injury such as a hip or knee fracture or reduce their risk. TCAA has the following questions and considerations about the proposed guidelines to bill and receive payment for this service:

- Do all E/M codes qualify as an E/M visit, for example, hospital initial, subsequent and discharge E/M visit codes, or is this service expected to be furnished concurrent with an office/outpatient visit only?
- The code states the SDOH assessment cannot be more frequent than every six months - is that limitation for the billing clinician or the patient? When a patient is seen by a trauma surgeon due to an injury, that clinician is not likely to know whether the patient had a SDOH from another clinician. SDOH assessments would be particularly important to understand patient needs to best enable recoupment and healing from traumatic injuries.
- Is the SDOH assessment intended to identify long-standing/systemic needs or does identification of short-term needs of patients meet the intent? For example, a patient expected to be in a wheelchair for several months through staged surgeries.
- If a patient is determined to not have any SDOH identified with “Z codes” (Z55-Z65), does this make the administration of the SDOH assessment not billable or non-covered? What if the assessment identifies other issues, but not any that fall within this Z code range, for example, conditions in the Z91 range concerning compliance with medical regimens?
- Just like patients complete a past medical, family, and social history, can patients complete the SDOH assessment and the auxiliary staff review and elicit explanations where needed and then provide to the clinician to include in their plan of care? Can patients complete the assessment via a patient portal prior to the visit as long as the responses are reviewed and discussed at the visit?

### **Caregiver Training Services (CTS)**

TCAA supports CMS’ proposals to acknowledge caregiver training services by clinicians and their teams in support of each patient’s individualized treatment plan. TCAA agrees that education and training of caregivers is vital to effectuate patient outcomes: this is particularly true for patients recuperating from traumatic injuries. Acknowledging clinicians’ significant investment in caregiver training is long overdue. TCAA emphasizes that caregiver training is not only necessary to assist the patient’s adherence to the treatment plan, but that major components of the plan would not be able to be implemented without caregiver involvement. TCAA has the following questions and considerations about the proposed guidelines to bill and receive payment for these services:

- Will CTS be covered when needed to effectuate a treatment plan for recovery from traumatic injury?
- Does CMS expect specific diagnosis codes such as those indicating problems with problem solving, environmental adaptation, training in use of equipment or assistive devices, or interventions focusing on motor, process, and communication skills to cover and pay CTS services or will the patient's primary diagnosis be acceptable?

### **Community Health Integration (CHI) Services**

TCAA also supports CMS' proposals for codes and payment for community health integration services. Patients serviced by our member trauma centers rely on significant community support in the communities that they reside. TCAA understands that a CHI initiating E/M visit would be a pre-requisite to billing for CHI services and that the SDOH needs of the patient would be the indication for CHI services including food insecurity, transportation, housing insecurity, and unreliable access to public utilities, when the needs significantly interfere with the treating clinicians ability to diagnose or treat the problem(s). However, TCAA strongly believes these services should be able to be ordered by emergency department and trauma surgeons based on patient history and needs that may or may not require further hospital care at the time of the visit or encounter, but which are likely to re-occur and result in further trauma, most notably a history of falling (Z91.81). TCAA has the following questions and considerations about the proposed guidelines to bill and receive payment for these services:

- Would CHI services to address accessibility problems in the home that could contribute to patient falls and other injuries be covered, billable and payable?
- If a patient is determined to not have any SDOH identified with "Z codes" (Z55-Z65), does this make the CHI services not billable or non-covered? What if the assessment identifies other issues, but not any that fall within this Z code range?
- Can CHI services be initiated without having performed and billed an SDOH assessment?
- When CHI services are ordered by the clinician, does the order need to identify the issue(s) that interfere with, or present a barrier to, diagnosis or treatment of the patient or can the auxiliary staff who perform the CHI services document that?
- Does CMS expect CHI services to be delineated in the plan of care like other diagnostic tests and therapeutic services?
- Since CHI services can be furnished by entities incident to the clinician, would email and other communication about the work the outside entities are furnishing be sufficient documentation in the patient's medical record to meet the incident to rules?

Thank you very much for this consideration.

Best regards



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 President  
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