Targeted Investments 2.0 Program

Social Determinants of Health (SDoH) Screening & Referral Coding Process

Definitions

SDoH are the conditions in the environments where people are born, live, learn, work, play, worship, and age.[1]

Health-related social needs (HRSNs) are an individual's unmet, adverse social conditions that contribute to poor health and are a result of underlying SDoH.[2]

1. CMS 2. KFF

G Codes

Procedure codes **G9919, G9920, and G9921** will be used in TI 2.0 to track SDoH screenings and referrals.

Z Codes

SDoH-related Z codes range from ICD-10-CM categories Z55-Z65 and are used to document SDOH data (e.g., housing, food insecurity, lack of transportation).[1]

In TI 2.0, there will be a particular emphasis on Z codes related to employment, food, housing, utility assistance, justice/legal involvement, interpersonal safety, social isolation, and transportation.

Step 1. Screen your patient with your organization's standardized SDoH screening tool.

Step 2: Assess your patient's SDoH screening result. If they screen positive, refer them (with their consent and input) to onsite resources or community-based organizations (CBOs) to help address their identified HRSN(s).

Step 3. Document your patient's results in your EHR with the appropriate G and Z codes.

If at least one HRSN is identified,

Document G9919 and the Z code(s) that best identifies their HRSN(s) **if they would like a referral.**

OR

Document G9921 and the Z code(s) that best identifies their HRSN(s) **if they would not like a referral at this time.**

If no HRSNs are identified,

Document G9920. No Z code is required.

Please contact us at targetedinvestments@azahcccs.gov and TIPQIC@asu.edu

AHCCCS Arizona Health Care Cost Containment System

TIP QIC Targeted Investments Program Quality Improvement Collaborative

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Frequently Asked Questions (FAQs)

- **What are G and Z codes?**
  - A claim can have several procedure codes and diagnoses associated with the visit. Each procedure code is billed on a separate claim "line," but the diagnoses apply to the entire visit. "G codes" are a type of procedure, and "Z codes" are a type of diagnosis.
  - All claims require at least one procedure code (max: 6) to indicate a service was provided. Most outpatient claims may indicate up to twelve diagnosis codes (UB-04 claims allow up to 67). Providers are responsible for prioritizing diagnosis codes according to medical coding guidelines.

- **What is the purpose of using the SDoH G and Z codes?**
  - TI 2.0 will use SDoH G and Z codes to track SDoH screenings and referrals at the claim level. This will provide the TIPQIC team, MCOs, ACOs/CINs, and AHCCCS with valuable insights into the non-medical factors influencing patients' health outcomes. AHCCCS and ASU TIPQIC rely on accurate coding by TI providers to track and analyze disparities, with the goal of enhancing health equity and improving health outcomes for the patient population. These codes are critical to demonstrating the importance of (and thereby rationale for reimbursing for) SDoH screening and referral case management.

- **What specific codes are required?**
  - G codes (Procedure Codes) will be used to indicate if a complete screening occurred, if a positive need was identified, and if a referral was made to a community service provider. TI participants will use G9919-G9921. As a mutually exclusive procedure code, only one G code can be submitted on a claim.
  - Z codes (Diagnosis Codes) will be used to indicate all of the needs identified through the screening regardless of referral status. TI participants will leverage Z55-Z65.

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FAQs - Continued

- **Will I be reimbursed for using the G codes?**
  - G and Z codes are not reimbursable in most outpatient settings by AHCCCS Medicaid. However, using the G and Z codes are required for participants to attain the financial incentives (20% of annual payment) associated with the TI Year 2 and Year 3 milestone for identifying, addressing, and recording SDoH screening and referral results. Additional details regarding TI milestones can be found on the AHCCCS TI website.

- **Can I use G0136 instead of G9919-G9921?**
  - No. Procedure code G0136 is intended to be a pointed SDoH assessment based on apparent needs and/or doctor's intuition. Per CMS, it is not intended for a full-panel screening of all required domains. TI requires the full screening to be performed to ensure that all of the individual's needs are identified and addressed simultaneously (i.e. whole person care).

- **Can I use 96160 and 96161?**
  - Yes, CPT codes 96160 and 96161 can be used **in addition to the required G codes**. These codes are reimbursable up to 4 times per year in most outpatient settings by AHCCCS Medicaid. These procedure codes can also be submitted for other screeners, such as trauma or other behavioral health conditions (e.g., caregiver depression during Peds PCP appointments). However, these procedure codes do not document if a referral was desired. Providers must adhere to medical coding guidelines to determine if 96160 and/or 96161 should be included on the claim and/or eligible for reimbursement. As no-pay codes specific to SDoH, G codes must be used by TI-participants to indicate an SDoH screening was performed and if the patient/ caregiver wanted a referral.

- **How much TI incentive will I receive by using the SDoH G codes and Z codes?**
  - Using the SDoH G and Z codes will make up about 20% of the total annual incentive. However, the specific incentive amount cannot be estimated until payments are calculated by AHCCCS at the end of the year.

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FAQs - Continued

- **Can I bill a Z code without completing a SDoH screening?**
  - Generally, yes. Diagnosis codes (e.g., Z codes) cannot be submitted on a claim without a procedure code. If an SDoH screening was not completed (i.e. no G code) at time of appointment, providers are still required to indicate all diagnoses relevant to the provided service. For example, an established adult patient with diabetes may discuss inaccessibility of healthy food options when discussing challenges associated with managing their A1c at their annual physical. If it's inappropriate for the provider to complete a full SDoH screening (e.g., patient declined), the provider may include Z59.41 (food insecure) with the typical procedure code for the service provided.
  - However, TI participants must use a prescribed G code to satisfy the TI milestone. Every Z code will need a G code, but not every G code will need a Z code (i.e. if the patient screened for SDoH has no needs identified).
- **What happens if a claim gets voided or denied? Will I need to resubmit the G and Z codes?**
  - No. The ASU TIPQIC team can see all claims from AHCCCS Complete Care (ACC) and ACC-RBHA plans regardless of adjudication status.
- **What G code do I submit if a patient screens positive in a SDoH screening for several HRSNs but only wants a referral for some services?**
  - Submit G9919 and the Z code(s) that align with the HRSN referrals. Detail all identified needs and referrals (requested or refused by the patient) in your EHR.

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