Community Health Worker medical billing payment models, codes, and payers

Category	Health Education Services	Community Health Integration (CHI) Services
Qualifying Conditions	▪ Patient education for health promotion and disease management ▪ The service must involve teaching the patient how to self-manage their health or oral health effectively in conjunction with the health care team	▪ Upstream drivers of health needs (including but not limited to food insecurity, transportation insecurity, housing insecurity, and unreliable access to public utilities) that significantly limit the practitioner's ability to diagnose or treat the patient
Non-Covered Services	▪ Social services such as enrollment assistance ▪ Case management ▪ Advocacy	▪ Services provided to groups
CHW Services	The content of the patient education plan or training program is consistent with established or recognized health or dental health care standards. Curriculum may be modified as necessary for the clinical needs, cultural norms, and health or dental literacy of the individual patients. **Examples of Topics of Patient Education:** ▪ Disease-specific patient education: heart disease, stroke, diabetes, cancer, dental disease, mental health, substance abuse, and others ▪ Non-disease-specific patient education for preventive or health promotion visit ▪ Understanding of health condition and treatments ▪ Understanding and using medications ▪ Wellness, prevention, immunizations, nutrition and other health promotion activities ▪ Elements of healthy lifestyles, weight, exercise, recreation, relationships, managing stress, and other topics within the context of patient's unique community culture ▪ Monitoring routine and preventive primary care, dental care and well child visits	Activities to address SDOH needs, may include but are not limited to: ▪ Person-centered, upstream drivers of health assessment (covered but not required) ▪ Practitioner-, home-, and community-based care coordination ▪ Health education ▪ Building patient self-advocacy skills ▪ Health care access / health system navigation ▪ Facilitating and providing social and emotional support; and ▪ Leveraging lived experience, when applicable CHI services can be billed when they are provided without patient present, but when the CHW is working on the patient's behalf **Person-centered assessment,** performed to better understand the individualized context of the intersection between the SDOH need(s) and the problem(s) addressed in the initiating visit ▪ Conducting a person-centered assessment to understand the patient's life story, strengths, needs, goals, preferences and desired outcomes, including understanding cultural and linguistic factors and including unmet SDOH needs (that aren't separately billed) ▪ Facilitating patient-driven goal-setting and establishing an action plan ▪ Providing tailored support to the patient as needed to accomplish the practitioner's treatment plan **Practitioner, home-, and community-based care coordination**

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	▪ Culturally appropriate communication, patient engagement, and patient education between providers and patients ▪ Current health behaviors assessment and recording patient data specific to health behaviors and psychological issues related to patient education activities ▪ Construction of health living contracts with patients based on health behavior assessments using goals to promote health ▪ Economic and socioeconomic impacts on health conditions ▪ Explanation of and accessing needed services ▪ Working with multiple providers and treatments and navigating visits and treatments ▪ Working with the patient and patient's providers to overcome cultural barriers ▪ Eligibility requirements, forms, and health care applications *The examples are from the MN DHS approved list in the Healthy Communities Task Force 2018 Final Report (Appendix 1).*	▪ Coordinating receipt of needed services from health care practitioners, providers, and facilities; and from home- and community-based service providers, social service providers, and caregiver (if applicable) ▪ Communication with practitioners, home- and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors ▪ Coordination of care transitions between and among health care practitioners and settings, including transitions involving referral to other clinicians; follow-up after an emergency department visit; or follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities ▪ Facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) to address the SDOH need(s) **Health education** – helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, and preferences, in the context of SDOH need(s), and educating the patient on how to best participate in medical decision-making **Building patient self-advocacy skills**, so that the patient can interact with members of the health care team and related community-based services addressing the SDOH need(s), in ways that are more likely to promote personalized and effective diagnosis or treatment **Health care access/health system navigation** ▪ Helping the patient access health care, including identifying appropriate practitioners or providers for clinical care and helping secure appointments with them ▪ Facilitating behavioral change as necessary for meeting diagnosis and treatment goals, including promoting patient motivation to participate in care and reach person-centered diagnosis or treatment goals ▪ Facilitating and providing social and emotional support to help the patient cope with the problem(s) addressed in the initiating visit, the SDOH need(s), and adjust daily routines to better meet diagnosis and treatment goals ▪ Leveraging lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goal

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Initiation of services	**Orders** ▪ A physician, advance practice registered nurse (APRN), dentist, certified public health nurse, or mental health professional must order the service and order that it be provided by a CHW ▪ Individual and standing orders are acceptable	**Ordering Provider** ▪ "Billing Practitioner" – this must be the same practitioner who provides continuity of care for the patient in the community **Initiating Visit** ▪ The initiating visit can occur during an annual wellness visit (AWV), an evaluation and management (E&M) visit to the patient's primary care practitioner (Medicare-enrolled physician, NP, CNS, CNM, PA), a Psychiatric Diagnostic Evaluation or a Health Behavior Assessment and Intervention (HBAI)CHW/Service Delivery
Supervising Providers	▪ CHW services must be provided under the general supervision of a MHCP-enrolled physician, advance practice registered nurse (APRN), dentist, non-enrolled certified public health nurse or registered nurse working for an enrolled organization	▪ Services are provided by "auxiliary personnel, including CHWs, who render services 'incident to' and under the general supervision of the billing practitioner"
Documentation	▪ Documentation of the patient education plan or training program used by the CHW. ▪ Documentation of periodic assessment of the member's progress and need for ongoing CHW services. ▪ Documentation of the following: Date of service, Start and end time for the service, Whether the service was group or individual and if group, number of patients present, summary of the session's content, and the CHWs signature and printed name	**MHCP** ▪ The billing provider must meet the same documentation requirements listed under CHW Education services. The documentation must support the number of units billed. **Medicare** ▪ Document the patient's unmet social needs that CHI services are addressing in the medical record. Documenting ICD-10 Z-codes can count as the appropriate documentation. ▪ Document the amount of time spent with the patient and the nature of the activities.
CHW Training Requirements	▪ CHW must have a valid CHW certificate verifying they have completed an approved CHW curriculum from MN State Colleges and Universities, or be a CHR (Community Health Representative) with Federal Indian Health Services (IHS) training or 5 years supervised experience ▪ CHW must enroll as an individual provider with MHCP	▪ CHW must be "certified": For Minnesota, this means CHW must have a valid CHW certificate verifying they have completed an approved CHW curriculum from MN State Colleges and Universities, or be a CHR (Community Health Representative) with Federal Indian Health Services (IHS) training or 5 years supervised experience ▪ CHWs do not enroll with Medicare
Billing Entity	▪ MHCP enrolled organization (See Eligible Provider List in MHCP CHW Provider Manual) NOTE: If FQHCs bill they will be paid $0.	▪ Billing practitioner employing (or contracting with) trained/certificate holding CHWs (indirect billing)

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	▪ MHCP Eligible Providers: APRN, Clinic, Community health clinic, CAH, Dentist, Family planning agency, FQHC, Hospital, IHS facility, MHPs, Physician, PHN clinic, RHCs, Tribal health facility	▪ Only one practitioner can bill for community health integration services per month; and that same practitioner bills for subsequent community health integration services.
Coding/Reimbursement Approach	**Diagnosis code:** ▪ Z71.89 (most often used when billing Health Education codes) **HCPCS CPT (procedure) codes:** ▪ 98960: self-management education and training 1 patient (30 min) ▪ 98961: self-management education and training (groups of 2-4 patients) (30 min) ▪ 98962: self-management education and training (groups of 5-8 patients) (30 min) (NOTE: Add a U9 modifier for groups >8) ▪ Maximum 2 hours (4 units)/day and 12 hours (24 units)/month	**Diagnosis code:** ▪ SDOH Z-codes - as primary or secondary **HCPCS "G" codes:** ▪ G0019 – initial CHW service per month (60 minutes) ▪ G0022 – add on code (30 min) ▪ No frequency limit on code G0022 ▪ Can be billed monthly for initial 60-minutes and then in additional 30-minute increments for aggregate time spent ▪ CHI services can be billed when they are provided without patient present, but when the CHW is working on the patient's behalf
Payment Rates	**MHCP payment rates (as of 1/1/25, per 30 min unit)** ▪ 98960: $23.53 ▪ 98961: $11.26/person ▪ 98962: $8.26/person ▪ 98962, U9 Modifier: $8.26/person	**Medicare federal payment rates (as of 10/29/2025):** ▪ G0019 ($80.56 non-facility; $49.60 facility) ▪ G0022 ($50.26 non-facility; $34.62 facility) **MHCP payment rates (as of 9/25/2025):** ▪ G0019 ($59.84 non-facility; $35.80 facility) ▪ G0022 ($37.05 non-facility; $25.04 facility)
Paid By	MHCP, MCOs	MHCP, Medicare, MCOs
References	See MHCP CHW Provider Manual and Appendix 1: Healthy Communities Task Force Report for full details.	See MHCP CHW Provider Manual and CMS Health Related Social Needs FAQs, pages 7-16, and Medicare CY 2026 Physician Fee Schedule for full details. MLN9201074 - Health Equity Services in the 2024 Physician Fee Schedule Final Rule

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