Health-Related Social Needs (HRSN)

Session 4: Using Z-Codes to Capture HRSN
December 13, 2023

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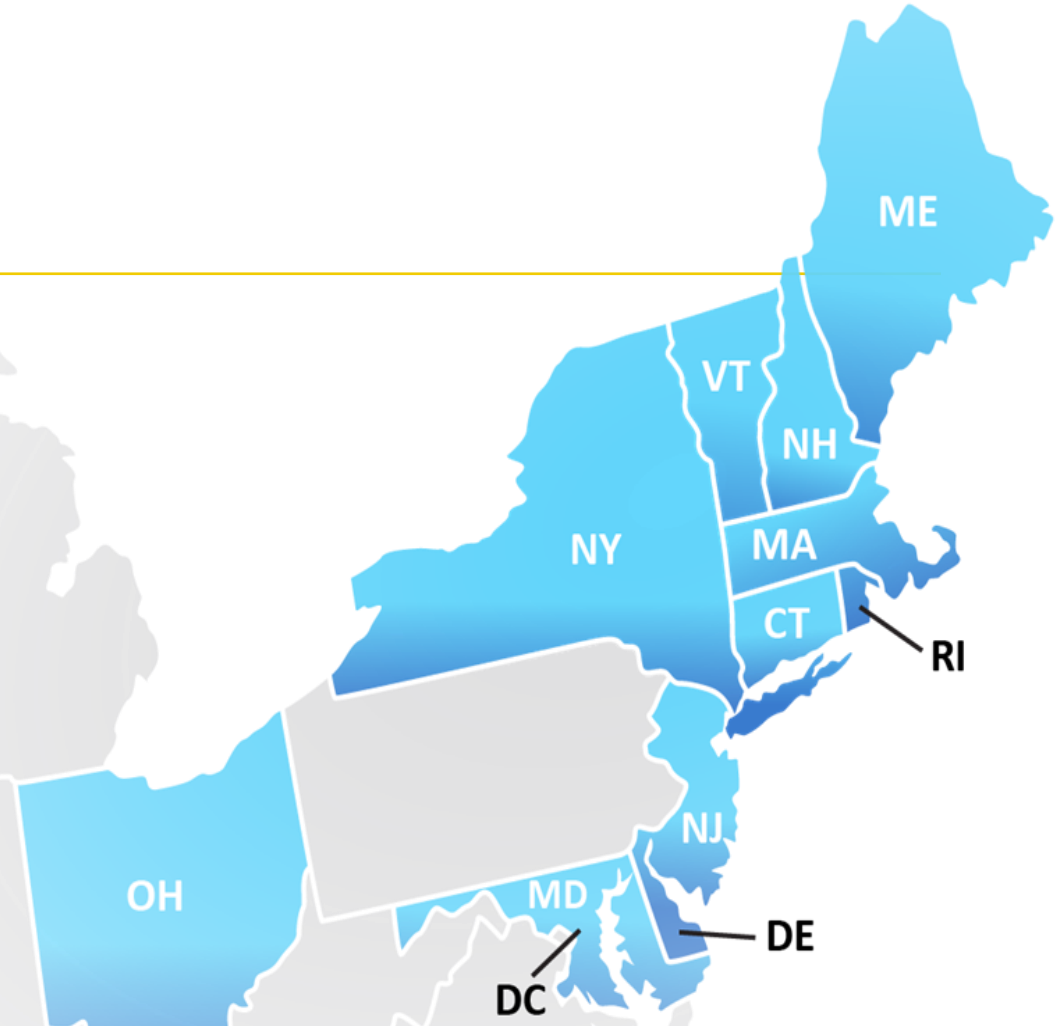

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- A federally funded Medicare Hospital Quality Improvement Contractor (HQIC) in 12 states
- IPRO collaborates with several organizations to reach hospitals.

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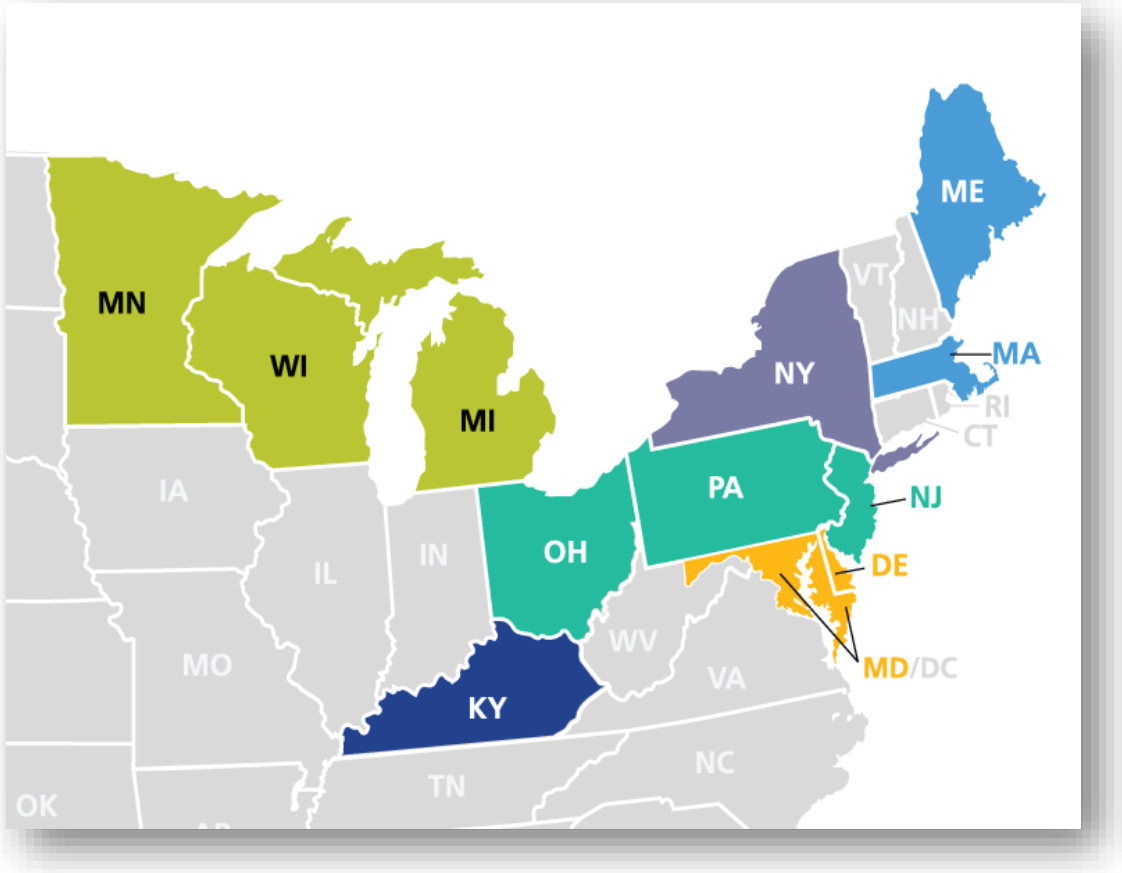

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Today's Session Objectives

- Learn from our coding expert about Z-codes: Karen S. Scott, MEd, RHIA, CCS-P, CPC, FAHIMA, AHIMA Approved ICD-10 Trainer

Introductions

Share your **name**, **title**, **organization** and response to:

What is your favorite Winter activity?

HSRN Series

Date	Time	Topic
9/13/2023	12:00 – 12:45 PM ET	Reviewing HRSN & the HRSN Measure
10/11/2023	12:00 – 12:45 PM ET	Training Providers and Staff to Screen for HRSN and Educating Patients
11/8/2023	12:00 – 12:45 PM ET	Incorporating Screening Tools into Workflow
12/13/2023	12:00 – 12:45 PM ET	Using Z-Codes to Capture HRSN
1/10/2024	12:00 – 12:45 PM ET	Connecting with CBOs to Close the Referral Loop
2/14/2024	12:00 – 12:45 PM ET	Involving Patients, Families, and Communities to Help Improve HRSN Screening and Referrals

To Register:
https://ipro.webex.com/webappng/sites/ipro/webinar/webinarSeries/register/6bb8cc607cd74404b38127444d16962d

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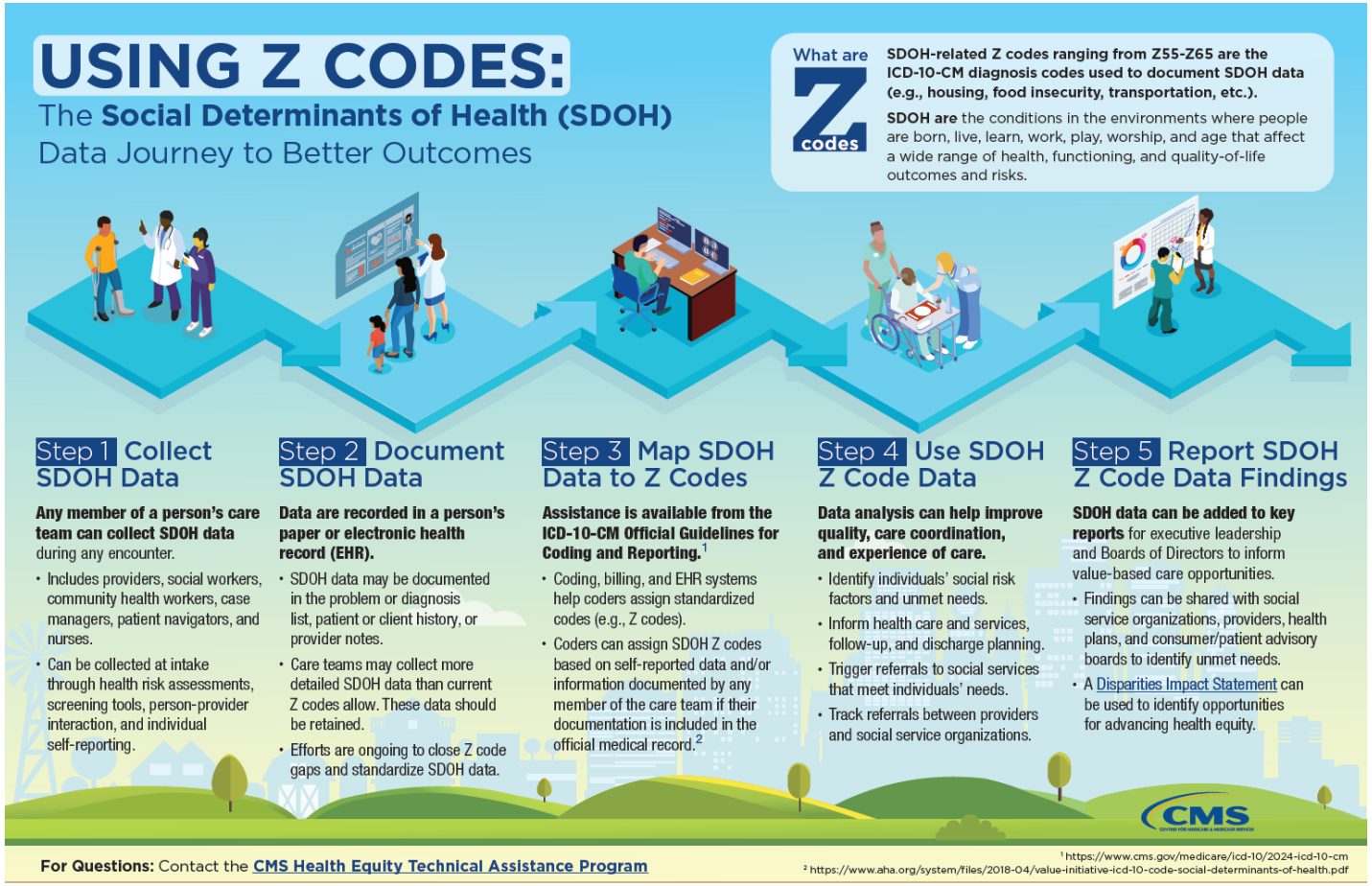
Z-Codes Overview



CDC, Using Z Codes: The Social Determinants of Health (SDOH) Data Journey to Better Outcomes, June 2023, https://www.cms.gov/files/document/zcodes-infographic.pdf

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Z-Codes Overview Cont.

CDC, Using Z Codes: The Social Determinants of Health (SDOH) Data Journey to Better Outcomes, June 2023, https://www.cms.gov/files/document/zcodes-infographic.pdf

Screening and Z-Codes

Karen S. Scott, MEd, RHIA, CCS-P, CPC, FAHIMA
AHIMA Approved ICD-10 Trainer
kscottseminars@comcast.net

CMS Quality Measures

- In the 2023 IPPS Final Rule, CMS mandated that hospitals reporting to the Inpatient Quality Reporting (IQR) program submit two brand new measures: SDOH-1 and SDOH-2. These measures are voluntary in 2023 and required by 2024.
- SDOH-1 POPULATIONS
- Of all the patients admitted to the hospital, how many did you screen for SDOH?
  - **Numerator:** The number of patients who were screened for the five domains of SDOH (listed below).
  - **Denominator:** All patients admitted to your hospital who are 18 years or older.
  - **Exclusions:** Patients who opt-out of screening and/or patients who are unable to complete the screening during their stay and have no legal guardian or caregiver who can do so on their behalf.

- SDOH-2 POPULATIONS
- Of all the patients admitted to the hospital who received a SDOH screening, how many were identified as having one or more social risk factor?
  - **Numerator:** The number of patients who screened positive for any of the five domains of SDOH.
  - **Denominator:** All patients admitted to your hospital who are 18 years or older and are screened for the five domains of SDOH.
  - **Exclusions:** Patients who opt-out of screening and/or patients who are unable to complete the screening during their stay and have no legal guardian or caregiver who can do so on their behalf.

Domains of SDOH Screening

The results of the SDOH-2 measure will be calculated as **five separate rates** – one for each of the five domains.

Food Insecurity

Food insecurity is defined as limited or uncertain access to adequate quality and quantity of food at the household level.

Housing Instability

Housing instability encompasses multiple conditions ranging from the inability to pay rent or mortgage, frequent changes in residence including temporary stays with friends and relatives, living in crowded conditions, and actual lack of sheltered housing in which an individual does not have a personal residence.

Transportation Needs

Unmet transportation needs include limitations that impede transportation to destinations required for all aspects of daily living.

Utility Difficulties

Inconsistent availability of electricity, water, oil, and gas services is directly associated with housing instability and food insecurity.

Interpersonal Safety

Assessment for this domain includes screening for exposure to intimate partner violence, child abuse, and elder abuse.

Screening Tool

- The AHC Health-Related Social Needs Screening Tool
- Strongly encouraged by Medicare to be used

JCAHO Measures

- Effective January 1, 2023, new and revised requirements to reduce health care disparities will apply to organizations in the Joint Commission's ambulatory health care, behavioral health care and human services, critical access hospital, and hospital accreditation programs.
- • A new standard in the Leadership (LD) chapter with 6 new elements of performance (EPs) has been developed to address health care disparities as a quality and safety priority.
  - Standard LD.04.03.08 will apply to the following Joint Commission–accredited organizations:
    - o All critical access hospitals and hospitals
    - o Ambulatory health care organizations providing primary care within the "Medical Centers" service in the ambulatory health care program (the requirements are not applicable to organizations providing episodic care, dental services, or surgical services)
    - o Behavioral health care and human services organizations providing "Addictions Services," "Eating Disorders Treatment," "Intellectual Disabilities/Developmental Delays," "Mental Health Services," and "Primary Physical Health Care" services
- • The Record of Care, Treatment, and Services (RC) requirement to collect patient race and ethnicity information has been revised
- • The Rights and Responsibilities of the Individual (RI) requirement prohibiting discrimination (Standard RI.01.01.01, EP 29) will apply to all Joint Commission–accredited ambulatory health care organizations and behavioral health care and human services organizations.

Standard LD.04.03.08

- Reducing health care disparities for the [organization's] [patients] is a quality and safety priority.
  - Requirement EP 1: The [organization] designates an individual(s) to lead activities to reduce health care disparities for the [organization's] [patients].
  - EP 2: The [organization] assesses the [patient's] health-related social needs and provides information about community resources and support services. Note 1: [Organizations] determine which health-related social needs to include in the [patient] assessment. Examples of a [patient's] health-related social needs may include the following: • Access to transportation • Difficulty paying for prescriptions or medical bills • Education and literacy • Food insecurity • Housing insecurity Note 2: Health-related social needs may be identified for a representative sample of the [organization's] [patients] or for all the [organization's] [patients]
  - EP 3: The [organization] identifies health care disparities in its [patient] population by stratifying quality and safety data using the sociodemographic characteristics of the [organization's] [patients].

Official Coding Guidelines-Updated!

- Social Determinants of Health Social determinants of health (SDOH) codes describing social **problems, conditions, or risk factors that influence a patient's health should be assigned when this information is documented in the patient's medical record. Assign as many SDOH codes as are necessary to describe all of the social problems, conditions, or risk factors documented during the current episode of care. For example, a patient who lives alone may suffer an acute injury temporarily impacting their ability to perform routine activities of daily living**
- **When documented as such, this would support assignment of code Z60.2, Problems related to living alone. However, merely living alone, without documentation of a risk or unmet need for assistance at home, would not support assignment of code Z60.2. Documentation by a clinician (or patient-reported information that is signed off by a clinician) that the patient expressed concerns with access and availability of food would support assignment of code Z59.41, Food insecurity. Similarly, medical record documentation indicating the patient is homeless would support assignment of a code from subcategory Z59.0-, Homelessness**.

Official Coding Guidelines (cont.)

- For social determinants of health, such as information found in categories Z55-Z65, Persons with potential health hazards related to socioeconomic and psychosocial circumstances, code assignment may be based on medical record documentation from clinicians involved in the care of the patient who are not the patient's provider since this information represents social information, rather than medical diagnoses. For example, coding professionals may utilize documentation of social information from social workers, community health workers, case managers, or nurses, if their documentation is included in the official medical record. Patient self-reported documentation may be used to assign codes for social determinants of health, as long as the patient self-reported information is signed-off by and incorporated into the medical record by either a clinician or provider.

Z55-59

- Persons with potential health hazards related to socioeconomic and psychosocial circumstances (Z55-Z65)
- Z55Problems related to education and literacy
- Z56Problems related to employment and unemployment
- Z57Occupational exposure to risk factors
- Z59Problems related to housing and economic circumstances

Z60-65

- Z60 Problems related to social environment
- Z62 Problems related to upbringing
- Z63 Other problems related to primary support group, including family circumstances
- Z64 Problems related to certain psychosocial circumstances
- Z65 Problems related to other psychosocial circumstances

MDM E&M Codes Risk Level

- Social determinants of health: Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity. ICD-10-CM Z55-65

Risk Levels

Level	Risk
Straightforward	Minimal risk of morbidity from additional testing/tx
Low	Low risk morbidity
Moderate	Moderate risk of morbidity Examples: Prescription Drug Management Decision regarding minor surgery with id pt or procedure risk factors Decision regarding elective major surgery without id pt/procedure risk factors Diagnosis/treatment significantly limited by social determinants of health (SDOH)

Examples

- Category Z56 Problems related employment and unemployment, subcategory Z56.3, Stressful work schedule: A stressful work schedule can certainly impact the health of an individual.
- Category Z59 Problems related to housing and economic circumstances, subcategory Z59.1, Inadequate housing: This may impact an individual's ability to prepare and eat healthy meals, get proper rest, and practice good personal hygiene.
- Category Z63 Other problems related to primary support group, including family circumstances, subcategory Z63.6, Dependent relative needing care at home: This situation can be very stressful for the caregiver, and oftentimes the caregiver may neglect their own health due to the responsibilities of caring for a relative.

Code the SDOH

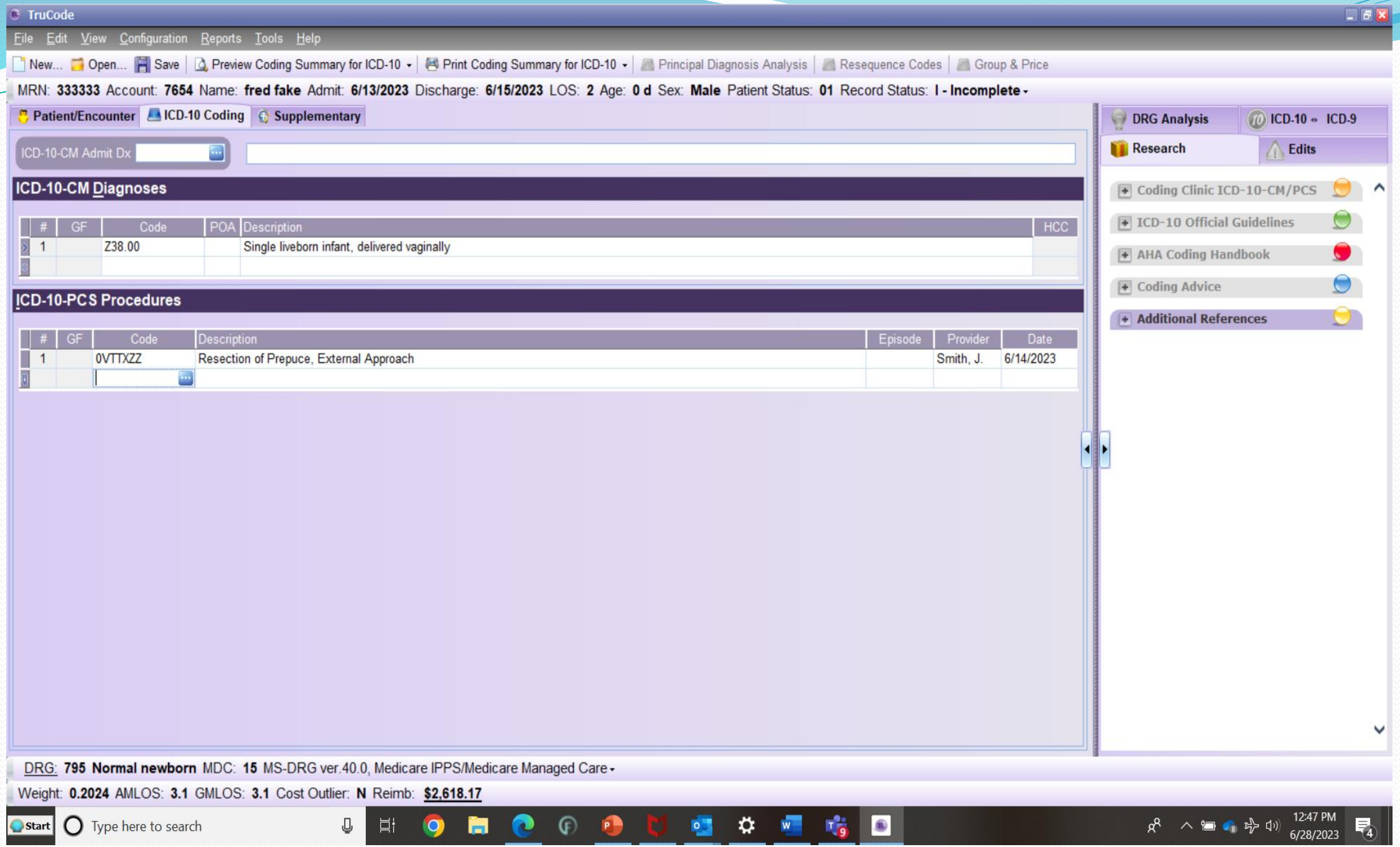
- New patient
- CHF; COPD, severe; HTN
- Extensive history taken, physical exam
- Counseling on diet, smoking cessation
- Reviewed current meds and dosages and discussed need to take all meds as prescribed.
- He had a job loss and this will lead to loss of insurance after the first of the year; he is worried this will have a serious impact on his healthcare.

Possible SDOH Codes

- Z56.0 Unemployment
- Z59.7 Insufficient social insurance and welfare support

Coding Tip Sheet

- From American Academy of Pediatrics
- “Often, the SDOH that is identified or continues to impact the patient will require interventions from the primary care physician and may result in coordinating with community and/or school resources. These efforts are time-consuming and often are unfunded.
- With the recognition by the Current Procedural Terminology Editorial Panel and the Centers for Medicare & Medicaid Services of increased complexity caused by social issues, there is hope these important services will be funded. Adding SDOH in the MDM risk table for office-based E/M services is a step in the right direction. However, it is important for physicians and clinical staff to document when these issues impact the encounter.”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Patient/Encounter ICD-10 Coding Supplementary
ICD-10-CM Admit Dx
ICD-10-CM Diagnoses
GF Code POA Description HCC
1 Z38.00 Single liveborn infant, delivered vaginally
ICD-10-PCS Procedures
GF Code Description Episode Provider Date
1 0VTTXZZ Resection of Prepuce, External Approach Smith, J. 6/14/2023
DRG Analysis ICD-10 ⇔ ICD-9
Research Edits
Coding Clinic ICD-10-CM/PCS
ICD-10 Official Guidelines
AHA Coding Handbook
Coding Advice
Additional References
DRG: 795 Normal newborn MDC: 15 MS-DRG ver.40.0, Medicare IPPS/Medicare Managed Care
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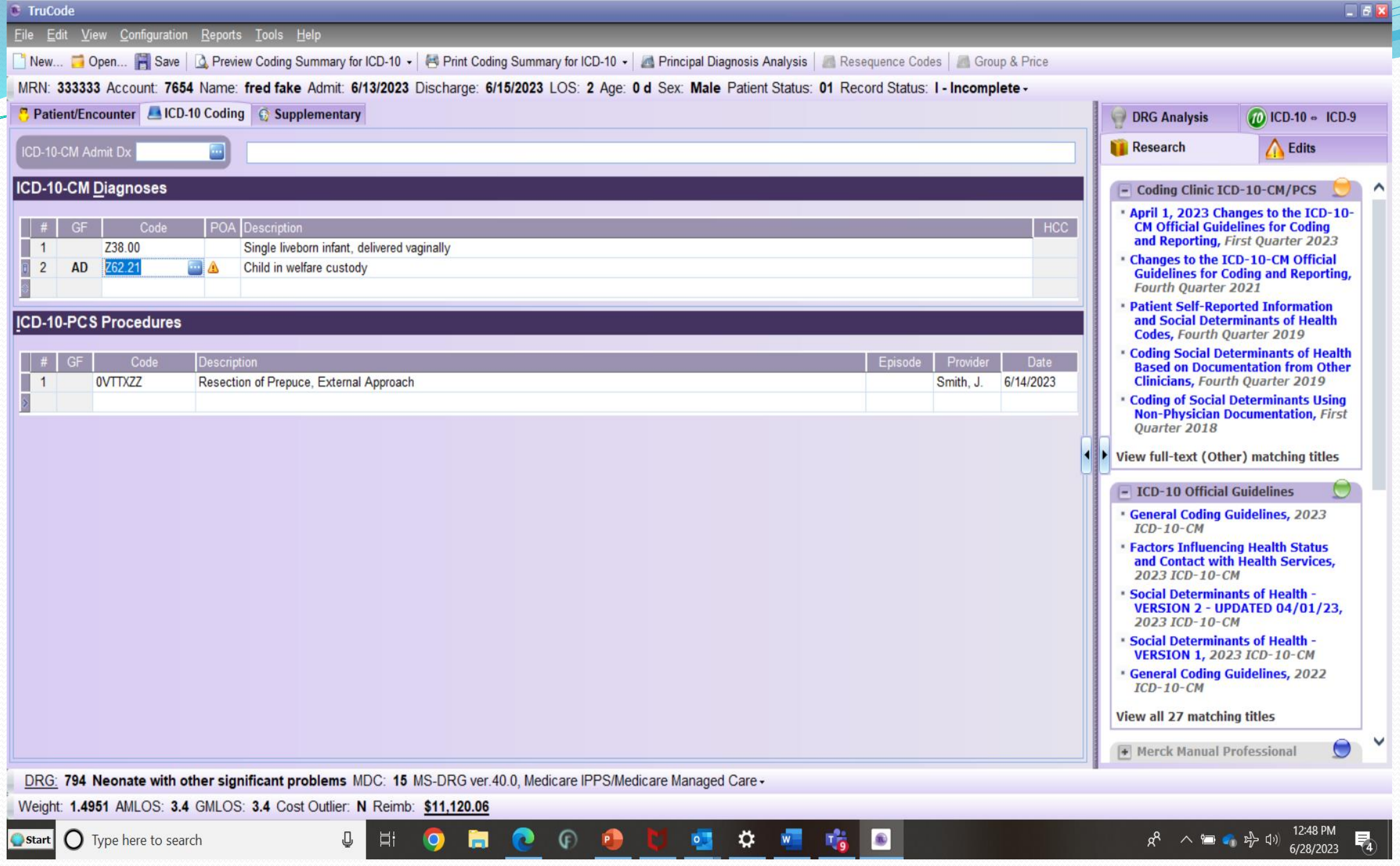
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DRG Analysis ICD-10 ⇔ ICD-9
Research Edits
Coding Clinic ICD-10-CM/PCS
April 1, 2023 Changes to the ICD-10-CM Official Guidelines for Coding and Reporting, First Quarter 2023
Changes to the ICD-10-CM Official Guidelines for Coding and Reporting, Fourth Quarter 2021
Patient Self-Reported Information and Social Determinants of Health Codes, Fourth Quarter 2019
Coding Social Determinants of Health Based on Documentation from Other Clinicians, Fourth Quarter 2019
Coding of Social Determinants Using Non-Physician Documentation, First Quarter 2018
View full-text (Other) matching titles
ICD-10 Official Guidelines
General Coding Guidelines, 2023 ICD-10-CM
Factors Influencing Health Status and Contact with Health Services, 2023 ICD-10-CM
Social Determinants of Health - VERSION 2 - UPDATED 04/01/23, 2023 ICD-10-CM
Social Determinants of Health - VERSION 1, 2023 ICD-10-CM
General Coding Guidelines, 2022 ICD-10-CM
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DRG: 794 Neonate with other significant problems MDC: 15 MS-DRG ver.40.0, Medicare IPPS/Medicare Managed Care
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CCs

- SDOH Codes
- CCs
- Z59.00 Homelessness
- Z59.01 Sheltered Homelessness
- Z59.02 Unsheltered Homelessness

SDOH Issues 2024 Fee Schedule

- Medicare will pay for
  - Community Health Integration
  - Social Determinants of Health (SDOH) Risk Assessment
  - Principal Illness Navigation services
  - To cover resources when clinicians involve health care support staff
    - such as community health workers, care navigators, and peer support specialists in furnishing medically necessary care

Payment for SDOH Assessment

- Added SDOH risk assessment to annual wellness visit
  - optional, additional element with an additional payment and no patient coinsurance nor deductible
  - when provided with the annual wellness visit
- payment for SDOH risk assessments furnished with an evaluation and management or behavioral health visit

Types of Services

- Community Health Integration (CHI)
  - address unmet SDOH needs that affect the diagnosis and treatment of the patient's medical problems

- Principal Illness Navigation (PIN)
  - to help people with Medicare diagnosed with high-risk conditions (for example, dementia, HIV/AIDS, and cancer) identify and connect with appropriate clinical and support resources.

AHIMA White Paper

- Survey Results on Collection and Use
  - Lack of Standardization/Integration
  - Insufficient training on
    - Capture
    - Collecting
    - Coding
    - Using data
  - Limited data usage for appropriate communication

Collection of Data

- Most collect electronically
- Look for fields available in your EHR
- Structured fields or “extra” for any usage
- Talk to your service provider to gauge their readiness and integration level
- Most common screening tools:
  - CMS AHC Core Domains
  - CMS AHC Supplemental Domains
  - UDS Measures
  - National Academy of Medicine Domains
  - Healthy Leads Screening Tool
  - Healthy People
  - Upstream Risk Screening Tools

Training and Education

- Who is collecting?
  - Nurses, physicians, registration staff
  - Are they receiving training on this?
- Challenges Faced
  - Lack of trained workforce
  - Lack of organizational policy
  - Patient distrust
  - Inability to address SDOH Needs

Items to Cover in Training

- Privacy protections, security standards, confidentiality requirements
- Official Coding Guidelines
- Collecting data in culturally sensitive way
- Documentation requirements to support accurate SDOH code assessment

Barriers to Coding

- Lack of staff training
- Inability to find SDOH information in patient record
- SDOH not collected by frontline staff
- Limited space on claims form
  - 25 diagnoses
- No ICD-10 equivalent for social screening item
- Revenue Cycle Deadlines

Process for Success

- Incorporate data into organization goals and objectives
- Communicate and refer patients to community-based organizations (CBOs)
- Identify/assess community-level needs
- Track population health
- Id/create facility-run services to address social needs
- Build reports to share with govt/non-profit entities or public
- Support need for policies on local, state, federal levels

What Can We Do?

- Need a standardized approach
- screening for, documenting and coding social needs
- Track social needs that impact patients, allowing for personalized care that addresses patients' medical and social needs;
- Aggregate data across patients to determine how to focus a social determinants strategy
- Identify population health trends and guide community partnerships

AHIMA Steps to SDOH Coding

- "Examples of internal guidelines include:
- In accordance with the AHA 4th Quarter 2019 issue of *Coding Clinic*, identifying the categories of clinicians, such as, community health workers, social workers and case managers whose health record documentation may be used for SDOH code assignment.
- Identifying documentation that would justify the assignment of an SDOH-related ICD-10-CM code. For example, documentation of "Tent City" resident or "Lives in vehicle" would justify the reporting of code Z59.0, Homelessness. Code Z56.6, Other physical and mental strain related to work, is to be assigned for documentation of patient being furloughed, underemployed, or reporting reduced work hours.
- Reporting SDOH-related codes on readmission records to support the healthcare organization's readmission reduction program.
- Requiring the reporting of SDOH-related codes on all well child visits to meet a state Medicaid requirement that this information be included on the claim.
- Requiring that SDOH-related ICD-10-CM codes be reported in the top 25 diagnosis fields to ensure that the information is included on claims submitted to payers."

Utilize Tools and Education

- Tools that can screen for SDOH
  - Your EHR
  - Specialty societies
  - Vendors
- Educate providers
  - Start with CPT office visit discussions
  - Checks to make sure coding of dx codes occurs
  - Consistency

SDOH Toolkit

- Social Determinants of Health Information Exchange Toolkit (healthit.gov)
- “intended to support conveners, facilitators, implementers, and the health IT community in the process of collaborative assessment, design, implementation, and governance to integrate information systems across sectors.”

Thank You

Thank you for your continued partnership and commitment to health equity.

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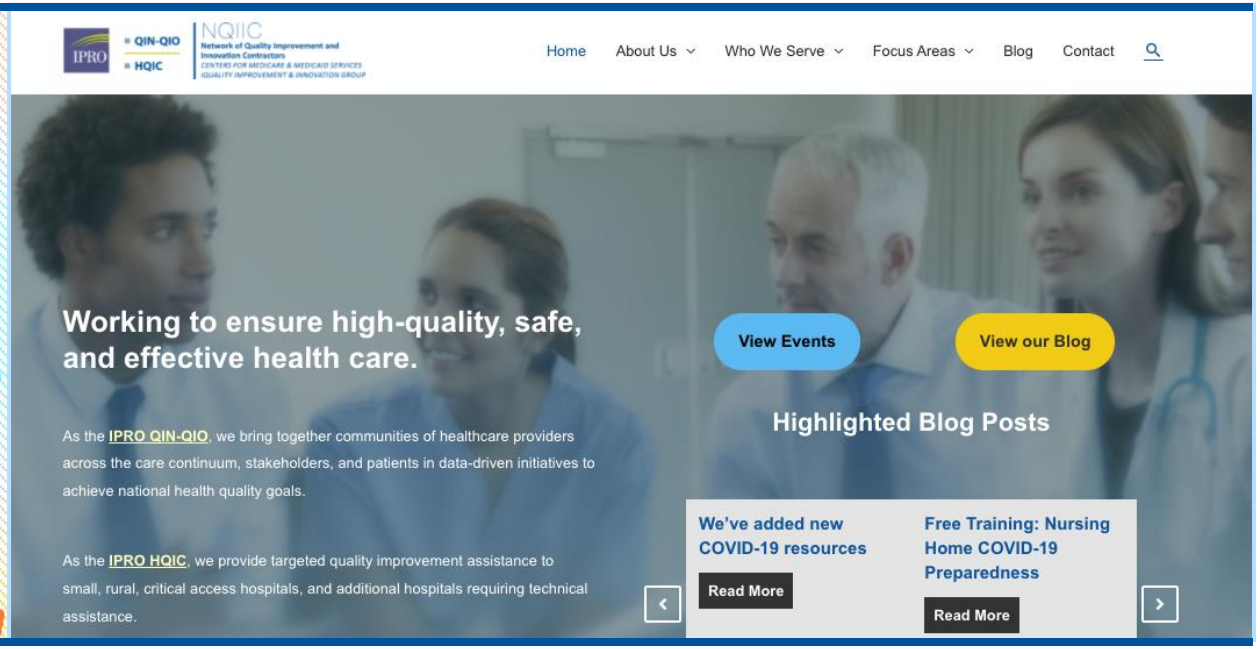

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