

A blue-tinted landscape featuring a city skyline on the left, a winding river or lake in the center, and mountains in the background. The scene is rendered in various shades of blue, creating a serene and professional atmosphere.

# Social Risk Coding & Documentation

Training Module  
August 2021

# Introductions



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# Learning Objectives

By the end of this session, learners will be able to...

1. Describe opportunities to identify social risk and advance equity using the new E/M coding guidelines
2. List specific ways to code social risk using the new coding guidelines
3. Identify ways in which social risk coding can help improve care, advance equity, and access revenue

# Key questions we'll address today

1. What are the new E/M Coding Guidelines and why do they matter for patients' social needs and health equity?
2. How can my practice code for social risk using the new coding guidelines?
3. What are simple steps my practice can take to use the social risk information we capture with the new coding guidelines to improve care, advance equity, and access revenue?

# 2021 E/M Coding Guidelines

What are the new E/M Coding Guidelines and why do they matter for patients' social needs and health equity?

# Why coding matters

- Medical coding takes information about diagnoses, treatments, procedures, medications and equipment and translates them into alphanumeric codes.
- Coding helps create a more complete picture of the complexity of a patient's health.
- Coding is key to a practice's financial success.
  - Under value-based programs, coding can also lead to appropriately higher reimbursement to cover the costs of treating patients.



# While many clinics are now screening for social needs, they may not be capturing or using that information well

- ICD-10-CM codes Z55-Z65 (“Z codes”) identify non-medical factors that may influence a patient’s health status.
- Any clinician or care team member can document a social need
- Many clinics and hospitals still don’t routinely use “Z-codes” to code social needs

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

**What are Z codes** SDOH-related Z codes ranging from Z55-Z65 are the ICD-10-CM encounter reason codes used to document SDOH data (e.g., housing, food insecurity, transportation, etc.). SDOH are the conditions in the environments where people are born, live, learn, work, play, and age.

**Step 1 Collect SDOH Data**  
**Any member of a person's care team can collect SDOH data** during any encounter.

- Includes providers, social workers, community health workers, case managers, patient navigators, and nurses.
- Can be collected at intake through health risk assessments, screening tools, person-provider interaction, and individual self-reporting.

**Step 2 Document SDOH Data**  
**Data are recorded in a person's paper or electronic health record (EHR).**

- SDOH data may be documented in the problem or diagnosis list, patient or client history, or provider notes.
- Care teams may collect more detailed SDOH data than current Z codes allow. These data should be retained.
- Efforts are ongoing to close Z code gaps and standardize SDOH data.

**Step 3 Map SDOH Data to Z Codes**  
**Assistance is available from the ICD-10-CM Official Guidelines for Coding and Reporting.<sup>1</sup>**

- Coding, billing, and EHR systems help coders assign standardized codes (e.g., Z codes).
- Coders can assign SDOH Z codes based on self-reported data and/or information documented in an individual's health care record by any member of the care team.<sup>2</sup>

**Step 4 Use SDOH Z Code Data**  
**Data analysis can help improve quality, care coordination, and experience of care.**

- Identify individuals' social risk factors and unmet needs.
- Inform health care and services, follow-up, and discharge planning.
- Trigger referrals to social services that meet individuals' needs.
- Track referrals between providers and social service organizations.

**Step 5 Report SDOH Z Code Data Findings**  
**SDOH data can be added to key reports** for executive leadership and Boards of Directors to inform value-based care opportunities.

- Findings can be shared with social service organizations, providers, health plans, and consumer/patient advisory boards to identify unmet needs.
- A **Disparities Impact Statement** can be used to identify opportunities for advancing health equity.

**CMS**  
CENTERS FOR MEDICARE & MEDICAID SERVICES

**For Questions:** Contact the **CMS Health Equity Technical Assistance Program**

<sup>1</sup> cms.gov/medicare/icd-10/2021-icd-10-cm  
<sup>2</sup> aha.org/system/files/2018-04/value-initiative-icd-10-code-social-determinants-of-health.pdf

# What's new: The 2021 E/M Coding Guidelines

- The AMA and Centers for Medicare & Medicaid Services (CMS) deployed landmark E/M office visit code changes on Jan. 1, 2021
  - This is the first overhaul of evaluation and management (E/M) office visit documentation and coding in almost 30 years.
- The goals of the new E/M Coding Guidelines are:
  - Decrease documentation burden and note bloat
  - Make code level selection more intuitive
  - To decrease the need for audits, through the addition and expansion of key definitions
  - Retain current code distribution
- **Key takeaway:** Code level should be based on clinician work in managing the patient's problem(s) with focus on decision making, not simply on volume of tests/treatments



# Coding based on time & medical decision making

- Clinicians and coders now have two choices to select from when deciding E/M visit levels
  - By determining the complexity of **Medical Decision-Making (MDM)** OR
  - Based on **Total time** on the date of the encounter (not just time spent in the encounter)
- Understanding how to appropriately document a visit to code and bill based on the complexity of your **MDM** can result in a higher level of compensation
  - There are four levels of complexity – straightforward, low, moderate, high – each correlated with different E/M visit levels
- When determining level of complexity, clinicians and coders must consider:
  - Problem: Number & complexity of problems addressed at encounter
  - Data : Amount and/or complexity of data reviewed and analyzed
  - Management Risk\*: Risk of complications or morbidity/mortality of patient management.
    - \*Capturing social needs/risk data is important here. **Is diagnosis or treatment limited by an identified social risk?**

# Why does this matter for social needs & equity?

- The 2021 E/M coding guidelines create opportunities to advance **health equity** by:
  - Improving the capture and consideration of **patient social risk data**, especially related to medical decision-making.
  - Paving the way for incentives to better support health-social care integration & practice-level equity work related to social needs.
- How?
  - The E/M coding guidelines allow providers to use ICD-10-CM Z55-Z65 SDoH codes as a reason for “moderate risk” under Medical Decision Making (MDM) when coding for office or other outpatient services.
- But...
  - If clinicians and coders implement these guidelines without an un explicit focus on health equity, they *may either miss opportunities to reduce health inequities*, including racial health inequities or, even worse, may inadvertently *exacerbate* them.

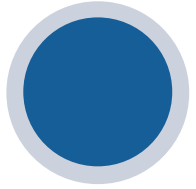
# Capturing Social Risk Information

How can my practice code for social risk using the new coding guidelines?

# Why collect social risk/ social need data?

- To better identify the complexity of a patient's health status
- To support clinicians and care teams to adjust patient care and improve quality of care
- To better identify patterns of health inequities, including racial health inequities
- To inform population health management approaches to address social and structural drivers of health equity
- To support preparation for and capacity to perform in VBP models that ask for social risk data

# 1. Define your social need screening strategy

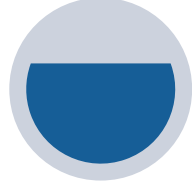


## Universal

Delivered to broad populations without consideration of individual differences in risk for specific needs

Aligned with primary prevention strategies

Example: Screen all children once a year for unmet social needs

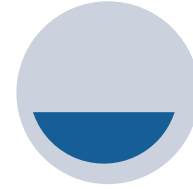


## Selective

Delivered to target sub-groups of individuals identified on the basis of their membership in a group that has an elevated risk for developing specific needs/issues

Aligned with secondary prevention strategies

Example: Screen children from 3 local census tracts with highest social vulnerability for unmet social needs at least twice a year



## Indicated

Tailored design and interventions to address specific risk conditions that are already appearing

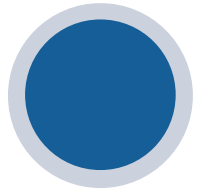
Aligned with tertiary prevention strategies

Example: Screen adolescents with poor grades, anxiety or repeat ER visits for unmet social needs at least once every 3 months



## 2. Decide where to start: Screen for 1-2 social needs or all?

Example of a FQHC with a social needs screening currently focused on: **food insecurity**

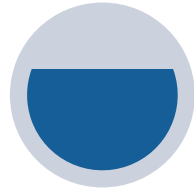


### Universal

Delivered to broad populations without consideration of individual differences in risk for specific needs

Aligned with primary prevention strategies

Example: Screen all children once a year for **food insecurity**

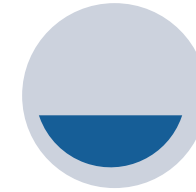


### Selective

Delivered to target sub-groups of individuals identified on the basis of their membership in a group that has an elevated risk for developing specific needs/issues

Aligned with secondary prevention strategies

Example: Screen children from 3 local census tracts with highest social vulnerability at least twice a year for **food insecurity**



### Indicated

Tailored design and interventions to address specific risk conditions that are already appearing

Aligned with tertiary prevention strategies

Example: Screen adolescents with poor grades, anxiety or repeat ER visits for **food insecurity** at least once every 3 months

# 3. Identify opportunities to collect social needs data

**TABLE 5.2. Summary of PRAPARE Workflow Models and Response**

WHO	WHERE	WHEN	HOW
<b>NON-CLINICAL STAFF</b> (Patient Advocates, Patient Navigators, Community Health Workers, etc.)	In patient advocate's office	After clinical visit	Administered PRAPARE and responded to needs identified. Discussed needs with provider and care team.
<b>NON-CLINICAL STAFF</b> (outreach and enrollment staff, eligibility assistance staff, etc.)	In waiting room	Before provider visit	Administered PRAPARE with patients who would be waiting 30+ minutes for provider
<b>CLINICAL STAFF</b> (nurses, medical assistants, etc.)	In exam room	Before provider enters exam room	Administered PRAPARE after vitals and reason for visit. Provider reviews data to inform treatment plan
<b>CARE COORDINATORS</b>	In care coordinator's office	When completing Health Risk Assessments	Administered PRAPARE in conjunction with Health Risk Assessments to address similar needs in real time

**TABLE 5.2. Summary of PRAPARE Workflow Models and Response**

WHO	WHERE	WHEN	HOW
<b>CHRONIC DISEASE MANAGEMENT TEAM</b>	In exam room	During the clinical visit	Administered PRAPARE with patients and discussed needs as a team to develop appropriate response and care management plan
<b>INTERPRETERS</b>	In waiting room or exam room	Before the clinical visit	Administered PRAPARE with patients requiring language assistance.
<b>ANY STAFF</b> (from front desk staff to providers)	"No Wrong Door" approach	"No Wrong Door" approach	"No Wrong Door" approach where any staff can ask PRAPARE questions at any time to paint fuller picture of patient
<b>SELF-ASSESSMENT</b>	In waiting room or at home	Before the clinical visit	Patient self-assesses using paper version of PRAPARE or Ipads, kiosks, tablets, email, patient portal, etc.

# Tools to create your social need workflows

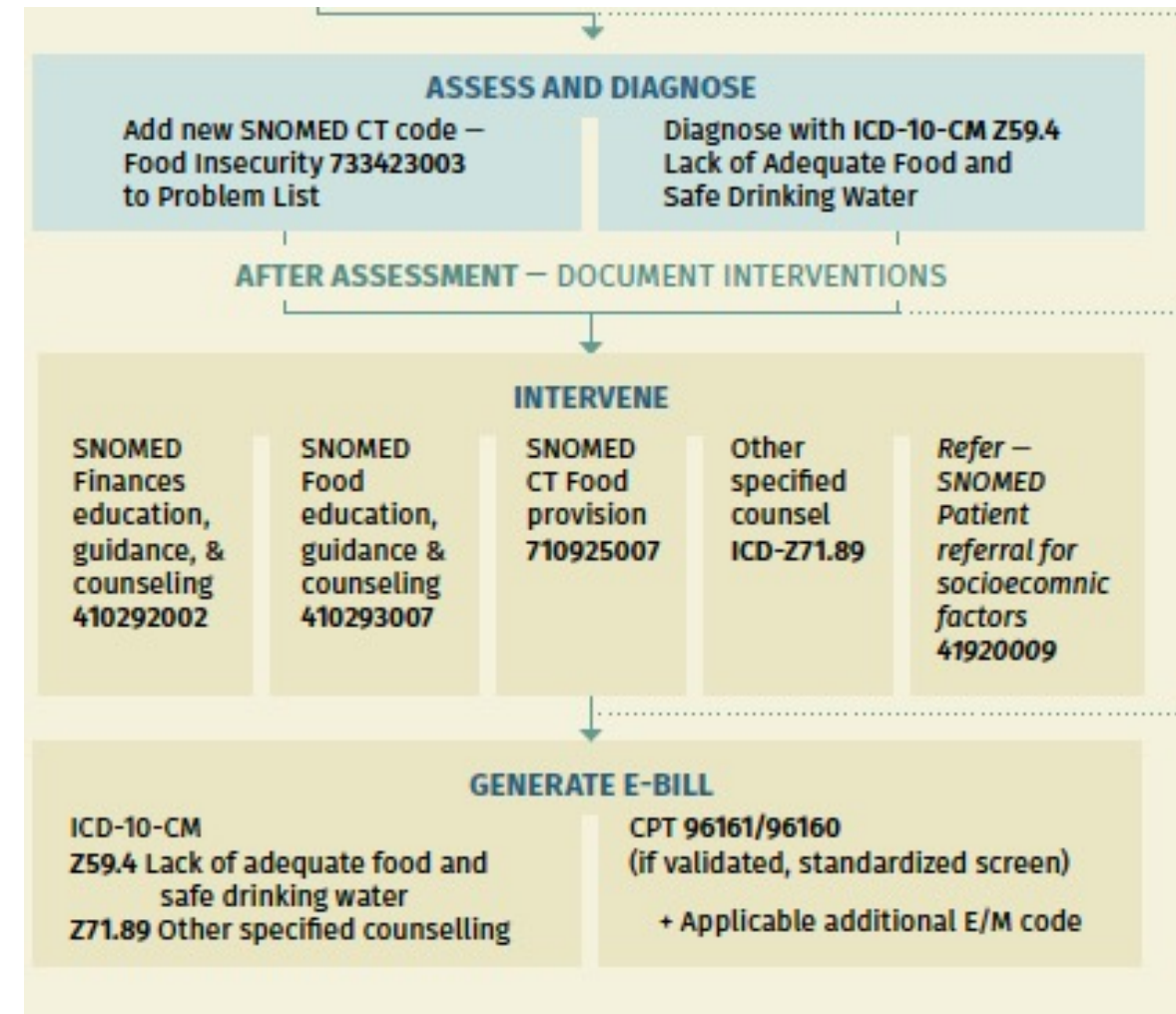
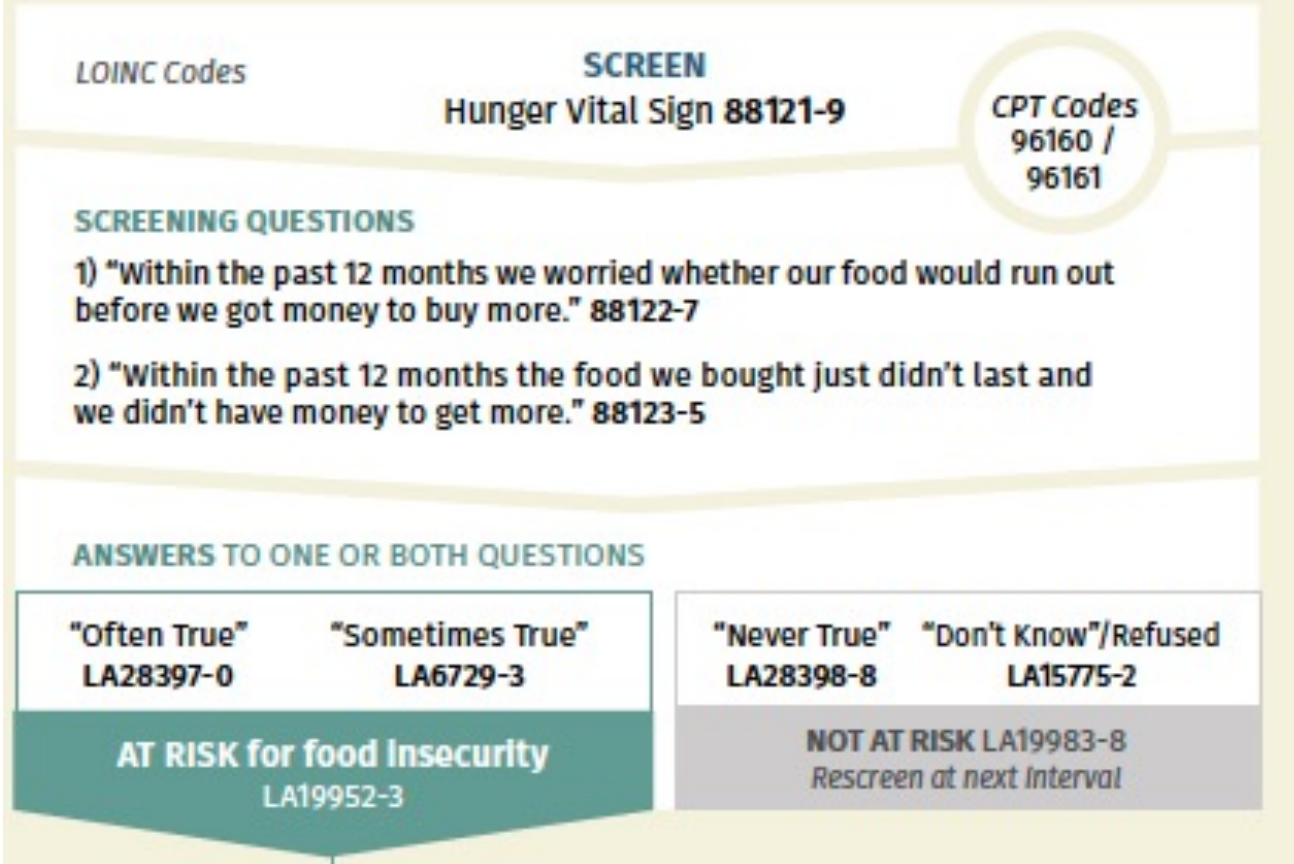
HealthBegins Workflow Template	Care Team Member	Role/ Process	Tools/ Data Source	Metric
Workflow improvement oversight				
<b><u>Pre-visit</u></b>				
<b><u>Screen</u></b>				
<b><u>Triage</u></b>				
<b><u>Exam</u></b>				
<b><u>Chart/Code</u></b>				
<b><u>Bill</u></b>				
<b><u>Refer</u></b>				
<b><u>Post-visit</u></b>				

HealthBegins Workflow Template (e.g. food insecurity)	Care Team Member	Role/ Process	Tools/ Data Source	Metric
Responsibility for workflow improvement	Upstream QI committee	Project Team oversees & tracks PDSAs	Upstream QI Project Charter	# QI team participation # PDSAs
<b><u>Pre-visit</u></b>	Patient	Patients receive automated info on food resources	Automated SMS / phone calls	# Message open rate
<b><u>Screen</u></b>	Medical Assistant	Ask during vitals of target population	Hunger Vital Sign	% screened
<b><u>Triage</u></b>	Medical Assistant	Flag in EMR	Triage Protocol	% positive % flagged
<b><u>Exam</u></b>	PCP	Review / Adjust care plan if food insecure	EMR autopopulates Problem List	% plans updated
<b><u>Chart/Code</u></b>	PCP, Medical Assistant, Coder	Scribe/ standing order to refer to SW and/or CBO Code social need	EMR ICD-10 z codes 2021 E/M coding	% referrals % coded correctly
<b><u>Bill</u></b>	Billing staff	Submit for reimbursement as needed	2021 E/M coding	% visits billed
<b><u>Refer</u></b>	Social Worker, CHW, and/or RN	Assess need (SW or CHW) Food bank referral	Online community resource database	% referred
<b><u>Post-visit</u></b>	Social Worker, CHW, and/or RN	Phone/SMS or in-person check-in Pop health management	EMR SMS/ Phone calls	% decrease in food insecurity & utilization



# Flow of Food Insecurity Coding in an Office Visit

## EXISTING Opportunities



DeSilvey, S., Ashbrook, A., Sheward, R., Hartline-Grafton, H., Ettinger de Cuba, S., & Gottlieb, L. (2018). An Overview of Food Insecurity Coding in Health Care Settings: Existing and Emerging Opportunities. Boston, MA: Hunger Vital Sign™ National Community of Practice. Available at: <http://childrenshealthwatch.org/foodinsecuritycoding/>



## 4. Document social needs with the Z codes

- **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

# 5. Document when social needs impact management risk using the new coding guidelines

The new coding guidelines state that *“Diagnosis or treatment significantly limited by social determinants of health”* may be a factor in determining *“Moderate risk of morbidity from additional diagnostic testing and treatment.”*

TODAY'S PROBLEM LEVEL <i>(Circle one)</i> LEVEL: 2 3 4 5	TODAY'S DATA LEVEL <i>(Circle one)</i> LEVEL: 2 3 4 5	TODAY'S RISK LEVEL <i>(Circle one)</i> LEVEL: 2 3 4 5	TODAY'S TIME TOTAL TIME ON DOS: _____
Number & Complexity of problems addressed	Amount and/or Complexity of Data Each unique test, order, or document contributes to a combination of 2 or of 3 in Category 1 below.	Risk of morbidity from additional diagnostic testing or treatment	Time See reverse side for time calculation tool based on activities
<b>LEVEL 2</b> 1 self-limited or minor problem	<b>LEVEL 2</b> Minimal or none	<b>LEVEL 2</b> Minimal risk	<b>LEVEL 2</b> 15-29 mins NEW: 99202 10-19 mins EST: 99212
<b>LEVEL 3</b> <ul style="list-style-type: none"> <li>2 or more self-limited or minor problems; <b>or</b></li> <li>1 stable chronic illness; <b>or</b></li> <li>1 acute, uncomplicated illness or injury</li> </ul>	<b>LEVEL 3</b> <i>One category required</i> <b>CATEGORY 1:</b> <i>Any 2 from the following:</i> <ul style="list-style-type: none"> <li>Review of <b>prior external note(s) from each unique source;</b></li> <li>Ordering of <b>each unique test or</b></li> <li>Review of the <b>result(s) of each unique test;</b></li> </ul> <b>CATEGORY 2:</b> <ul style="list-style-type: none"> <li>Assessment requiring an independent historian(s)</li> </ul> <i>For independent interpretation and discussion of management or test interpretation, see Level 4 or 5.</i>	<b>LEVEL 3</b> Low risk	<b>LEVEL 3</b> 30-44 mins NEW: 99203 20-29 mins EST: 99213
<b>LEVEL 4</b> <ul style="list-style-type: none"> <li>1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; <b>or</b></li> <li>2 or more stable chronic illnesses; <b>or</b></li> <li>1 undiagnosed new problem with uncertain prognosis; <b>or</b></li> <li>1 acute illness with systemic symptoms; <b>or</b></li> <li>1 acute complicated injury</li> </ul>	<b>LEVEL 4</b> <i>One category required</i> <b>CATEGORY 1:</b> <i>Any 3 from the following:</i> <ul style="list-style-type: none"> <li>Review of <b>prior external note(s) from each unique source;</b></li> <li>Ordering of <b>each unique test or</b></li> <li>Review of the <b>result(s) of each unique test;</b></li> <li>Assessment requiring an independent historian(s) <b>or</b></li> </ul> <b>CATEGORY 2:</b> <ul style="list-style-type: none"> <li>Independent interpretation of test performed by another MD/ QHCP/appropriate source (not separately reported); <b>or</b></li> </ul> <b>CATEGORY 3:</b> <ul style="list-style-type: none"> <li>Discussion of management or test interpretation with external MD/ QHCP/appropriate source (not separately reported)</li> </ul>	<b>LEVEL 4</b> Moderate Risk <b>EXAMPLES ONLY:</b> <ul style="list-style-type: none"> <li>Prescription drug management</li> <li>Decision regarding minor surgery with identified patient or procedure risk factors</li> <li>Decision regarding elective major surgery without identified patient or procedure risk factors</li> <li>Diagnosis or treatment significantly limited by social determinants of health</li> </ul>	<b>LEVEL 4</b> 45-59 mins NEW: 99204 30-39 mins EST: 99214
<b>LEVEL 5</b> <ul style="list-style-type: none"> <li>1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; <b>or</b></li> <li>1 acute or chronic illness or injury that poses a threat to life or bodily function</li> </ul>	<b>LEVEL 5</b> <i>Two categories required</i> <b>CATEGORY 1:</b> <i>Any 3 from the following:</i> <ul style="list-style-type: none"> <li>Review of <b>prior external note(s) from each unique source;</b></li> <li>Ordering of <b>each unique test or</b></li> <li>Review of the <b>result(s) of each unique test;</b></li> <li>Assessment requiring an independent historian(s) <b>or</b></li> </ul> <b>CATEGORY 2:</b> <ul style="list-style-type: none"> <li>Independent interpretation of test performed by another MD/ QHCP (not separately reported); <b>or</b></li> </ul> <b>CATEGORY 3:</b> <ul style="list-style-type: none"> <li>Discussion of management or test interp with external MD/ QHCP/appropriate source (not separately reported)</li> </ul>	<b>LEVEL 5</b> High Risk <b>EXAMPLES ONLY:</b> <ul style="list-style-type: none"> <li>Drug therapy requiring intensive monitoring for toxicity</li> <li>Decision re: elective major surgery with identified patient or procedure risk factors</li> <li>Decision re: emergency major surgery</li> <li>Decision re: hospitalization</li> <li>Decision not to resuscitate or to de-escalate care due to poor prognosis</li> </ul>	<b>LEVEL 5</b> 60-74 mins NEW: 99205 40-54 mins EST: 99215

**TODAY'S RISK LEVEL**

*(Circle one)*

**LEVEL: 2 3 4 5**

**Risk**  
of morbidity from additional diagnostic testing or treatment

**LEVEL 4**  
Moderate Risk

**EXAMPLES ONLY:**

- Prescription drug management
- Decision regarding minor surgery with identified patient or procedure risk factors
- Decision regarding elective major surgery without identified patient or procedure risk factors
- Diagnosis or treatment significantly limited by social determinants of health



# Equity & sustainability

What steps can we take to use the social risk data to improve care, advance equity, and access revenue?

# 1. Involve patients and community members

- How is your practice involving patients and other members who belong to historically marginalized communities in your health equity efforts?
- What patterns of inequity do they perceive when it comes to healthcare access, quality or outcomes?
- What social and structural drivers do they identify as the root causes for these inequities?
- How is your practice compensating them for their insights and contribution?

## 2. Identify patterns of health inequity

- How can you improve *collection and documentation* of
  - patient race, ethnicity, and primary language (REAL) data?
  - patient sexual orientation and gender identity (SOGI) data?
  - Patient income and geographic (address) data?
- How can you improve your capacity to *analyze* patient data to identify inequities in healthcare access, quality of care, and outcomes?
  - **Example:** With clinic data and local public health data, Clinic X identifies four zip codes with the highest rates of asthma diagnosis and associated ED utilization among children and teens.
    - With support from an academic partner, they identify inequities in health status, no-show rates, and ED utilization between Black and Latinx children with asthma compared to white counterparts who live in the same zip codes



# 3. Use social risk data to provide & document better care

- How well does your care team use social risk data to provide more empathic care and adjust patients care plans?
- Example:
  - A parent brings her asthmatic child to Clinic X for a new visit. In the waiting room, she uses an iPad-based screening tool to disclose housing instability and problems, including mold & water leaks.
  - During the visit, a FNP uses empathic inquiry to discuss this social risk with the family, advises on ways to minimize asthma triggers, adjusts treatment based on this information, and recommends a referral to a local CBO that specializes in housing remediation.
  - The coder documents this visit as Level 4- 99204, based in part on documentation of the social risk (Z code 59.1) and its impact on diagnosis and treatment of the patients' medical problems.

## 4. Use social risk data to better understand and address patterns of inequity

- To what extent are social risk data associated with the patterns of inequity you've identified?
- How are you working with community partners to address the social and structural drivers of health equity impacting your patients?
- Example:
  - Clinic X securely shares deidentified data with their public health agency. They identify that the housing problems that they've documented are associated with the racial inequities in asthma outcomes identified among their local patients.
  - A local CBO and legal aid organization use this data to increase enforcement of housing codes with landlords who own the buildings where many of Clinic X's impacted patients reside.

## 5. Use social risk data to do better under VBP

- To what extent is your practice involved in value-based payment (VBP) or alternative payment models (APM)?
  - Do the VBP or APM models provide incentives for collecting and acting on social risk data?
- Example:
  - As part of a broader network, Clinic X has an APM contract with a Medicaid managed care plan to care for a defined set of complex patients. If Clinic X meets specific quality of care benchmarks, including social need screening and referral benchmarks, it can receive shared savings from the plan.
  - Clinic X uses upfront payment and projected revenue from shared savings to expand and sustain housing and other social care services for patients. This revenue also helps offset the costs of health & social care for other patients, like asthmatic children.

# Recap

We hope that you are now able to..

1. Describe opportunities to identify social risk and advance equity using the new E/M coding guidelines
2. List specific ways to code social risk using the new coding guidelines
3. Identify ways in which social risk coding can help improve care, advance equity, and access revenue



# Thank you!

Training Module: Social Needs Coding & Documentation  
August 2021



# Additional Resources

# American Hospital Association's info sheet on ICD-10-CM Coding for SDOH (2019)

Table 1  
ICD-10-CM Code Categories

ICD-10-CM Code Category	Problems/Risk Factors Included in Category
<b>Z55</b> – Problems related to education and literacy	Illiteracy, schooling unavailable, underachievement in a school, educational maladjustment and discord with teachers and classmates.
<b>Z56</b> – Problems related to employment and unemployment	Unemployment, change of job, threat of job loss, stressful work schedule, discord with boss and workmates, uncongenial work environment, sexual harassment on the job, and military deployment status.
<b>Z57</b> – Occupational exposure to risk factors	Occupational exposure to noise, radiation, dust, environmental tobacco smoke, toxic agents in agriculture, toxic agents in other industries, extreme temperature, and vibration.
<b>Z59</b> – Problems related to housing and economic circumstances	Homelessness, inadequate housing, discord with neighbors, lodgers and landlord, problems related to living in residential institutions, lack of adequate food and safe drinking water, extreme poverty, low income, insufficient social insurance and welfare support.
<b>Z60</b> – Problems related to social environment	Adjustment to life-cycle transitions, living alone, acculturation difficulty, social exclusion and rejection, target of adverse discrimination and persecution.
<b>Z62</b> – Problems related to upbringing	Inadequate parental supervision and control, parental overprotection, upbringing away from parents, child in welfare custody, institutional upbringing, hostility towards and scapegoating of child, inappropriate excessive parental pressure, personal history of abuse in childhood, personal history of neglect in childhood, Z62.819 Personal history of unspecified abuse in childhood, Parent-child conflict, and sibling rivalry.
<b>Z63</b> – Other problems related to primary support group, including family circumstances	Absence of family member, disappearance and death of family member, disruption of family by separation and divorce, dependent relative needing care at home, stressful life events affecting family and household, stress on family due to return of family member from military deployment, alcoholism and drug addiction in family.
<b>Z64</b> – Problems related to certain psychosocial circumstances	Unwanted pregnancy, multiparity, and discord with counselors.
<b>Z65</b> – Problems related to other psychosocial circumstances	Conviction in civil and criminal proceedings without imprisonment, imprisonment and other incarceration, release from prison, other legal circumstances, victim of crime and terrorism, and exposure to disaster, war and other hostilities.

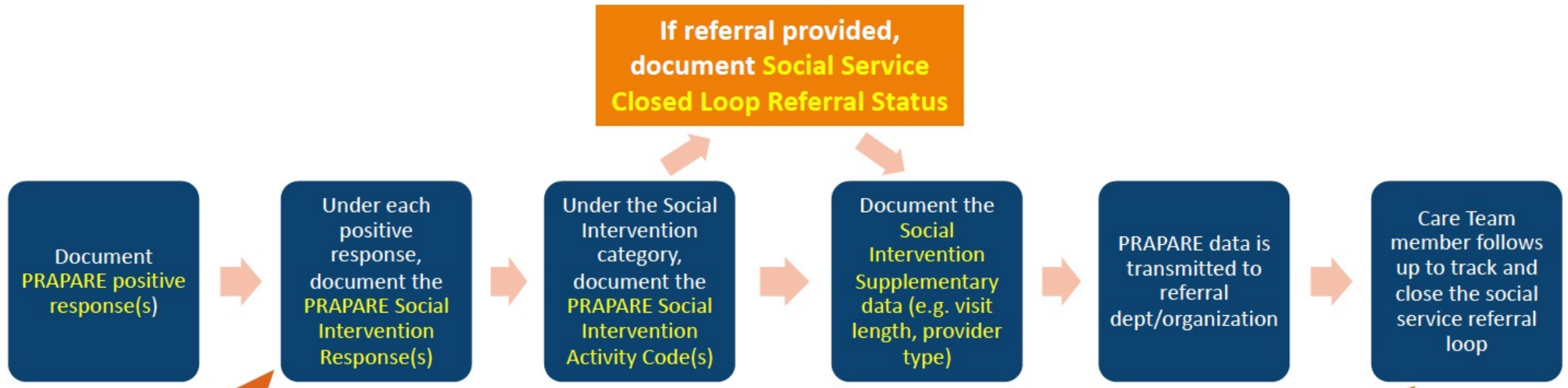
# Resources to improve coding & billing

- For clinics that use the PRAPARE screening tool, use their Toolkit
  - Code for social needs:
    - The [PRAPARE data documentation crosswalk](#) includes coding specifications and instructions for all PRAPARE measures and maps PRAPARE data to existing codes (such as ICD-10, LOINC, and SNOMED codes)
  - Code for social intervention responses based on need

Code	Social Intervention Response
SI-RE	Racial/Ethnic Support Services
SI-FW	Farmworker Support Services
SI-VN	Veteran Support Services
SI-IN	Interpretation Services
SI-HS	Housing Support Services
SI-FC	Financial Counseling/Eligibility Assistance
SI-ED	Education Support Services
SI-EM	Employment Support Services
SI-FD	Food Support Services
SI-UT	Utilities Support Services
SI-CC	Child Care Support Services
SI-MH	Medicine or Health Care Support Services

Code	Social Intervention Response
SI-CL	Clothing Support Services
SI-PH	Phone Support Services
SI-OM	Other Material Security Support Services
SI-MT	Medical Transportation Services
SI-NMT	Non-Medical Transportation Services
SI-SI	Social Integration Support Services
SI-ST	Mental Health Support Services
SI-IN	Incarceration Support Services
SI-RF	Refugee Support Services
SI-ST	Safety Support Services
SI-DV	Domestic Violence Support Services

# PRAPARE Social Intervention Documentation Workflow



Source: NACHC PRAPARE Toolkit [http://www.nachc.org/wp-content/uploads/2019/04/NACHC\\_PRAPARE\\_Full-Toolkit.pdf](http://www.nachc.org/wp-content/uploads/2019/04/NACHC_PRAPARE_Full-Toolkit.pdf)

# Additional Resources

**Assessing and Addressing Social Risk:** [https://www.episcopalhealth.org/wp-content/uploads/2020/01/PRAPARE\\_in\\_Texas\\_Final\\_Report\\_Designed\\_4\\_12\\_18.pdf](https://www.episcopalhealth.org/wp-content/uploads/2020/01/PRAPARE_in_Texas_Final_Report_Designed_4_12_18.pdf)

Food Insecurity Screening Workflow Compliance and Measuring Success  
<https://childrenshealthwatch.org/wp-content/uploads/Food-Insecurity-Screening-Workflow-Compliance-and-Measuring-Success.pdf>

An Overview of Coding  
[https://childrenshealthwatch.org/wp-content/uploads/An-Overview-of-Coding\\_2.15.18\\_final.pdf](https://childrenshealthwatch.org/wp-content/uploads/An-Overview-of-Coding_2.15.18_final.pdf)

FRAC- Screen and Intervene: A Toolkit for Pediatricians to Address Food Insecurity  
[https://frac.org/wp-content/uploads/FRAC\\_AAP\\_Toolkit\\_2021.pdf](https://frac.org/wp-content/uploads/FRAC_AAP_Toolkit_2021.pdf)

**CMS Infographic on using SDOH Z codes:**  
<https://www.cms.gov/files/document/zcodes-infographic.pdf>

**Flow of Food Insecurity Coding in an Office Visit Flowchart on page 6:**  
[https://childrenshealthwatch.org/wp-content/uploads/An-Overview-of-Coding\\_2.15.18\\_final.pdf](https://childrenshealthwatch.org/wp-content/uploads/An-Overview-of-Coding_2.15.18_final.pdf)

2021 E/M Coding Guidelines [https://learn.pcc.com/help/chart-code-and-bill-for-em-office-visits/#Select\\_a\\_Code\\_Based\\_on\\_Medical\\_Decision\\_Making](https://learn.pcc.com/help/chart-code-and-bill-for-em-office-visits/#Select_a_Code_Based_on_Medical_Decision_Making)

American Hospital Association's info sheet on ICD-10-CM Coding for SDOH (2019) with suggested resources:  
<https://www.aha.org/system/files/2018-04/value-initiative-icd-10-code-social-determinants-of-health.pdf>

2019 Social Determinants of Health ICD-10 Codes: <https://www.uhcprovider.com/en/resource-library/news/2019-net-bulletin-featured-articles/0619-social-determinants-health.html>