ASCO Practice Leadership Series

Coding for Social Determinants of Health in Oncology

Thursday, December 15, 2022
Welcome!

• Please mute your phones

• Q&A session at the end
  ▪ Use the Q&A button in the bar at the bottom of your Zoom window
  ▪ Type in your question
  ▪ We will address questions in the order they are received
Speakers

Allison Hirschorn
Associate Director, Coverage and Reimbursement
ASCO Care Delivery Department
Today’s Topics

DATA AND UTILIZATION
QUALITY PROGRAMS AND INITIATIVES
PRACTICE ADMINISTRATION
ICD-10 CM Z CODES DESCRIBING SDOH
CONNECTING Z CODES WITH CPT CODES
Social Determinants of Health: Data and Utilization
What are Social Determinants of Health (SDOH)?

Conditions of an individual’s living, learning, and working environments that affect one’s health risks and outcomes.

Recognized as important predictors in clinical care and positive conditions are associated with improved patient outcomes and reduced costs.
What are ICD-10 CM codes?

International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)

Classifying diagnoses and reason for visits in all health care settings.
How are ICD-10 CM codes connected to social determinants of health?

Persons with potential health hazards related to socioeconomic and psychosocial circumstances (Z55-Z65)

Social Determinants of Health
Impact of Identifying Patients with Social Determinants of Health

Identifying patients with SDOH → Reporting Z codes → Improved quality, care coordination, and experience of care

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

<table>
<thead>
<tr>
<th>Current Challenges</th>
<th>Potential Solutions</th>
</tr>
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<tbody>
<tr>
<td>▪ Lack of a standardized EHR-based screening tool.</td>
<td>▪ Reducing reliance on clinicians to capture SDOH.</td>
</tr>
<tr>
<td>▪ Lack of and multiplicity of codes.</td>
<td>▪ Filling gaps in codes.</td>
</tr>
<tr>
<td>▪ Lack of awareness among providers and medical coders.</td>
<td>▪ Improving provider and medical coder education.</td>
</tr>
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Z Codes Utilization among Medicare Fee-for-Service (FFS) Beneficiaries in 2019

Among 33.1 million total Medicare FFS beneficiaries in 2019, approximately 1.59% had claims with Z codes.

CMS Data Highlight
No. 24 September 2021
Utilization of Z Codes for Social Determinants of Health among Medicare Fee-for-Service Beneficiaries, 2019
Z Codes Utilization among Medicare Fee-for-Service (FFS) Beneficiaries in 2019

5 Most Utilized Z codes

- **Z59.0**
  - Homelessness

- **Z63.4**
  - Disappearance and death of family member

- **Z60.2**
  - Problems related to living alone

- **Z59.3**
  - Problems related to living in a residential institution

- **Z63.0**
  - Problems in relationship with spouse or partner
Z Codes Utilization among Medicare Fee-for-Service (FFS) Beneficiaries in 2019

Race and Ethnicity Proportions

Medicare FFS Beneficiaries with Z Codes

- **White (79.5%)**
- Black and African American (8.8%)
- Hispanic (5.9%)
- Asian and Pacific Island (2.7%)
- American Indian and Alaska Native (0.6%)
Why is the utilization of these codes low?

- Lack of awareness regarding the codes.
- Difficulty in determining when and how to report the codes.
- Lack of internal processes to incorporate Z codes into the workflow.
- Confusion as to who can (or should) document SDOH.
- Lack of explicit financial incentives for their use.
Social Determinants of Health: Quality Programs and Initiatives
SDOH and Quality Initiatives

ASCO/COA Oncology Medical Home

- Patient Engagement
- Pt Centered Cancer Care
- Availability & Access to Care
- Evidence-based Medicine
- Equitable and Team-based Care
- Quality Improvement
- Goals of Care, Palliative & End of Life Discussions
- Chemotherapy Safety (QCP)
Enhanced Oncology Model (EOM)

EOM participants will be required to:

- Develop and establish a health equity plan.
- Collect and report beneficiary-level sociodemographic data.
- Use health-related social needs (HRSN) screening tools.
- Provide patient navigation to EOM beneficiaries.
- Provide EOM beneficiaries with 24/7 access to a clinician.
SDOH and Quality Patient Care

**National Comprehensive Cancer Control Program (CDC)**
- Train and maintain a culturally competent workforce.
- Promoting equitable access to resources.

**Accountable Health Communities Model (CMS)**
- Address gaps in clinical care and community services.
- Identify and address health-related social needs.

**Healthy People 2030 (HHS)**
- Access to high-quality health care services.
- Increase both preventive care and cancer screenings.
Practice Administration
Integration and Implementation of SDOH into Cancer Care

Unique factors that vulnerable populations experience because of social and historical discrimination across multiple levels (individual and health care system levels) must be considered.

Social Determinants of Health and Disparities in Cancer Care for Black People in the United States
Reginald D. Tucker-Seeley
JCO Oncology Practice 2021 17:5, 261-263
Connecting Z Codes with SDOH

1. Collect SDOH data: Collect SDOH data via health risk assessments, screening tools, person-provider interaction, and self-reporting.

2. Document SDOH data: Record data in a patient’s paper or electronic health record.

3. Map SDOH data to Z codes: Select the ICD-10 CM Z code(s) that corresponds to the SDOH.

4. Analyze SDOH Z code data findings: Add to key reports and share with social service organizations, providers, and health plans.

5. Identify unmet patient needs: A “Disparities Impact Statement” may be used to discover opportunities for advancing health equity.

Center for Medicare and Medicare Services: “Using Z Codes: The Social Determinants of Health (SDOH) Data Journey to Better Outcomes”
Achieving Health Equity
Disparities Impact Statement

Using the SDOH and Z code data:

1. **Identify** health disparities, priority populations, and needs.
2. **Define** goals and targets.
3. **Establish** a health equity strategy.
4. **Monitor** and evaluate progress.

Source: CMS Disparities Impact Statement

Updated March 2021
<table>
<thead>
<tr>
<th>Initial Concern/Challenge</th>
<th>After Education and Program Exposure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discomfort with screening</td>
<td>Participation in a screening and referral program improved provider comfort with social risk screening.</td>
</tr>
<tr>
<td>Time and workflow</td>
<td>Time &amp; workflow were not burdensome, less than anticipated, or worth the time following social determinant of health program participation.</td>
</tr>
<tr>
<td>Patient/provider relationship and trust</td>
<td>Screening for social risks enhanced their relationship with patients or had no negative impact.</td>
</tr>
<tr>
<td>Ability to address patient needs</td>
<td>Overall provider concerns regarding the ability to provide resources to address needs continued.</td>
</tr>
</tbody>
</table>
Addressing SDOH is a continuous process.

1. Identify patients with SDOH.
2. Connect SDOH with Z codes.
3. Link practice processes for SDOH to the appropriate CPT codes.
4. Evaluate progress and goals.
Social Determinants of Health: ICD-10 CM Z Codes
### ICD-10 CM Z Codes

<table>
<thead>
<tr>
<th>Category</th>
<th>Category Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z55</td>
<td>Problems related to education and literacy</td>
</tr>
<tr>
<td>Z56</td>
<td>Problems related to employment and unemployment</td>
</tr>
<tr>
<td>Z57</td>
<td>Occupational exposure to risk factors</td>
</tr>
<tr>
<td>Z58</td>
<td>Problems related to physical environment</td>
</tr>
<tr>
<td>Z59</td>
<td>Problems related to housing and economic circumstances</td>
</tr>
<tr>
<td>Z60</td>
<td>Problems related to social environment</td>
</tr>
<tr>
<td>Z62</td>
<td>Problems related to upbringing</td>
</tr>
<tr>
<td>Z63</td>
<td>Other problems related to primary support group, including family circumstances</td>
</tr>
<tr>
<td>Z64</td>
<td>Problems related to certain psychosocial circumstances</td>
</tr>
<tr>
<td>Z65</td>
<td>Problems related to other psychosocial circumstances</td>
</tr>
</tbody>
</table>

**Chapter 21- Factors Influencing Health Status and Contact with Health Services**

"Persons with potential health hazards related to socioeconomic and psychosocial circumstances (Z55-Z65)"

**Source:** 2023 ICD-10 CM
ICD-10 CM Z Codes

Z59 Problems related to housing and economic circumstances

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z59.0</td>
<td>Homelessness</td>
</tr>
<tr>
<td>Z59.00</td>
<td>Homelessness, unspecified</td>
</tr>
<tr>
<td>Z59.01</td>
<td>Sheltered homelessness</td>
</tr>
<tr>
<td>Z59.02</td>
<td>Unsheltered homelessness</td>
</tr>
<tr>
<td>Z59.1</td>
<td>Inadequate housing</td>
</tr>
<tr>
<td>Z59.2</td>
<td>Discord with neighbors</td>
</tr>
<tr>
<td>Z59.3</td>
<td>Problems related to living in residential institution</td>
</tr>
<tr>
<td>Z59.4</td>
<td>Lack of adequate food</td>
</tr>
<tr>
<td>Z59.41</td>
<td>Food insecurity</td>
</tr>
<tr>
<td>Z59.48</td>
<td>Other specified lack of adequate food</td>
</tr>
<tr>
<td>Z59.5</td>
<td>Extreme poverty</td>
</tr>
<tr>
<td>Z59.6</td>
<td>Low income</td>
</tr>
<tr>
<td>Z59.7</td>
<td>Insufficient social insurance and welfare support</td>
</tr>
<tr>
<td>Z59.8</td>
<td>Other problems related to housing and economic circumstances</td>
</tr>
<tr>
<td>Z59.81</td>
<td>Housing instability, housed</td>
</tr>
<tr>
<td>Z59.811</td>
<td>Housing instability, housed, with risk of homelessness</td>
</tr>
<tr>
<td>Z59.812</td>
<td>Housing instability, housed, homelessness in past 12 months</td>
</tr>
<tr>
<td>Z59.819</td>
<td>Housing instability, housed unspecified</td>
</tr>
<tr>
<td>Z59.82</td>
<td>Transportation insecurity</td>
</tr>
<tr>
<td>Z59.86</td>
<td>Financial insecurity</td>
</tr>
<tr>
<td>Z59.87</td>
<td>Material hardship</td>
</tr>
<tr>
<td>Z59.89</td>
<td>Other problems related to housing and economic circumstances</td>
</tr>
<tr>
<td>Z59.9</td>
<td>Problem related to housing and economic circumstances, unspecified</td>
</tr>
</tbody>
</table>
ICD-10 CM Z Codes: Reporting Guidelines

Z55-Z65 identify issues related to a patient’s socioeconomic situation and are not procedural in nature.

The Z codes must be accompanied by a procedure code (CPT, HCPCS, ICD-10 PCS).

The Z codes do not have to be the principal or first-listed diagnosis (primary reason for the visit).
ICD-10 CM Z Codes: Reporting Guidelines

Who can document SDOH and their corresponding Z code(s)?

- Case Manager
- Social Worker
- Discharge Planner
- Clinical Staff
- Patient
NCCN Distress Thermometer

Patient Self-Reporting SDOH

Example: Connecting SDOH to Z Codes

The patient indicates on the “NCCN Distress Thermometer” they are experiencing significant stress regarding medical expenses, covering rent, and unemployment.
### Example: Connecting SDOH to Z Codes

<table>
<thead>
<tr>
<th>NCCN Distress Thermometer: Practical Concerns</th>
<th>ICD-10 CM Z Codes: Persons with potential health hazards related to socioeconomic and psychosocial circumstances</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Insurance</td>
<td>Z59.81 Housing instability, housed</td>
</tr>
<tr>
<td>✓ Housing</td>
<td>Z59.7 Insufficient social insurance and welfare support</td>
</tr>
<tr>
<td>✓ Work</td>
<td>Z56.0 Unemployment, unspecified</td>
</tr>
</tbody>
</table>

**Don’t forget!**
- Code to the highest level of specificity.
- Include other relevant diagnoses in the claim and medical record.
- The Z code must be accompanied by a HCPCS, CPT, or ICD-PCS code.
Social Determinants of Health: Connecting Z codes and CPT® Codes
CPT
What?

ICD-10 CM
Why?
CPT Codes for Addressing SDOH

- Evaluation and Management Services
- Prolonged Evaluation and Management Services
- Care Management Services
- Transitional Care Management Services
Medical Decision Making

- Z code(s) may justify and support medical decision making and medical necessity.

Time

- Face to face and non face to face activities can account for work associated with addressing SDOH
Additional time for evaluating, assessing, and managing a new or established patient on a single date of service.

- Z code may support the additional time needed (in addition to the primary E/M) working with patients who have a SDOH.
Management and support for patients with a single high-risk condition or multiple conditions over a calendar month.

- Addressing a patient’s SDOH may be part of the required care plan in addition to work performed by the physician/QHP or clinical staff.
Transitional Care Management Services

Management of patients discharged or transitioned from a hospital/facility setting to their home/community setting over 29 days.

- A Z code indicates whether a patient may require attention to psychosocial needs and activities of daily living support.
- Go to practice.asco.org
- Select “Coding & Reimbursement” under the “Billing, Coding, and Reporting” tab.
Available Resources

- Important Updates to E/M Services in 2023
- ASCO’s Guide to 2021 Changes
- Coding and Reimbursement Updates
- Care Management Services Practice Administration Guide
Resources

American Society of Clinical Oncology

Health Equity

- ASCO has developed a wide range of resources to help its members and the larger cancer community better understand and address health equity issues in cancer research and care.

Care Management Services Practice Administration and Reimbursement Guide

- Care management services provide continuous monitoring and support to patients over a calendar month with either a single high-risk condition or multiple conditions.

Enhanced Oncology Model (EOM) Fact Sheet

- The Center for Medicare and Medicaid Innovation’s (CMMI) Enhancing Oncology Model (EOM) aims to ensure quality care is provided to fee-for-service beneficiaries who are undergoing treatment for cancer, while also reducing spending.
Resources

Centers for Medicare and Medicaid Services

Equity Initiatives

The CMS Office of Minority Health has designed several initiatives to eliminate disparities in health care quality and access, so that all CMS beneficiaries can achieve their highest level of health.

National Comprehensive Cancer Network (NCCN)

NCCN Guidelines Version 1.2022- Distress Management
Resources

National Comprehensive Cancer Control Program (CDC)
- CDC’s National Comprehensive Cancer Control Program (NCCCP) has provided the funding, guidance, and technical assistance that programs use to design and implement impactful, strategic, and sustainable plans to prevent and control cancer.

Accountable Health Communities Model (CMS)
- The Accountable Health Communities Model addresses a critical gap between clinical care and community services in the current health care delivery system through screening, referral, and community navigation services will impact health care costs and reduce health care utilization.

Healthy People 2030 (HHS)
- Healthy People 2030 sets data-driven national objectives to improve health and well-being over the next decade.
Wrap Up
Next Steps?

1. Evaluate current practice processes.
2. Learn the Z codes.
3. Review related CPT codes and services.
4. Develop an action plan or next steps.
Questions?

Use the Q&A button in the bar at the bottom of your Zoom window
Questions and Discussion

Questions regarding Z codes or any other billing/coding questions may be sent to ASCO staff at practice@asco.org.
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  ▪ Medical oncology/hematology
  ▪ Radiation oncology
  ▪ Gynecologic oncology
  ▪ Oncology Care Model

• Must have at least 1 ASCO member at your practice
• Contact us at practicenet@asco.org
Next Call

• Thursday, January 19
  ▪ Topic: Updates on the CMSS/CDC Vaccine Grant

• 3rd Thursday of each month, 4:00pm Eastern Time

https://practice.asco.org/calendar