Social Determinants of Health and ICD-10 CM Z Codes

GASCO Administration and Business of Oncology Meeting
June 10th, 2022

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Associate Director of Coverage and Reimbursement
Topics

- Data and utilization
- Care delivery
- Practice administration
- ICD-10 CM Z Codes
- Connecting Z codes with CPT codes
Social Determinants of Health:
Data and Utilization
Social Determinants of Health (SDOH)

Conditions of an individual’s **living**, **learning**, and **working** environments that affect one’s health risks and outcomes.

Recognized as **important predictors** in **clinical care** and positive conditions are associated with **improved patient outcomes** and **reduced costs**.

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persons with potential health hazards related to socioeconomic and psychosocial circumstances (Z55-Z65)
ICD-10 CM Z Codes

Identifying patients with SDOH → Reporting Z codes → Improved quality, care coordination, and experience of care

Resource: USING Z CODES: The Social Determinants of Health (SDOH) Data Journey to Better Outcomes

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# Social Determinants of Health (SDOH)

## Data Collection Challenges

<table>
<thead>
<tr>
<th>Current Challenges</th>
<th>Potential Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Lack of a standardized EHR-based screening tool.</td>
<td>▪ Reducing reliance on clinicians to capture SDOH.</td>
</tr>
<tr>
<td>▪ Lack of and multiplicity of codes.</td>
<td>▪ Filling gaps in codes.</td>
</tr>
<tr>
<td>▪ Lack of awareness among providers and medical coders.</td>
<td>▪ Improving provider and medical coder education.</td>
</tr>
</tbody>
</table>

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Among 33.7 million total Medicare FFS beneficiaries in 2019, approximately 1.59% had claims with Z codes.
# Z Codes Utilization among Medicare Fee-for-Service (FFS) Beneficiaries in 2019

## 5 Most Utilized Z codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z59.0</td>
<td>Homelessness</td>
</tr>
<tr>
<td>Z63.4</td>
<td>Disappearance &amp; death of family member</td>
</tr>
<tr>
<td>Z60.2</td>
<td>Problems related to living alone</td>
</tr>
<tr>
<td>Z59.3</td>
<td>Problems related to living in a residential institution</td>
</tr>
<tr>
<td>Z63.0</td>
<td>Problems in relationship with spouse or partner</td>
</tr>
</tbody>
</table>
Z Codes Utilization among Medicare Fee-for-Service (FFS) Beneficiaries in 2019

Race and Ethnicity Group
Medicare FFS Beneficiaries with Z Codes- Overall %
- White 79.5%
- Black and African American 8.8%
- Hispanic 5.9%
- Asian and Pacific Islander 2.7%
- American Indian and Alaska Native 0.6%

Rurality
<table>
<thead>
<tr>
<th>Overall %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
</tr>
<tr>
<td>Rural</td>
</tr>
</tbody>
</table>

Gender
<table>
<thead>
<tr>
<th>Overall %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
</tr>
<tr>
<td>Male</td>
</tr>
</tbody>
</table>

CMS Data Highlight
No. 24  September 2021
Utilization of Z Codes for Social Determinants of Health among Medicare Fee-for-Service Beneficiaries, 2019

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Why is the utilization of these codes low?

- Lack of awareness regarding the codes.
- Difficulty in determining when and how to report the codes.
- Lack of internal processes to incorporate Z codes into the workflow.
- Confusion as to who can (or should) document SDOH.
- Lack of explicit financial incentives for their use.
Social Determinants of Health: Care Delivery
SDOH and Quality Initiatives

ASCO/COA Oncology Medical Home

- Patient Engagement
- Availability & Access to Care
- Evidence-based Medicine
- Equitable and Team-based Care
- Pt Centered Cancer Care
- Quality Improvement
- Goals of Care, Palliative & End of Life Discussions
- Chemotherapy Safety (QCP)
SDOH and Quality Patient Care

**National Comprehensive Cancer Control Program (CDC)**
- Train and maintain a culturally competent workforce.
- Promoting equitable access to resources.

**Accountable Health Communities Model (CMS)**
- Address gaps in clinical care and community services.
- Identify and address health-related social needs.

**Healthy People 2030 (HHS)**
- Access to high-quality health care services.
- Increase both preventive care and cancer screenings.
Practice Administration
Integration and Implementation of SDOH into Cancer Care

Unique factors that vulnerable populations experience because of social and historical discrimination across multiple levels (individual and health care system levels) must be considered.

Social Determinants of Health and Disparities in Cancer Care for Black People in the United States
Reginald D. Tucker-Seeley
JCO Oncology Practice 2021 17:5, 261-263
Connecting Z Codes with SDOH

1. Collect SDOH data-
   Collect SDOH data via health risk assessments, screening tools, person-provider interaction, and self-reporting.

2. Document SDOH data-
   Record data in a patient’s paper or electronic health record.

3. Map SDOH data to Z codes-
   Select the ICD-10 CM Z code(s) that corresponds to the SDOH.

4. Analyze SDOH Z code data findings-
   Add to key reports and share with social service organizations, providers, and health plans.

5. Identify unmet patient needs-
   A “Disparities Impact Statement” may be used to discover opportunities for advancing health equity.

Center for Medicare and Medicare Services: “Using Z Codes: The Social Determinants of Health (SDOH) Data Journey to Better Outcomes”
Achieving Health Equity
Disparities Impact Statement

Using the SDOH and Z code data:

1. Identify health disparities, priority populations, and needs.
2. Define goals and targets.
3. Establish a health equity strategy.

Source: CMS Disparities Impact Statement
Updated March 2021
Addressing SDOH is a continuous process.

- **Identify patients with SDOH.**
- **Connect SDOH with Z codes.**
- **Link practice processes for SDOH to the appropriate CPT codes.**
- **Evaluate progress and goals.**
Social Determinants of Health: ICD-10 CM Z Codes
## ICD-10 CM Z Codes

<table>
<thead>
<tr>
<th>Category</th>
<th>Category Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z55</td>
<td>Problems related to education and literacy</td>
</tr>
<tr>
<td>Z56</td>
<td>Problems related to employment and unemployment</td>
</tr>
<tr>
<td>Z57</td>
<td>Occupational exposure to risk factors</td>
</tr>
<tr>
<td>Z58</td>
<td>Problems related to physical environment</td>
</tr>
<tr>
<td>Z59</td>
<td>Problems related to housing and economic circumstances</td>
</tr>
<tr>
<td>Z60</td>
<td>Problems related to social environment</td>
</tr>
<tr>
<td>Z62</td>
<td>Problems related to upbringing</td>
</tr>
<tr>
<td>Z63</td>
<td>Other problems related to primary support group, including family circumstances</td>
</tr>
<tr>
<td>Z64</td>
<td>Problems related to certain psychosocial circumstances</td>
</tr>
<tr>
<td>Z65</td>
<td>Problems related to other psychosocial circumstances</td>
</tr>
</tbody>
</table>

Chapter 21 - Factors Influencing Health Status and Contact with Health Services

“Persons with potential health hazards related to socioeconomic and psychosocial circumstances (Z55-Z65)”

Source: 2022 ICD-10 CM
## ICD-10 CM Z Codes

### Z59 Problems related to housing and economic circumstances

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z59.0</td>
<td>Homelessness</td>
</tr>
<tr>
<td>Z59.00</td>
<td>Homelessness, unspecified</td>
</tr>
<tr>
<td>Z59.01</td>
<td>Sheltered homelessness</td>
</tr>
<tr>
<td>Z59.02</td>
<td>Unsheltered homelessness</td>
</tr>
<tr>
<td>Z59.1</td>
<td>Inadequate housing</td>
</tr>
<tr>
<td>Z59.2</td>
<td>Discord with neighbors</td>
</tr>
<tr>
<td>Z59.3</td>
<td>Problems related to living in residential institution</td>
</tr>
<tr>
<td>Z59.4</td>
<td>Lack of adequate food</td>
</tr>
<tr>
<td>Z59.41</td>
<td>Food insecurity</td>
</tr>
<tr>
<td>Z59.48</td>
<td>Other specified lack of adequate food</td>
</tr>
<tr>
<td>Z59.5</td>
<td>Extreme poverty</td>
</tr>
<tr>
<td>Z59.6</td>
<td>Low income</td>
</tr>
<tr>
<td>Z59.7</td>
<td>Insufficient social insurance and welfare support</td>
</tr>
<tr>
<td>Z59.8</td>
<td>Other problems related to housing and economic circumstances</td>
</tr>
<tr>
<td>Z59.81</td>
<td>Housing instability, housed</td>
</tr>
<tr>
<td>Z59.811</td>
<td>Housing instability, housed, with risk of homelessness</td>
</tr>
<tr>
<td>Z59.812</td>
<td>Housing instability, housed, homelessness in past 12 months</td>
</tr>
<tr>
<td>Z59.819</td>
<td>Housing instability, housed unspecified</td>
</tr>
<tr>
<td>Z59.89</td>
<td>Other problems related to housing and economic circumstances</td>
</tr>
<tr>
<td>Z59.9</td>
<td>Problem related to housing and economic circumstances, unspecified</td>
</tr>
</tbody>
</table>
ICD-10 CM Z Codes: Reporting Guidelines

Z55-Z65 identify issues related to a patient’s socioeconomic situation and are not procedural in nature.

The Z codes must be accompanied by a procedure code (CPT, HCPCS, ICD-10 PCS).

The Z codes do not have to be the principal or first-listed diagnosis (primary reason for the visit).
ICD-10 CM Z Codes: Reporting Guidelines

Who can document SDOH and their corresponding Z code(s)?

- Case Manager
- Social Worker
- Discharge Planner
- Clinical Staff
- Patient (self-reporting or screening tool)
NCCN Distress Thermometer

Patient Self-Reporting SDOH

Connecting SDOH to Z Codes

Example

1. The patient indicates on the “NCCN Distress Thermometer” they are experiencing significant stress regarding medical expenses (they do not have medical insurance) and covering rent. They are also currently unemployed.

2. Go to chapter 21 in the ICD-10 CM manual and then “Persons with potential health hazards related to socioeconomic and psychosocial circumstances” (Z55-Z65).

3. Under the headings Z59- “Problems related to housing and economic circumstances” and Z56- “Problems related to employment and unemployment” select the codes that most accurately describe the patient’s indicated SDOH.
# Connecting SDOH to Z Codes

<table>
<thead>
<tr>
<th>NCCN Distress Thermometer: Practical Concerns</th>
<th>ICD-10 CM Z Codes: Persons with potential health hazards related to socioeconomic and psychosocial circumstances</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Insurance</td>
<td>Z59.81 Housing instability, housed</td>
</tr>
<tr>
<td>✓ Housing</td>
<td>Z59.7 Insufficient social insurance and welfare support</td>
</tr>
<tr>
<td>✓ Work</td>
<td>Z56.0 Unemployment, unspecified</td>
</tr>
</tbody>
</table>

### Don’t forget!
- Code to the highest level of specificity.
- Include other relevant diagnoses in the claim and medical record.
- The Z code must be accompanied by a HCPCS, CPT, or ICD-PCS code.
Social Determinants of Health: Connecting Z codes and CPT® Codes
CPT ® Codes for Addressing SDOH

Evaluation and Management Services

Prolonged Evaluation and Management Services

Care Management Services

• Chronic care management
• Complex chronic care management
• Principal care management

Transitional Care Management Services
CPT Codes and Services
Addressing SDOH

Evaluation and Management Services
CPT® codes 99202-99215 (office/outpatient); 99221-99223, 99231-99239 (hospital/inpatient)

Evaluating, assessing, and managing a new or established patient on a single date of service.

MDM
- A Z code may justify and support medical decision making and medical necessity.
- Moderate risk of morbidity from additional diagnostic testing or treatment
  - Diagnosis or treatment significantly limited by social determinants of health

Time
- Face to face and non face to face activities can account for work associated with addressing SDOH.
  - Obtaining and/or reviewing separately obtained history
  - Counseling and educating the patient/family/caregiver
  - Referring and communicating with other health care professionals (when not separately reported)
  - Care coordination (not separately reported)
Prolonged Evaluation and Management Services
HCPCS and CPT® codes: G2212 or 99417 (15- minute, same day), 99358 and 99359 (1+ hour, different day), 99415 and 99416 (1+ hours, clinical staff)

Time in addition to a primary E/M service.

- Z code may support the additional time needed (in addition to the primary E/M) working with patients who have a SDOH.
- G2212/99417 and 99358/99359 includes non face to face activities.
CPT Codes and Services
Addressing SDOH

Care Management Services
CPT® codes 99490, 99439, 99491, 99437 (chronic care mgmt.); 99487-99489 (complex chronic care mgmt.); 99426, 99427, 99424, 99425 (principal care mgmt).

Management and support services for patients with a single high-risk condition or multiple conditions over a calendar month.

- Addressing a patient's SDOH may be part of the care plan required as part of a care management service in addition to work performed by the physician/QHP or clinical staff.

- Includes communication and coordination with home- and community-based clinical service providers. Also accounts for non face to face communication with the patient/family/caregiver.

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CPT Codes and Services
Addressing SDOH

Transitional Care Management Services
CPT ® codes 99495 and 99496

Management of patients discharged or transitioned from a hospital/facility setting to home/community setting over 29 days.

- A Z code will indicate whether a patient may require attention to psychosocial needs and ADL support.
- Services include both face to face and non face to face activities.
- Activities may consist of coordination of care with community service agencies, follow ups, and referrals.
## CPT Code Comparison

<table>
<thead>
<tr>
<th>Evaluation and Management Services</th>
<th>Care Management Services</th>
<th>Transitional Care Management Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ May be reported based on time or medical decision making.</td>
<td>▪ <strong>Time based</strong> CPT codes.</td>
<td>▪ <strong>Time based</strong> CPT codes.</td>
</tr>
<tr>
<td>▪ <strong>Date of service</strong> activities only.</td>
<td>▪ Accounts for time over a <strong>calendar month</strong> (not date of service).</td>
<td>▪ Accounts for time over <strong>29 days</strong>.</td>
</tr>
<tr>
<td>▪ Time includes <strong>face to face and non face to face activities</strong>.</td>
<td>▪ Time includes <strong>face to face and non face to face activities</strong>.</td>
<td>▪ Time includes <strong>face to face and non face to face activities</strong>.</td>
</tr>
<tr>
<td></td>
<td>▪ May only be reported by <strong>one provider per beneficiary</strong> per calendar month (exception may be made for PCM services).</td>
<td>▪ May only be reported by <strong>one provider per beneficiary</strong>.</td>
</tr>
</tbody>
</table>
For full CPT code descriptions and guidelines refer to the AMA CPT® Professional Edition 2022.
Resources

American Society of Clinical Oncology

Health Equity

ASCO has developed a wide range of resources to help its members and the larger cancer community better understand and address health equity issues in cancer research and care.

Centers for Medicare and Medicaid Services

Equity Initiatives

The CMS Office of Minority Health has designed several initiatives to eliminate disparities in health care quality and access, so that all CMS beneficiaries can achieve their highest level of health.

National Comprehensive Cancer Network (NCCN)

NCCN Guidelines Version 1.2022- Distress Management
Resources

National Comprehensive Cancer Control Program (CDC)

CDC’s National Comprehensive Cancer Control Program (NCCCP) has provided the funding, guidance, and technical assistance that programs use to design and implement impactful, strategic, and sustainable plans to prevent and control cancer.

Accountable Health Communities Model (CMS)

The Accountable Health Communities Model addresses a critical gap between clinical care and community services in the current health care delivery system by testing whether systematically identifying and addressing the health-related social needs of Medicare and Medicaid beneficiaries through screening, referral, and community navigation services will impact health care costs and reduce health care utilization.

Healthy People 2030 (HHS)

Healthy People 2030 sets data-driven national objectives to improve health and well-being over the next decade.
Questions and Discussion

Questions regarding Z codes or any other billing/coding questions may be sent to ASCO staff at practice@asco.org.