Z-Code Optimization & Reimbursement Opportunities

An IPRO Health Equity Cross-Task Event

December 7, 2021

This webinar is being recorded.

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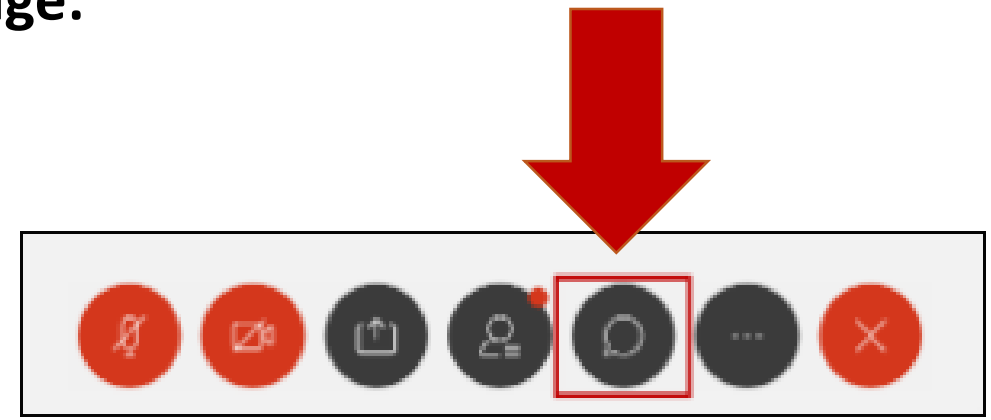

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Agenda

- IPRO QIN-QIO and HQIC Networks
- Social Determinants of Health Overview, Regulatory Trends, and Intersection with Health Equity and Health Disparities
- Coding Social Determinants of Health, Z-Code Usage and Reimbursement Opportunities
- Discussion, Q&A
- Wrap-Up

The IPRO QIN-QIO

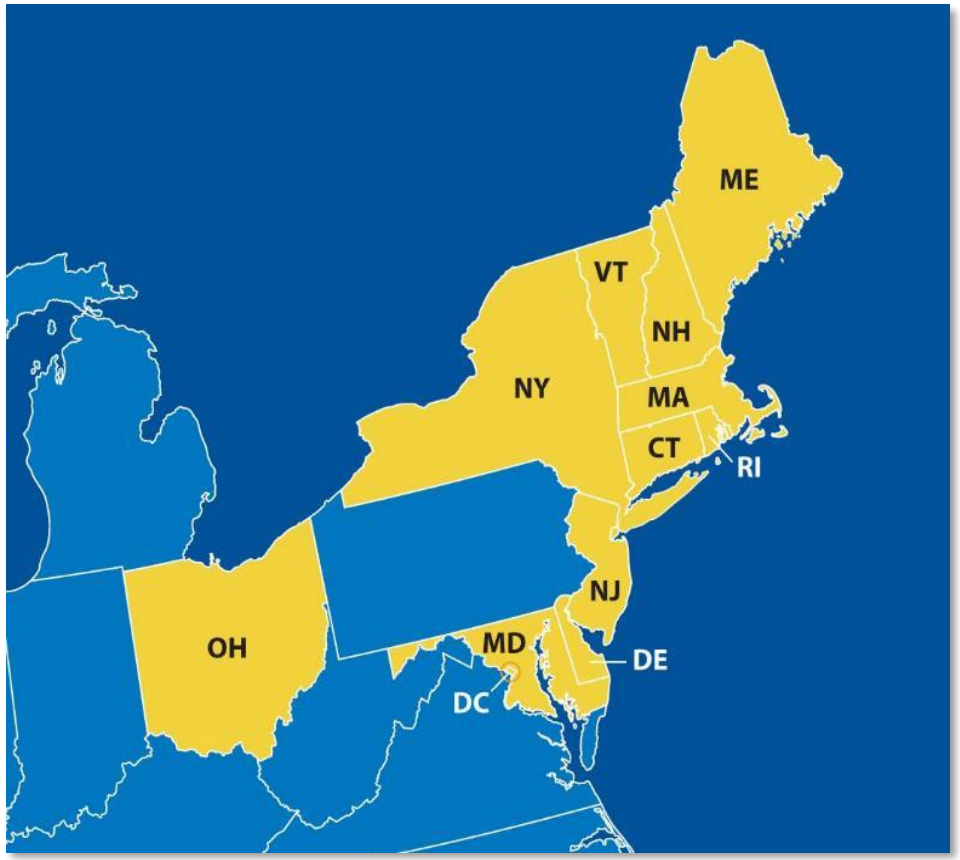
The IPRO QIN-QIO

- A federally-funded Medicare Quality Innovation Network – Quality Improvement Organization (QIN-QIO)
- 12 regional CMS QIN-QIOs nationally

IPRO:
New York, New Jersey, and Ohio

Healthcentric Advisors:
Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont

Qlarant:
Maryland, Delaware, and the District of Columbia



Working to ensure high-quality, safe healthcare for
20% of the nation's Medicare FFS beneficiaries

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The IPRO HQIC

The IPRO HQIC

- A federally funded Medicare Hospital Quality Improvement Contractor (HQIC) in 12 states:

IPRO

Healthcentric Advisors

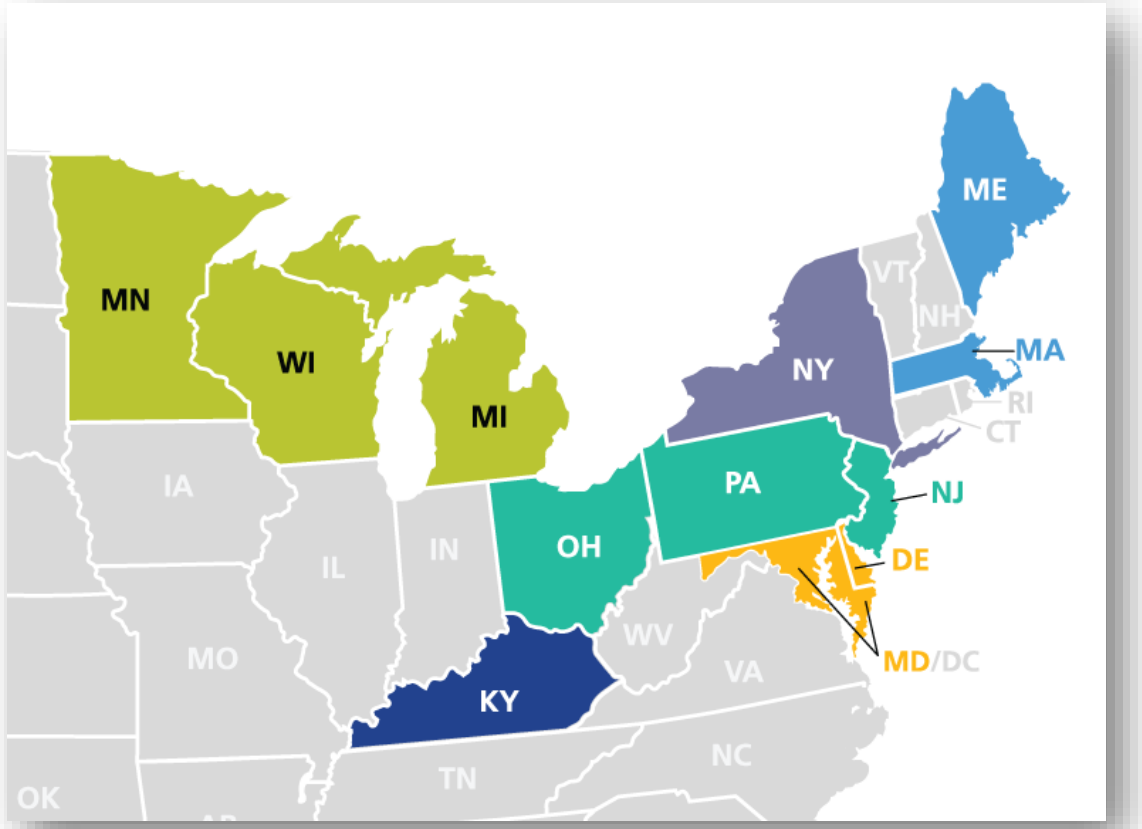
Kentucky Hospital Association

Qlarant

Q3 Health Innovation Partners

Superior Health Quality Alliance

American Institutes for Research (AIR)



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Our Presenters

Andrea Green, RN
Manager, Healthcare Strategy, SDOH
LexisNexis Risk, Healthcare

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Owner, Karen Scott Seminars & Consulting

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Speaker Introduction

Andrea Green, RN

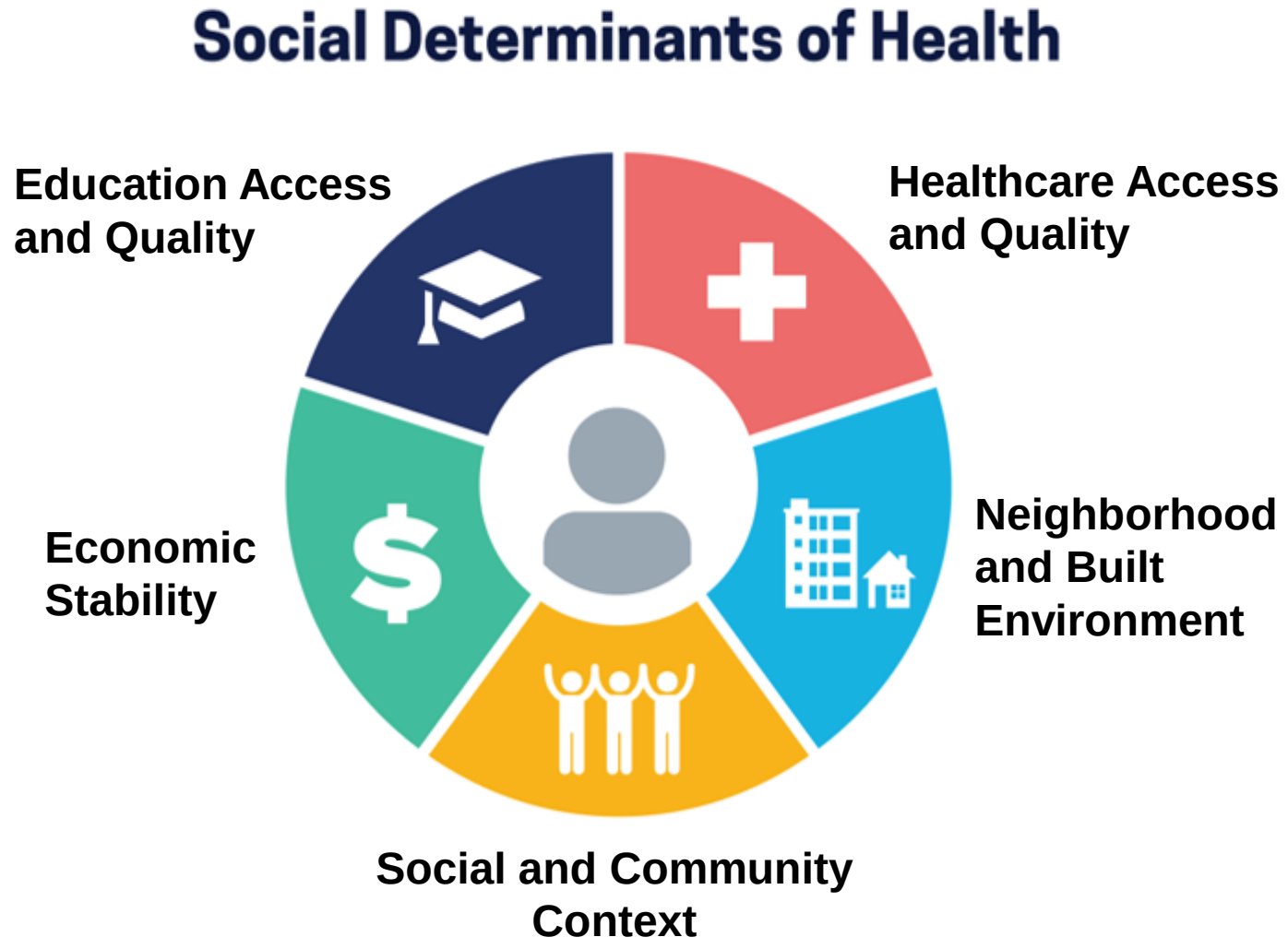
Manager Healthcare Strategy SDoH
LexisNexis Risk - Healthcare

Andrea Green currently assists in the execution of market planning and strategy for the Social Determinants of Health Product solutions. As a licensed registered nurse with a background in clinical informatics, she provides subject matter expertise on insights and use of SDoH data. Prior to joining LexisNexis, Ms. Green worked as a Chief Nursing Informatics Officer at Trinity Health of New England, holding an MBA in Healthcare Administration from Western Governors University.

Contents

- SDoH Overview
- Market and Regulatory trends
- Intersection between Health Equity, SDoH, and Health Disparities

Healthy People 2030



Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved [date graphic was accessed], from https://health.gov/healthypeople/objectives-and-data/social-determinants-health

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Regulatory and Market Drivers

- Standard way to collect and research health disparities and clarification on who can collect data
- Development of the Congressional Social Determinants of Health Caucus
- Expansion of CDC SDOH program
- The Gravity Project

Using Z Codes: The Social Determinants of Health (SDOH) Data Journey to Better Outcomes found here
The Gravity Project Confluence page can be found here

Understanding the Intersection Between Health Equity, SDoH, and Health Disparities

Goal

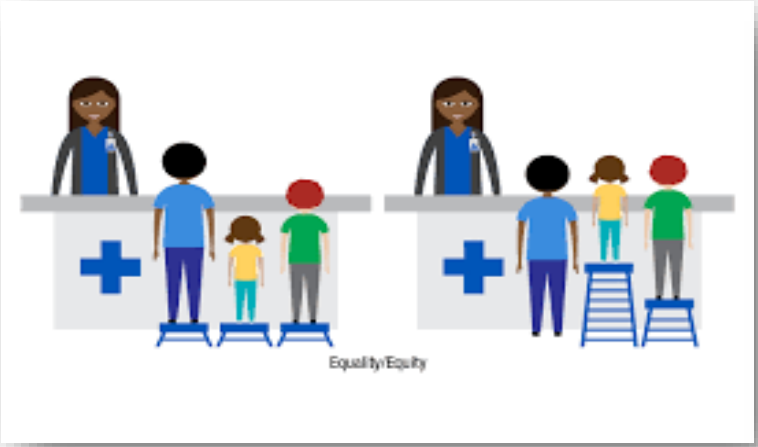
Health equity is achieved when every individual has the opportunity to "attain his or her full health potential."

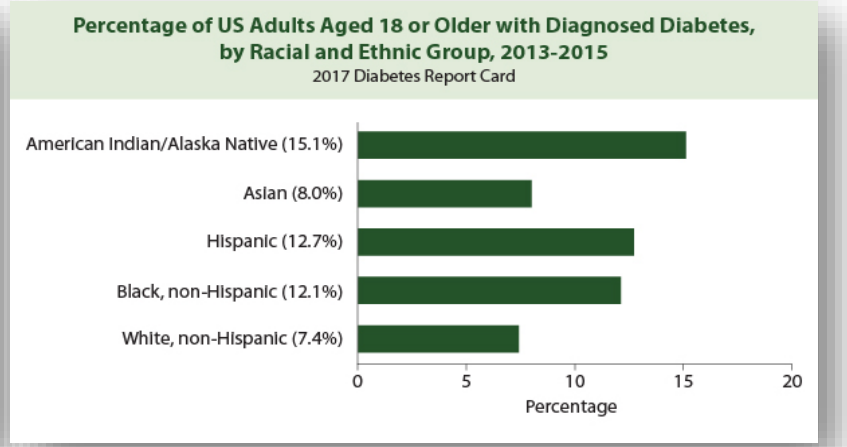
Approach

Social Determinants of Health (SDoH)- "Impacting conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life-risks and outcomes."

Metrics

Health disparity is defined as "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage."





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Resource on ICD-10-CM Coding for Social Determinants of Health, Accessed here

Virtual Mentor. 2013;15(4):283-285. doi: 10.1001/virtualmentor.2013.15.4.fred1-1304. From Medicine's Response to Lifestyle-Related Preventable Illness | Journal of Ethics | American Medical Association (ama-assn.org)

Social Determinants of Health

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Physician SDOH Resources

American Academy of Family Physicians

- The EveryONE Project™
  SDOH Guide to Social Needs Screening
  https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/hops19-physician-guide-sdoh.pdf

Journal of AHIMA

- Improving ICD-10-CM Coding for SDOH
  https://journal.ahima.org/improving-icd-10-cm-coding-for-social-determinants-of-health/

From AHIMA

- Currently, a tremendous amount of healthcare data is captured electronically. The data is used by local, state, and federal agencies for population health reporting, trending, research, and more.
- The clinical documentation from sources other than the provider will assist in the accurate capture of data on social determinants of health. The data provided from the code categories Z55-Z65 may be very important information to collect.
- Any of these social determinants can impact an individual's health; for example, not taking prescribed medications as ordered, lack of follow-up care, or exacerbations of chronic illness.

Official Coding Guidelines

- 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.

- **Patient self-reported documentation may also 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 health 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

National Healthcare for the Homeless Council

- "Consistent use of the codes… can increase opportunities to compare data across systems and raise providers' attention to a high-risk acuity factor as patients (and their medical records) move within and across systems.
- For health centers, standardizing data coding and reporting helps document patient complexity compared to other providers, and can help demonstrate the value of the health center model of care by showing good outcomes for a complex patient population.
- Regular coding also helps ensure providers are not penalized for serving a high-needs, complex population.
- New payment methodologies that include social determinants of health, patient acuity, and other risk factors will become more important to ensure reimbursements and performance metrics accurately reflect the breadth and depth of patient need, services delivered, and actual health outcomes."

https://nhchc.org/wp-content/uploads/2019/08/ask-code-documenting-homelessness-throughout-the-healthcare-system.pdf

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

Example

- An elderly patient new to your practice is underweight and not thriving. After talking with the caregiver and asking about food intake, you determine the patient has food insecurity.
- The appropriate diagnosis codes are:
  - R63.6 Underweight
  - R62.7 Failure to thrive (adult)
  - Z68.1 Body mass index (BMI)19.9 or less, adult
  - Z59.41 Food Insecurity

Coding Tip Sheet

From American Academy of Pediatrics
https://downloads.aap.org/AAP/PDF/SDOH.pdf

- Discussion of addition of SDOH to risk table:

  "If the patient has a documented SDOH that fits this criteria it could potentially lead to a higher level code. This is appropriate as patients with one or more SDOHs may have higher risk for morbidity. This was an important addition to the MDM table for 2021. However, it is strongly advised to not only document how the identified SDOH may impact the diagnosis or treatment, but to also code for it using the many ICD-10-CM codes available for reporting."

What Can We Do?

From the American Hospital Association
https://www.aha.org/system/files/2018-04/value-initiative-icd-10-code-social-determinants-of-health.pdf

- 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."

https://journal.ahima.org/improving-icd-10-cm-coding-for-social-determinants-of-health/

Utilize Tools and Education

- Tools that 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

More Resources

- **CMS Office of Minority Health**
  - Utilization of Z Codes for SDOH among Medicare Fee-For-Service Beneficiaries, 2019 https://www.cms.gov/files/document/z-codes-data-highlight.pdf
  - Using Z Codes: The SDOH Data Journey to Better Outcomes https://www.cms.gov/files/document/zcodes-infographic.pdf
- **National Health Care for the Homeless Council**
  - Ask & Code: Documenting Homelessness Throughout the Health Care System https://nhchc.org/wp-content/uploads/2019/08/ask-code-documenting-homelessness-throughout-the-healthcare-system.pdf
- **The Gravity Project**
  - https://thegravityproject.net/
- **The Centers for Disease Control and Prevention**
  - National Center for Health Statistics ICD-10-CM Browser Tool https://icd10cmtool.cdc.gov/?fy=FY2022

Discussion

We welcome your questions and comments in the Chat.

IPRO Health Equity Team

Have a question? Contact us!

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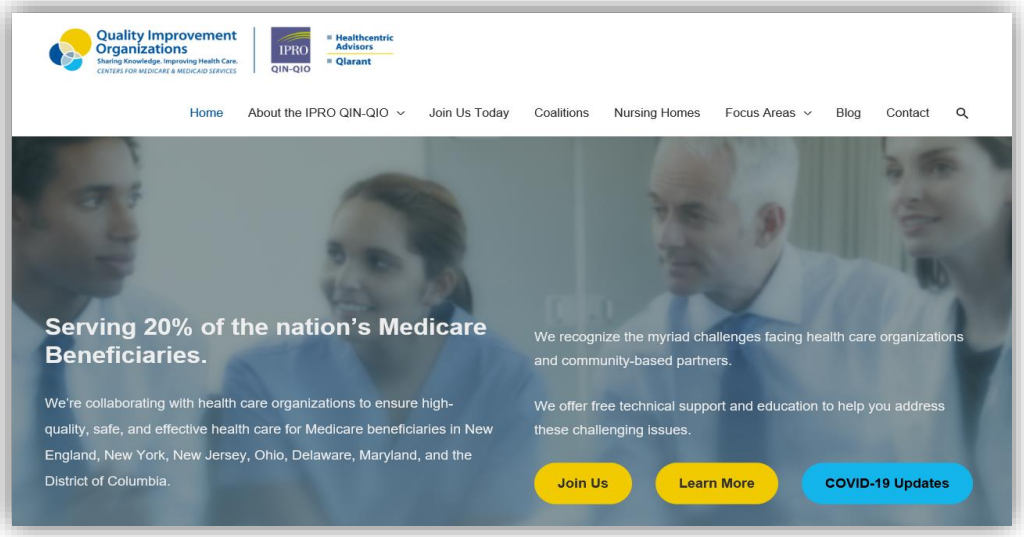

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