ICD-10-CM Coding

for Social Determinants of Health

eHEALTH INITIATIVE

UnitedHealthcare®

An eHealth Initiative Collaborative Project | 2019

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1 What is the eHealth Initiative ICD-10-CM Coding for SDOH Collaboration?

In Summer of 2019, eHealth Initiative and UnitedHealthcare's National Strategic Partnerships Division convened a collaborative meeting of leaders from payer organizations and other stakeholder groups to address the use of ICD-10-CM codes for capturing social determinants of health (SDOH) data. (Participants are listed at the end of this document.) This meeting marked a significant milestone in the shift to value-based care. Despite the competitive nature of healthcare, the private sector is working together to address factors pertinent to patient care and well-being in a sustainable, scalable manner. The group discussed the need for better education of provider and billing coders on the value of collecting and using SDOH data and identified strategies to accomplish this task:

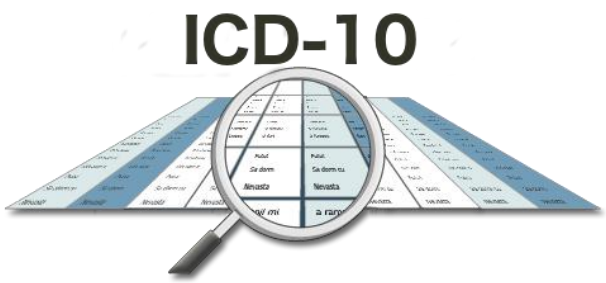
- Develop a consistent and unified approach to **communicate** and assist providers and coders in utilizing existing ICD-10-CM codes for SDOH.
- Formulate a strategy and unified approach for providers and coders to assist with **adoption** and **utilization** of the proposed SDOH codes once approved.

Attendees agreed that the best strategy to communicate and promote the adoption of ICD-10-CM codes for SDOH to various stakeholder audiences was to:

- Develop this document as well as two-page communication tools for various audiences, including providers and coders. The coder tool, *Transforming health care: Why including SDOH codes on claims is critical* and provider tool, *Using SDOH coding to transform health outcomes* are available for use.
- Promote the use of the communication tools at various payer organizations through a high-level communication plan that outlines dissemination to stakeholder groups.

2 What is an ICD-10-CM code and why is coding for SDOH important to payers?

Patients with unmet SDOH needs often experience delayed screenings and interventions, which can necessitate more intensive care and lead to the consumption of more healthcare services. In response, organizations are ramping up efforts to address SDOH within their communities and using proactive approaches to help identify patients in need, including assisting with referrals to social and governmental services. International Classification of Diseases, Tenth Revision, Clinical Modification coding, known as ICD-10-CM coding, for SDOH offers an opportunity to better serve patients. With the appropriate coding, all healthcare providers and



organizations are better positioned to proactively assess patients' level of need and to help vulnerable populations receive screenings and interventions at appropriate times.

The ICD-10-CM is a system used by clinicians to classify and code all diagnoses and symptoms, and to connect these codes to procedures for physical and behavioral care within the United States. These codes are based on the International Classification of Diseases, which is published by the World Health Organization (WHO), using unique alphanumeric codes to identify known diseases and other health problems. ICD-10-CM codes provide a level of detail that is necessary for diagnostic specificity and morbidity classification in the U.S.[1] Through the use of ICD-10-CM codes included in categories Z55-Z65, clinicians are currently able to document patients' SDOH in a standardized manner.

Categories Z55-Z65 identify the socioeconomic and psychosocial circumstances that could negatively impact health. Capturing ICD-10-CM codes puts SDOH data into the ecosystem of the payer-provider environment. Care managers, social workers, home healthcare professionals, and others involved in a patient's care can use and share this data to improve care management across the continuum. The codes also allow payers to collect, understand, and address the social needs of patients. A recent, nationally representative survey of U.S. clinicians revealed that the average clinician spends almost 17% of their working hours on administration, with more extensive use of electronic health records (EHRs) associated with greater burden.[2] When other stakeholders in the healthcare ecosystem (i.e., nurses, social workers, community health workers) and payers can actively engage in addressing social issues for individuals and populations, clinicians' administrative burden may be reduced, as well as the severity of burnout faced by healthcare workers.

Unfortunately, despite their availability, ICD-10-CM codes describing SDOH conditions are infrequently used in inpatient settings other than discharges related to mental health and alcohol/substance abuse. These codes are also not widely used in outpatient settings. Better stakeholder education is needed on the value of collecting and using SDOH data to understand treatment plans and the value of providing training for coding professionals on use of these codes. If payers are more consistent in communicating to providers the importance of collecting ICD-10-CM codes for SDOH, they may discover a correlation between SDOH and high-cost claims, encourage advancements in paying for SDOH, and make the case for standardizing coding and billing for SDOH.

In March 2019, UnitedHealthcare, in conjunction with the American Medical Association (AMA), The National Council on Quality Accreditation (NCQA), the Arizona Health Care Cost Containment System (AHCCS), the National Association of Community Health Centers (NACHC), and many other healthcare organizations, submitted a request to the ICD-10 Coordination and Maintenance Committee to expand the existing code set to include new codes that would capture "barrier situations" which prevented consumers from obtaining routine care, medications, and preventive care. Once the code set is expanded, the process of collecting ICD-10-CM codes for SDOH should already be routine.

[1] https://searchhealthit.techtarget.com/definition/ICD-10-CM
[2] https://www.ncbi.nlm.nih.gov/pubmed/25626223

3 How does collecting SDOH data benefit patients and population health?

There are numerous facets and many ways of addressing SDOH. Not all communities and individuals require the same intervention, therefore approaches must be tailored based on the unique needs that ICD-10-CM codes can help identify. For instance, Aetna is helping the employer understand how SDOH affect their employee populations, especially those considered low-wage workers. Aetna will soon release an analytics tool that will "quantify the probable impact of social determinants of health on employer's health plan results." Through a pilot program, the tool will also help guide CVS Health in determining how the right interventions can be most effectively deployed to plan sponsors and individuals who are most likely to benefit.[3] Below are additional examples of community partnerships that address SDOH.

Bold Goal

The Bold Goal population health strategy is Humana's integrated approach to improve the health of the communities it serves by 20% by 2020 and beyond. Bold Goal uses Healthy Days, the Center for Disease Control and Prevention's (CDC) health-related quality of life measurement tool that takes into account self-reported unhealthy days for mental and physical health, over a 30-day period. Healthy Days insights pointed to top SDOH focus areas of food insecurity (the inability to reliably access sufficient amounts of affordable, nutritious food), social isolation, and loneliness. Humana screened over 500,000 members for these needs in 2018, finding the Medicare members who screen positive for loneliness experience twice as many Unhealthy Days. In response, Humana launched a plan benefit for a Friendly Visitor Program in conjunction with Meals on Wheels, and has tested opportunities with an organization called Papa, which pairs college students—called Papa's Pals—with senior citizens to alleviate their loneliness. Humana's *2019 Bold Goal Progress Report* contains information on the initiative's progress.[4] Humana expects to see continued demand for a support structure that addresses social needs, along with clinical needs.[5]

Thrive 18

Informed by resident input and health outcomes data, Highmark Health and other community partners developed Thrive 18. This partnership focuses on populations on Pittsburgh's Northside, providing community-based connections between residents, community health resources, and social service providers through door-to-door outreach and enhanced data collection. Although the partnership gathers information across 18 SDOH categories, it is currently focused on critical

Thrive18

[3] https://www.prnewswire.com/news-releases/cvs-health-announces-destination-health-a-new-platform-addressing-social-determinants-of-health-300889643.html

[4] https://populationhealth.humana.com/wp-content/themes/humana/docs/Humana_2019_BoldGoal_ProgressReport.pdf

[5] https://humananews.com/2019/04/humanas-2019-bold-goal-progress-report-details-a-focus-on-social-determinants-of-health-and-improved-healthy-days-in-its-medicare-advantage-population/

issues such as housing, food insecurity, and working utilities. Since its launch in 2018, the partnership has identified and surveyed more than 250 families for critical needs and connected them with a resource provider network that consists of more than 50 organizations.[6]

Metropolitan Area Neighborhood Nutritional Alliance (MANNA)

To address the social and environmental needs of their Keystone 65 Individual HMO Medicare Advantage members, Independence Blue Cross partnered with MANNA to offer members with three combined diagnoses of diabetes, congestive heart failure (CHF), and stage four or five chronic kidney disease (CKD) home-delivered meals after their discharge from an inpatient hospital stay. For up to two four-week periods during the year, MANNA delivers meals on a weekly basis to eligible members who are convalescing at home after their hospitalization. In addition to providing meals, the program also offers free nutritional education at the beginning and end of the program. As of August 2019, MANNA has served 48 Independence Blue Cross members 3,990 meals. In 2020, the program will expand to offer meals to members who have two combined diagnoses of CHF and diabetes.

4 What are frequently asked questions about SDOH Data and ICD-10-CM Coding?

How is SDOH data different from clinical data?

Traditionally, data recorded during a patient visit directly relates to a patient's health but does not incorporate outside factors that can impact well-being. SDOH data captures information at a level traditional health data sources cannot and gives deeper insights into factors impacting health, such as employment, food insecurity, and housing.

What is the benefit of standardizing the capture of SDOH data?

Although healthcare systems are well equipped to treat disease, those same systems are not structured to adequately address SDOH. Standardizing SDOH would assist in identifying, documenting, and tracking additional markers of health, beyond the physical, and would permit clinicians, hospitals, and health plans to share the information through medical records and insurance claims data.

What do ICD-10-CM codes mean to healthcare and patients?

ICD-10-CM codes are a way for clinicians and care providers to classify and record all diagnoses and symptoms. ICD-10-CM codes are used for many things, including processing health insurance claims, storing and retrieving diagnostic information, and compiling national mortality and morbidity statistics.

[6] https://www.bcbs.com/sites/default/files/file-attachments/investing-health-america/HOA_Community_Report_2018_FINAL.pdf

Why are ICD-10-CM codes important in their applications for SDOH?

Rather than a new system or new tool to capture SDOH, leveraging existing ICD-10-CM codes offers an opportunity to expand on the existing system. This practical application brings SDOH into a clinician's workflow and becomes a part of the patient's electronic medical record and claims history.

What is an ICD-10-CM Z code for SDOH?

ICD-10-CM codes include a category called Z codes, which are used to describe experiences, problems, or circumstances, that affect patient health, but are not considered a specific disease or injury. Codes Z55-Z65 identify circumstances that are socioeconomic and psychosocial in nature, which may influence patient health status and contact with health services.

What are the limitations of ICD-10-CM Z codes for SDOH?

Currently, ICD-10-CM Z codes for SDOH capture some, but not all, domains of SDOH. Stakeholder groups have requested that the ICD-10 Coordination and Maintenance Committee expand the codes to represent more granular information that would inform more precise, effective, and efficient social interventions. Although coding for SDOH is not mandated, when there is documentation of SDOH in the patient's notes, it is still possible to use Z codes in the same manner that medical coding is done. Coding professionals may not know to scan for SDOH or may be hesitant to use the codes.

Are coding professionals allowed to use non-physician documentation to support ICD-10-CM coding for societal and environmental conditions?

Yes, coding professionals at hospitals and health systems can report these codes based on documentation by all clinicians involved in the care of patients, such as case managers, discharge planners, social workers and nurses. In early 2018, the American Hospital Association (AHA) *Coding Clinic* published guidance advice that allows the reporting of SDOH ICD-10 codes based on non-physician documentation. The ICD-10-CM Cooperating Parties approved the advice, with the change effective February 2018.

Why should providers, non-physician healthcare providers, and coders use Z codes for SDOH?

Utilizing Z codes for SDOH enables hospitals and health systems to better track patient needs and identify solutions to improve the health of their communities. The extraction of SDOH data from the EHR for clinical, operational, and research purposes can facilitate tracking, identification, and referrals to social and governmental services.

What happens when a code has not been developed for an SDOH?

If a code has not been developed for a specific SDOH issue, the issue will not be coded and will not be included in the patient's overall plan of care, nor as part of the claim submission process, unless it is recorded as narrative text.

Are there guidelines for using ICD-10-CM codes for SDOH?

ICD-10-CM diagnosis codes have been adopted under the Health Insurance Portability and Accountability Act (HIPAA) for all healthcare settings. Guidelines for Z codes are included in the Centers for Medicare & Medicaid Services (CMS) ICD-10-CM Official Guidelines for Coding and Reporting for FY 2020.[7]

Where can I find more resources and initiatives around SDOH data and ICD-10-CM Coding?

American Academy of Family Physicians (AAFP)'s EveryONE Project Toolkit	Resource Link
American Hospital Association (AHA) Information sheet on ICD-10 Coding for Social Determinants of Health	Resource Link
AHA's Social Determinants of Health and Value Resources	Resource Link
AMA and UnitedHealthcare's collaboration to support the creation of new ICD-10 codes related to SDOH	Resource Link
AMA's Integrated Health Model Initiative (IHMI)	Resource Link 1 Resource Link 2
Centers for Disease Control (CDC) Social Determinants of Health Webpage	Resource Link
CMS 2020 ICD-10-CM Files	Resource Link
CMS ICD-10-CM Official Guidelines for Coding and Reporting for FY 2020	Resource Link
CMS' Accountable Health Communities Health-Related Social Needs Screening Tool and FAQ	Resource Link
"Health Disparities: Social Determinants of Health)" (Free online education module by the American Medical Association (AMA)	Resource Link
Healthy People 2020's Social Determinants of Health Webpage	Resource Link
Humana Food Insecurity and Loneliness Toolkits	Resource Link
The National Association of Community Health Centers (NACHC) Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)	Resource Link
NCQA Population Health Management Resource Guide	Resource Link
SIREN's (Social Interventions Research and Evaluation Network) Gravity Project — a national collaborative to advance interoperable social risk and protective factors documentation	Resource Link 1 Resource Link 2

[7] https://www.cdc.gov/nchs/data/icd/10cmguidelines-FY2020_final.pdf

Collaborators

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About eHealth Initiative

eHealth Initiative and Foundation (eHI) convenes executives from every stakeholder group in healthcare to discuss, identify, and share best practices that transform the delivery of healthcare, through technology and innovation. eHI, and its coalition of members, focus on education, research, and advocacy to promote the use of sharing data to improve healthcare. Our vision is to harmonize new technology and care models in a way that improves population health, consumer experiences and lowers costs. eHI serves as a clearinghouse and has become the go-to resource for industry through its eHealth Resource Center. For more information, visit https://www.ehidc.org/pages/social-determinants-health.

About UnitedHealthcare's National Strategic Partnerships

UnitedHealthcare's National Strategic Partnerships is redefining health care to consider the patient beyond the clinical environment. Since January 2017, they have identified barriers to care, engaged social and government services, and helped members get the assistance they need and are valuing these services through our patent-pending Imputed Market PriceTM tool. Data tracking, aggregation and analysis provides valuable insights into SDOH impact on health outcomes and the total cost of care. Via collaboration with providers, organizations, employers, policymakers, and others, the National Strategic Partnerships strive to affect foundational aspects of health and cultivate a large-scale impact on quality of life.