Targeted Investments 2.0 Program

Updated Non-Medical Drivers of Health (NMDOH) Screening & Referral Coding Process

Definitions

The NMDOH are the conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes.[1]

NMDOH were previously referred to as Health-Related Social Needs (HRSNs) in TI 2.0 Years 1-3.

1. Texas Health and Human Services

G Codes

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

Z Codes

NMDOH-related Z codes range from ICD-10-CM categories Z55x-Z65x and are used to document NMDOH need data (e.g., housing, food insecurity, lack of transportation).[2]

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.

2. CMS

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

Step 2: Assess your patient's NMDOH 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 NMDOH need(s).

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

If at least one NMDOH need is identified

and the patient would like a referral, document G9919 and the Z code(s) that best identifies their NMDOH need(s)

OR

and they decline a referral at this time, document G9919, **either*** modifier V4 **or** Z13.9, and the Z code(s) that best identify their NMDOH need(s).

*Note: Submitting both will result in an error and will not be tracked correctly

If no NMDOH needs are identified,

Document G9920. No Z code is required.

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

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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 NMDOH G and Z codes?**
  - TI 2.0 will use NMDOH G and Z codes to track NMDOH 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 demonstrate the importance of (and thereby the rationale for reimbursing for) NMDOH 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 and G9920. 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 Z55x-Z65x.

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FAQs - Continued

- **What happened to G9921? Why did the TI G code methodology change?**
  - The TI G-code methodology changed because HCPCS code G9921 was terminated on December 31, 2024.[3] Recognizing the continued need to capture instances where a patient screened positive but declined a referral for an identified NMDOH, AHCCCS and ASU collaborated with stakeholders to update the guidance. Under the revised methodology, providers may now document these cases using either the V4 modifier or Z13.9 with G9919 (positive screen). Importantly, only one option should be submitted, as using both will result in an error and will not be tracked correctly.

- **Will I be reimbursed for using the NMDOH G codes?**
  - G and Z codes are not reimbursable in most outpatient settings by AHCCCS Medicaid. However, using the G and Z codes is required for participants to attain the financial incentives associated with the TI Year 3 and Year 4 milestones for screening non-medical drivers of health and managing referral systems. Additional details regarding TI milestones can be found on the AHCCCS TI website.

- **Can I use G0136 instead of G9919-G9920?**
  - No. Procedure code G0136 is intended to be a pointed NMDOH 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 NMDOH screening to be performed to ensure that all the individual's needs are identified and addressed simultaneously (i.e. whole person care).

3. HCPCS Data

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FAQs - Continued

- **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 NMDOH, G codes must be used by TI-participants to indicate that an NMDOH screening was performed and if the patient/caregiver wanted a referral.

- **How much TI incentive will I receive by using the NMDOH G codes and Z codes?**
  - Using the NMDOH G and Z codes will account for approximately 20% and 25% of the total annual incentive in Years 3 and 4, respectively. However, the specific incentive amount cannot be estimated until payments are calculated by AHCCCS at the end of the year.

- **Can I bill a Z code without completing an NMDOH screening?**
  - Generally, yes. Diagnosis codes (e.g., Z codes) cannot be submitted on a claim without a procedure code. If an NMDOH screening was not completed (i.e., no G code) at the 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 the 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 NMDOH 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 NMDOH has no needs identified).

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FAQs - Continued

- **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. Since G9919 and G9920 are no-pay codes, it is expected that these claim lines will be denied. However, if the entire claim (including a payable service) is voided or denied, please contact the ASU TIPQIC and AHCCCS TI teams.

- **What G code do I submit if a patient screens positive in an NMDOH screening for several NMDOH needs but only wants a referral for some services?**
  - Submit G9919 and the Z code(s) that align with the NMDOH referrals. Detail all identified needs and referrals (requested or refused by the patient) in your EHR.

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