

Social Determinants of Health

December 2020 Provider Education

New AMA Coding Guidelines

New [AMA coding guidelines](#), effective 1/1/2021, will allow providers to use ICD-10-CM Z55-Z65 Social Determinants of Health (SdoH) codes as a reason for moderate risk under Medical Decision Making (MDM) when coding E/M for office or other outpatient services. According to the new guidelines examples of “Diagnosis or treatment significantly limited by social determinants of health” may be a deterrent factor in MDM,

“Moderate risk of morbidity from additional diagnostic testing and treatment.” National Government Services (NGS) will be providing further information on the new AMA coding guidelines over the next several months. Please visit the Education tab on [our website](#) for upcoming events. We compiled the following resources to help prepare you for the new coding guidelines.



Social Determinants Contribute Significantly to Beneficiaries' Healthcare Outcomes

Federal agencies such as the Centers for Disease Control and Prevention (CDC) recognize that clinical care contributes only a fraction toward the patient's health outcomes. Larger contributing factors to positive health outcomes include individual genetics, beneficiary actions and choices to stay healthy such as exercising, not smoking and social factors such as access to healthy food. SDoH have long been studied and clinical journal articles substantiate the role that social determinants play in managing whole person care. Research findings indicate that SDoH programs lower health care costs and result in fewer emergency department and inpatient admissions and readmissions.

Addressing Social Determinants Helps Improve Outcomes for Beneficiaries

Discussing social determinants with your patients is the first step in helping to address social risks. There are resources and toolkits available to assist providers with understanding the SDoH ICD-10-CM Z55-Z66 codes to ensure appropriate coding is used.

Helping Beneficiaries Address Gaps in Social Determinants of Health

Gaps in food security, housing, etc. may be found after assessing patients' SDoH status. The following are some resources which can help providers try to mitigate these gaps:

- [Aunt Bertha](#) is a free resource that helps to locate support services including: food pantries, residential housing assistance, transportation and other assistance. Information is quick and easy to use. Simply enter the beneficiary's zip code. Aunt Bertha also offers help with COVID-19 resources during the PHE.
- The NGS March 2020 edition of the [Social Determinants of Health](#) discusses screening tools and includes links to the AMA and hospital toolkits to help providers screen for, code and address gaps in social determinants.

- The [AMA Ed Hub](#) has information about how to assess SDoH at the patient level and how to link patients to SDoH resources, such as the 211-Essential Community Services Program which is available throughout the country.
- The [American Hospital Association: SDoH Food Insecurity and the Role of Hospitals](#) has examples of hospital solutions to food insecurity.
- The [CDC](#) has a list of tools and resources which can help practitioners take action to address SDoH.
- The [American Academy of Family Physicians Neighborhood Navigator](#) helps provide next steps for improving social determinants of patient's health.
- CMS through their [Accountable Health Communities Model](#) has developed the [Accountable Health Communities Health Related Social Needs Screening](#) tool consisting of ten questions related to; housing stability, food insecurity, transportation problems, utility help needs and interpersonal safety.
- The National Association of Community Health Centers (NACHC) developed the [Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences \(PRAPARE\)](#) tool for providers to help health centers and other providers collect the data needed to better understand and act on their patients' social determinants of health. NACHC worked with EHR vendors and Health Center Controlled Networks to create PRAPARE EHR templates that are freely available to users. They currently have free PRAPARE templates and configuration/implementation guides for Cerner, Epic, eClinicalWorks, GE Centricity and NextGen and an excel template for providers to utilize.
- Health Leads developed a [Social Screening Toolkit](#) in 2016, which was updated in 2018 to identify and screen patients for adverse social determinants of health.

SDoH in NGS's Jurisdiction 6 and Jurisdiction K

To better understand the impact of SDoH for Medicare beneficiaries within NGS jurisdictions, we looked at hospital/provider utilization and chronic conditions within rural and non-rural areas. The results of our analysis were:

- Regardless of whether the beneficiary lived in a rural or non-rural area, social determinants were a significant factor for increased utilization of services.
- Beneficiaries with documented social determinants living in rural communities had a slightly higher total Part A cost while beneficiaries with documented social determinants living in non-rural communities had higher Part B physician services costs and higher ED claims.
- A consistent finding was the lack of SDoH documentation on the beneficiaries' claim, SDoH codes are underreported.
- Looking at the differences between rural and non-rural areas, beneficiaries living in a rural area with a social risk have higher rates of acquired hyperthyroidism, acute myocardial infarction, Alzheimer's Disease and related disorders, atrial fibrillation, cataracts, COPD, bronchiectasis, heart failure, hip/pelvic fracture, hypertension, ischemic heart disease and rheumatoid arthritis when compared beneficiaries who live in a non-rural area with a social risk. Beneficiaries living in non-rural communities that have a social risk are more affected by anemia, asthma, chronic kidney disease, depression and diabetes.

Research References

- A study in Health Affairs, [Meal Delivery Programs Reduce the Use of Costly Health Care in Dually Eligible Medicare and Medicaid Beneficiaries](#), looked at significant reductions in utilization and cost savings.
- [JAMA Research: Association Between Receipt of a Medically Tailored Meal Program and Health Care Use](#)
- [CMS Fact Sheet: Accountable Health Communities Model](#)
- [CNBC: Diabetes defeated by diet: How new fresh-food prescriptions are beating pricey drugs](#)
- [Kaiser Permanente Research: Social Needs in America](#)
- [American Hospital Association: Social Determinants of Health Series: Food Insecurity and the Role of Hospitals](#)

How to Document Social Determinants of Health

Below are the SDoH categories from Chapter 21 of ICD-10-CM, Persons with Potential Health Hazards related to Socioeconomic and Psychosocial Circumstances:

- Z55 - Problems related to education and literacy
 - Illiteracy/low-level, schooling availability, failing school, underachievement, discord with teachers
- Z56 - Problems related to employment and unemployment
 - Changing of job, losing job, no job, stressful work schedule, discord with boss/coworkers, bad working conditions
- Z57 - Occupational exposure to risk factors
 - Noise, radiation, dust, other air contaminants, tobacco, toxic agents in farming, extreme temperatures, vibration, others
- Z59 - Problems related to housing and economic circumstances
 - Homeless, inadequate housing, discord with neighbors/landlord, problems with residential living, lack of adequate food/safe drinking water, poverty, low income, insufficient social insurance/welfare support
- Z60 - Problems related to social environment
 - Adjustment to life-cycle transitions, living alone, cultural differences, social exclusion and rejection, discrimination/persecution
- Z62 - Problems related to upbringing
 - Inadequate parental supervision/control, parental overprotection, upbringing away from parents, child in custody, institutional upbringing (orphan or group home), hostility towards child, inappropriate/excessive parental pressure, child abuse including history of (physical and/or sexual), neglect, forced labor, child-parent conflict
- Z63 - Other problems related to primary support group, including family circumstances
 - Spousal conflict, in-law conflict, absence of family member (death, divorce, deployment), dependent relative needing care, family alcoholism/drug addiction, isolated family
- Z64 - Problems related to certain psychosocial circumstances
 - Unwanted pregnancy, multiparity, discord with counselors
- Z65 - Problems related to other psychosocial circumstances
 - Civil/criminal convictions, incarceration, problems after release from prison, victim of crime, exposure to disaster/war, religious persecution