MARCH 2025

Health Equity: Ensuring You Are Properly Coding and Documenting for SDOH Disparities

VDMP-MARCH-2025

Veradigm's Provider Engagement Team

Amanda Banister, CPC

SR MANAGER, PROVIDER PERFORMANCE AND TECH UTILIZATION

Previous Experience: Amanda has over 25 years of healthcare experience, including 15 years of practice administration for both private practice and regional healthcare systems. Amanda has extensive experience coaching teams in the implementation of process and quality improvement activities. She has worked directly with Providers and their teams to improve their care coordination, population health management and risk stratification efforts as well as improvements in documentation and accurate coding related to HCC's and HEDIS quality scores including 5 Star and Part D measures. .

Education: Amanda is a Lean Six Sigma in HealthCare Black Belt, a Certified Clinical Microsystems Coach and a Certified Professional Coder.

Aimee Fritz, CPC, CRC, CCS

PROVIDER ENGAGEMENT SPECIALIST

Previous Experience: Aimee has over 20 years of experience in the healthcare field on the provider/clinic side as well as the insurance/payer side. She has been involved with the education and training of Providers, their staff and other medical coders on Risk Adjustment models, associated incentive programs, HCC coding guidelines and documentation requirements. Aimee has also assisted with process flows in office, as well as RAF score improvement.

Education: Aimee is a Lean Six Sigma in HealthCare Green Belt, a Certified Professional Coder, a Certified Risk Adjustment Coder and a Certified Coding Specialist.

Ryan Stull

PROVIDER ENGAGEMENT SPECIALIST

Previous Experience: Ryan has over 20 years of experience in the healthcare field working in the business office of a large-scale health system, on the provider clinic side as well as the insurance/payor side. He has been involved with educating providers and their office staff on Quality and Risk, how to close gaps in care and process flow.

Education: Ryan has a bachelors degree in Management and Organizational Leadership and a Black Belt in Six Sigma

Cindy Guarino, CRC, LPN

PROVIDER ENGAGEMENT SPECIALIST

Previous Experience: Cindy has over 12 years of diversified healthcare experience, including HCC coding, HEDIS abstracting, and risk adjustment coding. As a nurse, she has experience in pediatrics, community health, Covid response, ambulatory care, and health coaching. She is a skilled preceptor and educator.

Education: Cindy earned an associate degree in nursing, is a Licensed Practical Nurse, and a Risk Adjustment Coder.

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AGENDA

FEBRUARY 2025

- Overview of Social Determinants of Health (SDOH)
- Authoritative Guidance
- SDOH Coding
- HCPCS Code G0136 – Assessment for SDOH
- Clinical Coding Examples
- Summary and Tips

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Disclaimer

Educational Webinars

All documentation provided is researched and collected by today's presenter for the education of our customers. Any questions concerning the meaning or interpretation of coding requirements or application should be directed to your coding advisor or legal counsel.

The information included in the following slides is accurate as of 2/20/25.

ALL CODING GUIDANCE OBTAINED FROM THE AAPC ICD-10CM EXPERT
https://www.aapc.com/icd-10/

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Speakers

Kim Felix, RHIA, CCS

Currently the Director of Education at e4health. Has over 30 years of HIM coding experience including coder, auditor, educator and manager at various University and Community Hospitals. For the past 8 years, has been the project manager for the CMS HHS-RADV audit.

Has been an adjunct faculty member at Temple University, Gwynedd-Mercy College, Pierce College, Thomas Jefferson University, Anne Arundel Community College, and Study Mentor at Western Governors University.

Over many years, she has presented at various state-wide and local Coding and CDI conferences.

Jeanie Heck, BBA, CCS, CPC, CRC

Jeanie has over 30 years of experience as an expert physician and coder educator for CPT, ICD-10-CM and an accomplished Evaluation and Management auditor.

The majority of Jeanie's career has been in the outpatient physician office arena

She has been the lead senior auditor for the CMS HHS-RADV (Risk Adjustment Data Validation) audit from 2016 to present

She is currently an adjunct faculty member at Camden County College, Santa Barbara City College & Temple University teaching various coding courses. Her management positions include Director of Education, Coding and Billing Director, Practice Manager, and Business Manager

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Overview of Social Determinants of Health (SDOH)

SDOH defined …

CDC/WHO

Social determinants of health (SDOH) are the nonmedical factors that influence health outcomes

AHIMA

HIM professionals capture economic, social, and behavioral conditions that impact health, aiding clinical and financial teams in creating meaningful health journeys for individuals and communities

CMS

The conditions in the environment where people are born, live, work, play, and age

[1] Social Determinants of Health (SDOH) | About CDC | CDC
[2] Social Determinants of Health | Advocacy
[3] Health Equity Terminology and Quality Measures | The Measures Management System

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Health Inequities

- Hospitals and health systems are working to address the social needs of their patients and the systemic causes that lead to health inequities
- These societal factors include:

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Data

- In 2021, 10.20% of United States households were food insecure or unable to acquire enough food to feed their families due to lack of finances or other resources to obtain nutritious food[4]
- The U.S. Department of Housing and Urban Development's (HUD) 2021 Worst Case Housing Needs report found that 7.77 million households were classified as having worst-case housing needs
  - Very low-income renters paying more than half their income in rent, live in severely inadequate conditions, or both
  - Almost a third of those households contain children[5]
- According to a study published in the Annals of Emergency Medicine, housing instability is known to adversely affect health. This population was shown to have frequent emergency department use, and the findings suggest that patients may benefit from efforts to identify housing instability[6]
- According to the U.S. Dept. of Transportation, having access to public transportation is important for people who are unable to drive, are members of low-income households, have children, are individuals with disabilities, and who are older adults.
  - Safe, accessible transport is vital for improving health, preventive healthcare, employment, and educational opportunities to improve economic well-being[7]

[4]U.S. Department of Agriculture. (September 2021). Food Security in the U.S. Key Statistics & Graphics. Retrieved from: https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/key-statistics-graphics.aspx#foodsecure
[5]U.S. Department of Housing and Urban Development. Office of Policy Development and Research. (July 2021). Worst Case Housing Needs 2021 Report to Congress. Retrieved from: https://www.huduser.gov/portal/sites/default/files/pdf/Worst-Case-Housing-Needs-2021.pdf
[6]Doran, K., et al. (October 2020). Homeless Shelter Entry in the Year After an Emergency Department Visit: Results from a Linked Data Analysis. Health Policy/Brief Research Report. Volume 76, Issue 4, 462-467. Annals of Emergency Medicine. Retrieved from: https://www.annemergmed.com/article/S0196-0644(20)30180-3/fulltext
[7]U.S Department of Transportation: https://www7.transportation.gov/mission/health/connectivity

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Definitions

Homelessness

Because of economic difficulties, currently living in a shelter, motel, temporary or transitional living situation, scattered site housing, not having a consistent place to sleep at night, or sleeping in a place not meant for human habitation

**Source* *Homelessness During Infancy: Associations With Infant and Maternal Health and Hardship Outcomes*

**Source* *Unstable Housing and Caregiver and Child Health in Renter Families*

Homelessness, sheltered

Because of economic difficulties, currently living in a shelter, motel, temporary or transitional living situation, scattered site housing, or not having a consistent place to sleep at night

**Source* *Homelessness During Infancy: Associations With Infant and Maternal Health and Hardship Outcomes*

**Source* *Unstable Housing and Caregiver and Child Health in Renter Families*

Homelessness, unsheltered

Residing in a place not meant for human habitation, such as cars, parks, sidewalks, abandoned buildings (on the street)

**Source* *HUD*

[8]Coding Clinic, 4Q, 2021, pages 33-37

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Definitions

Housing instability, housed

Currently consistently housed, but experiencing any of the following circumstances in the past 12 months: being behind on rent or mortgage, multiple moves

Source *Promoting Caregiver and Child Health Through Housing and Stability Screening in Clinical Settings*

Housing instability, housed with risk of homelessness

Currently consistently housed, but with the imminent threat of being forced to live in a shelter, motel, temporary or transitional living situation, scattered site housing, not having a consistent place to sleep at night, or in a place not meant for human habitation

Housing instability, housed, homelessness in the past 12 months

Currently consistently housed, but with a history of homelessness, for any period of time during the past 12 months

**Source Homelessness During Infancy: Associations With Infant and Maternal Health and Hardship Outcomes*

**Source Unstable Housing and Caregiver and Child Health in Renter Families*

[8]Coding Clinic, 4Q, 2021, pages 33-37

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Tracking

- Robust social needs data is critical to hospitals' efforts to improve the health of their patients and communities

- Hospitals need to:
  - Track the social needs that impact the patients' medical and non-medical needs
  - Identify population health trends and guide community partnerships

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Impact

- At the national level, adding social needs data to hospital claims helps gain a better understanding of the health-related social needs of patients and communities around the country

- Hospital leaders should educate physicians, nonphysician health care providers and coding professionals of the important need to screen, document and code data on patients' social needs

- As payment moves from volume to **value**, having claims data connected to social needs can support policy and payment reforms
  - Including appropriate risk-adjustments

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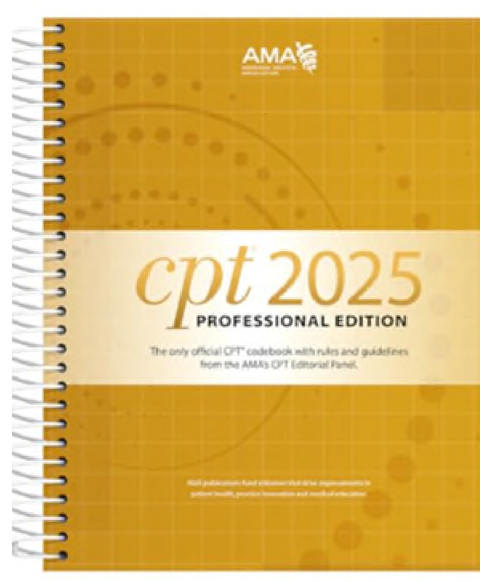
SDOH – Authoritative Guidance & Coding

SDOH – Authoritative Guidance



ICD-10-CM Official Guidelines for Coding and Reporting
FY 2025 -- UPDATED October 1, 2024
(October 1, 2024 - September 30, 2025)

Narrative changes appear in bold text
Items underlined have been moved within the guidelines since the April 2024, FY 2024 version
***Italics* are used to indicate revisions to heading changes**

The Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS), two departments within the U.S. Federal Government's Department of Health and Human Services (DHHS) provide the following guidelines for coding and reporting using the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM). These guidelines should be used as a companion document to the official version of the ICD-10-CM as published on the NCHS website. The ICD-10-CM is a morbidity classification published by the United States for classifying diagnoses and reason for visits in all health care settings. The ICD-10-CM is based on the ICD-10, the statistical classification of disease published by the World Health Organization (WHO).

These guidelines have been approved by the four organizations that make up the Cooperating Parties for the ICD-10-CM: the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), CMS, and NCHS.

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SDOH ICD-10-CM Code Categories

Z55-Z65

SDOH Codes are located primarily in these Z code categories:

ICD-10-CM Code Category	Problems/Risk Factors	Code Example
Z55 Problems related to literacy	Illiteracy, schooling unavailable, underachievement in a school, less than a high school diploma, no general equivalence degree (GED), educational maladjustment, and discord with teachers and classmates	**Z55.1** Schooling unavailable and unattainable
Z56 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	**Z56.2** Threat of job loss **Z56.82** Military deployment status
Z57 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	**Z57.1** Occupational exposure to radiation
Z58 Problems related to physical environment	Inadequate drinking-water supply, and lack of safe drinking water.	**Z58.6** Inadequate drinking-water supply
Z59 Problems related to housing and economic circumstances	Sheltered homelessness, unsheltered homelessness, residing in street, inadequate housing, housing instability, discord with neighbors, lodgers and landlord, problems related to living in residential institutions, inadequate food, lack of adequate food, food insecurity, extreme poverty, low income, and insufficient social insurance and welfare support	**Z59.02** Unsheltered homelessness **Z59.5** Extreme poverty

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SDOH Codes are located primarily in these Z code categories:

ICD-10-CM Code Category	Problems/Risk Factors	Code Example
Z60 Problems related to social environment	Adjustment to life-cycle transitions, living alone, acculturation difficulty, social exclusion and rejection, target of adverse discrimination and persecution	**Z60.4** Social exclusion and rejection
Z62 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, personal history of unspecified abuse in childhood, parent-child conflict, and sibling rivalry	**Z62.22** Institutional upbringing **Z62.81** Personal history of abuse in childhood
Z63 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, and alcoholism and drug addiction in family	**Z63.5** Disruption of family by separation and divorce
Z64 Problems related to certain psychosocial circumstances	Unwanted pregnancy, multiparity, and discord with counselors	**Z64.0** Problems related to unwanted pregnancy
Z65 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	**Z65.4** Victim of crime and terrorism

Did you know there are over 100 codes that fall between Z55-Z65? The best way to familiarize yourself with them is to page through an ICD-10-CM manual!

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Inpatient Coding

Some SDOH codes can affect IP Reimbursement (MS-DRGs)

*Currently, SDOH codes do not affect APR-DRG assignment

Z59.00	Homelessness, unspecified
Z59.01	Sheltered homelessness
Z59.02	Unsheltered homelessnes
Z59.10	Inadequate housing, unspecified
Z59.11	Inadequate housing environmental temperature
Z59.12	Inadequate housing facilities
Z59.19	Other inadequate housing
Z59.811	Housing instability, housed, with risk of homelessness
Z59.812	Housing instability, housed, homelessness in past 12 months
Z59.819	Housing instability, housed, unspecified

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CMS and SDOH

CMS Mandated SDOH Requirements for Hospitals & Facilities that Admit Patients(effective 1/1/24)

Beginning January 1, 2024: CMS *requires* hospitals and facilities that admit patients to screen for five social risk drivers (this was voluntary in 2023)

- Reporting period will run through all of 2024
- All data must be submitted by May 15, 2025
- **The required 5 SDOH domains:**
  - Food Insecurity
  - Interpersonal Safety
  - Housing Instability
  - Transportation Needs
  - Utility Difficulties

[9] FY 2025 IPPS Final Rule Home Page | CMS

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CMS Calendar Year 2025 OPPS (Outpatient Prospective Payment System) Final Rule

- CMS adopted 3 new health equity measures
- **Screening for Social Drivers of Health (SDOH) is one of the three**
- The reporting is voluntary for CY2025
- **Mandatory reporting begins CY2026 reporting period**

[10] CMS-1809-FC | CMS

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CMS website – Data Tools to Assist with SDOH

The CMS website provides 2 data tools to help identify & explore health disparities and support practices and health care systems in enhancing their standardized demographic data collection fostering equity in healthcare delivery

- "Improving the Collection of SDOH Data with ICD-10-CM Z codes"
- "Using Z codes: SDOH Data Journey Map"

[11] Data Tools | CMS

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CMS & SDOH

USING Z CODES:

The **Social Determinants of Health (SDOH)** Data Journey to Better Outcomes

What are

SDOH-related Z codes ranging from Z55-Z65 are the ICD-10-CM diagnosis 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, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

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.[1]

- 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 by any member of the care team if their documentation is included in the official medical record.[2]

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

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

[1] https://www.cms.gov/medicare/icd-10/2024-icd-10-cm
[2] https://www.aha.org/system/files/2018-04/value-initiative-icd-10-code-social-determinants-of-health.pdf

[1,2]USING Z CODES

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AMA/CPT and SDOH

CPT: 3 Elements of Medical Decision Making (MDM) in E/M

1. Number & Complexity of Problem(s) that are addressed during the encounter
2. Amount and/or Complexity of Data to be reviewed & analyzed
3. Risk of Complications and/or Morbidity or Mortality of patient management

"SDOH factors may raise the risk of complications, morbidity, or mortality by limiting treatment options & diagnosis capability"

[13] Social determinants of health and medical coding: What to know | American Medical Association

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CPT – 3 Elements of MDM – "Risk" Element

SDOH is considered "moderate" in the Risk element

Risk of Complications and/or Morbidity or Mortality of Patient Management

One element used in selecting the level of service is the risk of complications and/or morbidity or mortality of patient management at an encounter. This is distinct from the risk of the condition itself.

Social determinants of health: Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity.

Elements of Medical Decision Making			
Level of MDM (Based on 2 out of 3 Elements of MDM)	**Number and Complexity of Problems Addressed at the Encounter**	**Amount and/or Complexity of Data to Be Reviewed and Analyzed** ****Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.***	**Risk of Complications and/or Morbidity or Mortality of Patient Management**
Moderate	**Moderate** ■ **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment; **or** ■ **2** or more stable, chronic illnesses; **or** ■ **1** undiagnosed new problem with uncertain prognosis; **or** ■ **1** acute illness with systemic symptoms; **or** ■ **1** acute, complicated injury	**Moderate** *(Must meet the requirements of at least 1 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** ■ **Any combination of 3 from the following:** • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) **or** **Category 2: Independent interpretation of tests** ■ Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **or** **Category 3: Discussion of management or test interpretation** ■ Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	**Moderate risk of morbidity from additional diagnostic testing or treatment** *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

[14]2025 CPT manual

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SDOH & E/M

SDOH factors may raise the risk of complications, morbidity/mortality by limiting treatment options

Must be addressed in the progress note & their presence affects management of the patient

Risk element definition states “diagnosis or treatment SIGNIFICANTLY LIMITED by…”

Smoking and alcohol are part of social history and not considered SDOH

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AMA: Debunking Regulatory Myths - Use of Note Templates for Documenting Medical Information

- CMS does *not* prohibit the use of templates to assist in documentation
- CMS defines a template as a "tool/instrument/interface that assists in documenting a progress note"
- "Templated text should be reviewed and revised as necessary for each individual patient"

About AMA Debunking Medical Practice Regulatory Myths Learning Series

Providing physicians and other medical professionals with regulatory clarification to streamline clinical workflow processes, improve patient outcomes and reduce burnout.

[15] Use of note templates for documenting medical information | American Medical Association
[16] About AMA Debunking Medical Practice Regulatory Myths Learning Series | AMA Debunking Medical Practice Regulatory Myths Learning Series | Ed Hub

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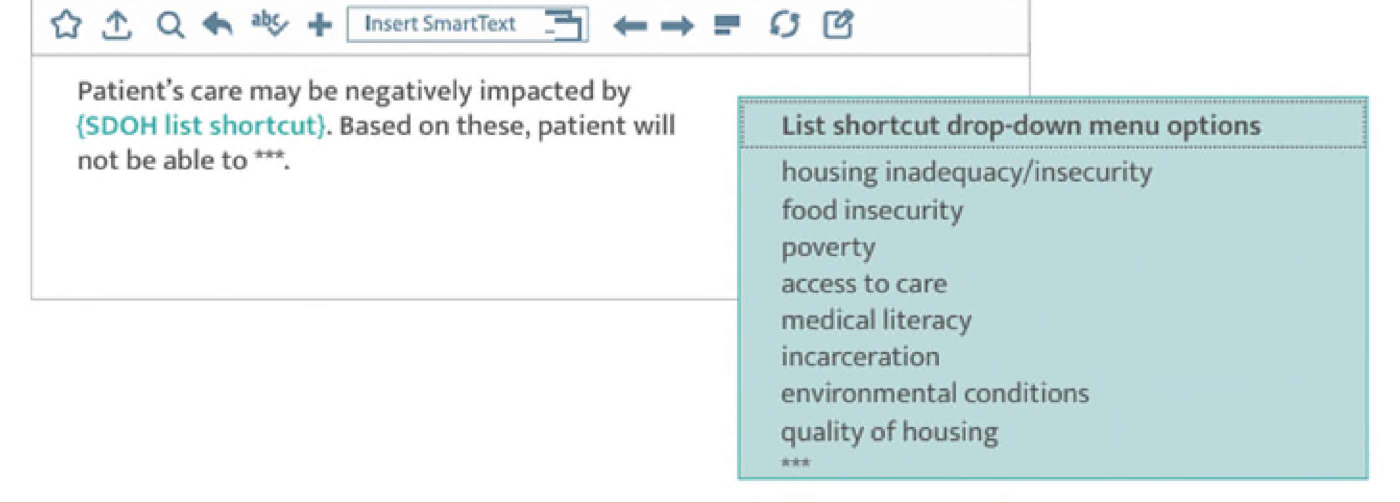
AMA: Simplified Outpatient Documentation & Coding



How do patients' social determinants of health (SDOH) affect coding?

Social determinants of health can contribute to the complexity of patient issues and, as a result, may affec both the time spent during an encounter coordinating care and the level of MDM. Getting in the habit of adding any ICD-10 SDOH diagnoses on the claim being used in MDM will demonstrate the SDOH impact. These ICD-10 SDOH diagnoses will also help support medical necessity for higher levels of service. Example of SDOH Z codes can be found in this infographic from CMS (PDF).

Here is an example of an EHR shortcut to document SDOH issues:

Insert SmartText

Patient's care may be negatively impacted by {SDOH list shortcut}. Based on these, patient will not be able to ***.

List shortcut drop-down menu options

housing inadequacy/insecurity
food insecurity
poverty
access to care
medical literacy
incarceration
environmental conditions
quality of housing
***

[17] AMA Simplified Outpatient Documentation and Coding Toolkit.pdf

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ICD-10-CM Guidelines & SDOH

ICD-10-CM & SDOH – Section I.B.14

14. Documentation by Clinicians Other than the Patient's Provider

Code assignment is based on the documentation by the patient's provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis). There are a few exceptions when code assignment may be based on medical record documentation from clinicians who are not the patient's provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis). In this context, "clinicians" other than the patient's provider refer to healthcare professionals permitted, based on regulatory or accreditation

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requirements or internal hospital policies, to document in a patient's official medical record.

These exceptions include codes for:

- Body Mass Index (BMI)
- Depth of non-pressure chronic ulcers
- Pressure ulcer stage
- Coma scale
- NIH stroke scale (NIHSS)
- Social determinants of health (SDOH) classified to Chapter 21
- Laterality
- Blood alcohol level
- Underimmunization status

This information is typically, or may be, documented by other clinicians involved in the care of the patient (e.g., a dietitian often documents the BMI, a nurse often documents the pressure ulcer stages, and an emergency medical technician often documents the coma scale). However, the associated diagnosis (such as overweight, obesity, acute stroke, pressure ulcer, or a condition classifiable to category F10, Alcohol related disorders) must be documented by the patient's provider. If there is conflicting medical record documentation, either from the same clinician or different clinicians, the patient's provider should be queried for clarification.

The BMI, coma scale, NIHSS, blood alcohol level codes, codes for social determinants of health and underimmunization status should only be reported as secondary diagnoses.

See Section I.C.21.c.17. for additional information regarding coding social determinants of health.

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ICD-10-CM & SDOH – Section I.C.21.c.17

17) Social Determinants of Health

Social determinants of health (SDOH) codes describing social problems, conditions, or risk factors that influence a patient's health should be assigned when this information is documented in the patient's medical record. Assign as many SDOH codes as are necessary to describe all of the social problems, conditions, or risk factors documented during the current episode of care. For example, a patient who lives alone may suffer an acute injury temporarily impacting their ability to perform routine activities of daily living. When documented as such, this would support assignment of code Z60.2, Problems related to living alone. However, merely living alone, without documentation of a risk or unmet need for assistance at home, would not support assignment of code Z60.2. Documentation by a clinician (or patient-reported information that is signed off by a clinician) that the patient expressed concerns with access and availability of food would support assignment of code Z59.41, Food insecurity. Similarly, medical record documentation indicating the patient is homeless would support assignment of a code from subcategory Z59.0-, Homelessness.

For social determinants of health classified to chapter 21, such as information found in categories Z55-Z65, Persons with potential health hazards related to socioeconomic and psychosocial circumstances, code assignment may be based on medical record documentation from clinicians involved in the care of the patient who are not the patient's provider since this information represents social information, rather than medical diagnoses. For example, coding professionals may utilize documentation of social information from social workers, community health workers, case managers, or nurses, if their documentation is included in the official medical record.

Patient self-reported documentation may be used to assign codes for social determinants of health, as long as the patient self-reported information is signed-off by and incorporated into the medical record by either a clinician or provider.

Social determinants of health codes are located primarily in these Z code categories:

Z55	Problems related to education and literacy
Z56	Problems related to employment and unemployment
Z57	Occupational exposure to risk factors
Z58	Problems related to physical environment
Z59	Problems related to housing and economic circumstances
Z60	Problems related to social environment
Z62	Problems related to upbringing
Z63	Other problems related to primary support group, including family circumstances
Z64	Problems related to certain psychosocial circumstances
Z65	Problems related to other psychosocial circumstances

See Section I.B.14. Documentation by Clinicians Other than the Patient's Provider.

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American Hospital Association (AHA)/Coding Clinic & SDOH

American Hospital Association (AHA)/Coding Clinic & SDOH

In the beginning of 2018, the AHA published articles in Coding Clinic regarding who can document codes from categories Z55-Z65

In 2019, additional guidance was published regarding the definition of "clinician" & self-reported patient social needs.

Result: coding professionals can use documentation of "social needs" from clinicians such as social workers, community health workers, case managers, nurses or other providers.

[18] Resource on ICD-10-CM Coding for Social Determinants of Health | AHA

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Coding Clinic & SDOH

AHA Coding Clinic, 4Q 2023, pages 83-85

Codes from categories Z55-Z65 can be assigned based on information documented by all clinicians involved in the care of the patient

The AHA Coding Clinic clarified that for the purpose of documenting social information, "clinicians" can include anyone deemed to meet the requirements, set by regulation or internal hospital policy, to document in the patient's official medical record

Including documentation from (but not limited to):

- Nonphysician providers
- Social workers
- Community health workers
- Case managers
- Nurses

[19]AHA Coding Clinic, 4Q 2023, pages 83-85

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Coding Clinic & SDOH

AHA Coding Clinic, 1Q 2023, page 8

Assign as many SDOH codes as necessary to describe all of the social problems, conditions, or risk factors documented during the current episode

Ex: Documentation by a clinician or patient-reported info (signed off by a clinician) stating patient expressed concerns with access & availability of food supports code Z59.41 – Food insecurity

Ex: Documentation indicating the patient is homeless supports assignment of a code from subcategory Z59.0- "Homelessness"

[20]AHA Coding Clinic, 1Q 2023, page 8

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Coding Clinic & SDOH

AHA Coding Clinic, 4Q 2021, pages 93-95

Patient Self-Reported Documentation

Hospitals often utilize patient self-report tools to identify social needs

If the patient self-reported information is **signed-off** and incorporated into the medical record by a clinician, that information can support the use of a Z code by coding professionals

**The clinician has reviewed, approved, and authenticated the patient self-reported information by adding their signature and the date to the visit note.*

[21] AHA Coding Clinic, 4Q 2021, pages 93-95

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CPT Assistant & SDOH

CPT Assistant & SDOH – Bulletin 1 (2023)

"Social Determinants of Health & Their Effect on Health and Health Care"

- Bulletin discusses the 5 domains of SDOH:
  - Economy
  - Education
  - Healthcare
  - Physical Infrastructure
  - Social & Community

- It also provides links to SDOH screening tools & gives insights into coding SDOH

[22]CPT Assistant Bulletin 2023

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CPT Assistant & SDOH – Bulletin 2023

Social determinants of health in health care

CPT Assistant, Bulletin 2023 Page: 1 Category: Bulletin

Related Information

Social Determinants of Health and Their Effect on Health and Health Care

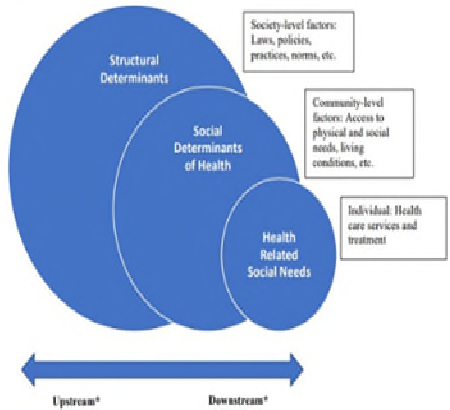
Efforts to address social determinants of health (SDOH) in health care have received renewed attention in recent years, building on studies and other initiatives dating back to the 1990s. The Centers for Disease Control and Prevention (CDC) defines SDOH as "the conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life,"[1] which is adopted from the World Health Organization (WHO). The United States (US) Department of Health and Human Services (HHS) Healthy People 2030's definition of SDOH includes "the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks,"[2] which expands the elements of people's day-to-day lives and the influence those elements have on their health.

It is estimated that only 20% of a person's health status is influenced by the health care services they receive, whereas the other 80% is the result of social, physical, and economic factors.[3] Therefore, the majority of someone's health status is related to social drivers that encompass multiple levels of factors. Structural determinants are the overarching social policies and hierarchies that have been established through history, laws, regulations, practices, and norms. The structural determinants in turn shape the SDOH of a community (see Figure 1). Health care systems have been making strides in addressing SDOH at the community level by investing in building more inclusive and sustainable local economies.

SDOH consist of the following five domains[2]:

1. **Economy:** a person's access to employment, their employment status, stability of employment, income, and poverty level.
2. **Education:** a person's ability to reach their highest level of education, which is related to access to quality day care, schools, and adult education.
3. **Health care:** a person's access to high-quality health care, insurance, and other health care needs.
4. **Physical infrastructure:** a person's neighborhood and physical environment and the availability of housing, transportation, food, green spaces, and safe air and water.
5. **Social and community:** a person's social and community network, including social support, cohesion, and demographics (eg, race, ethnicity, religion, gender).

Figure 1. Social and Individual Drivers of Health



*Upstream are the broad, macro-level factors and influences, whereas downstream are the individual-level factors and influences.

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CPT Assistant & SDOH – Bulletin 2023

When coding the patient's medical record, the coder identifies in the documentation any appropriate social factors and includes them in the claim with the other diagnosis codes related to the services provided. Including Z codes in the claim enables the health plan to capture information about the patient's social needs and health factors. These codes are also included in claims-based public health reporting efforts.

The Centers for Medicare #38; Medicaid Services (CMS) created an infographic (see Figure 3[8]), which is also available at https://www.cms.gov/files/document/zcodes-infographic.pdf, to demonstrate how Z codes can be used throughout the health care system to improve patient outcomes.

Figure 3. CMS: How to Use Z Codes

Social determinants of health in health care

CPT Assistant, Bulletin 2023 Page: 1 Category: Bulletin

Related Information

Table 2. ICD-10-CM Z-Code Categories and Influencing Factors

Z-Code SDOH Categories	Examples of Influencing Factors
Z55: Problems related to education and literacy	Illiteracy and low-level literacy, lack of schooling, underachievement in school, less than a high school diploma or general equivalence degree (GED).
Z56: Problems related to employment and unemployment	Unemployment, threat of job loss, stressful work schedule, difficult relationships with boss or co-workers, difficult working conditions, sexual harassment.
Z57: Occupational exposure to risk factors	Exposure to noise, radiation, dust, tobacco smoke, toxic agents, extreme temperatures.
Z58: Problems related to physical environment	Lack of or inadequate safe drinking water.
Z59: Problems related to housing and economic circumstances	Homelessness, inadequate housing, housing instability, difficulties with neighbors or property owner, lack of food, extreme poverty, low income, financial insecurity, transportation insecurity, material hardship including inability to obtain childcare.
Z60: Problems related to social environment	Life-cycle transitions, difficulties due to migration, social rejection, discrimination.
Z62: Problems related to upbringing	Lack of parental supervision, overprotective parenting, welfare custody, physical abuse, psychological abuse, neglect, parent-child estrangement.
Z63: Other problems related to primary support group, including family circumstances	Problems with spouse/partner, family separation or divorce, military deployment of a family member, alcoholism or drug dependency in the family.
Z64: Problems related to certain psychosocial circumstances	Unwanted pregnancy, multiple birth children, discord with counselors (eg, probation officer, social worker).
Z65: Problems related to other psychosocial circumstances	Civil or criminal proceedings, incarceration, child custody proceedings, victim of a crime, exposure to a disaster or war, etc.

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CPT Assistant & SDOH – Bulletin 2023 (cont'd)

The CMS has been tracking the reporting of Z codes on Medicare fee-for-service (FFS) and Medicare Advantage claims. In 2019, more than 1.2 million FFS claims included Z codes, representing 0.11% of all FFS claims that year.[7] The top five Z codes reported were homelessness (Z59.0); disappearance and death of a family member (Z63.4); problems related to living alone (Z60.2); problems related to living in a residential institution (Z59.3); and problems in relationship with spouse or partner (Z63.0).[7] For Medicare Advantage claims, a sample of claims from 2019 showed 1.07% included at least one Z code.[8] The top five codes reported, from most to least reported, were problems related to living alone (Z60.2); disappearance and death of a family member (Z63.4); homelessness (Z59.0); problems in relationship with spouse or partner (Z63.0); and other specified problems related to upbringing (Z62.8).[8]

The Current Procedural Terminology (CPT®) code set also plays a role in the data-driven efforts to address SDOH. The CPT code set is a well-established nomenclature for coding medical procedures and services with a code-development process that can respond rapidly to health care demands. The CPT codes capture the services provided by physicians and other QHPs; however, they also can provide a broader picture of care received by patients when paired with Z codes. Therefore, the potential effect of SDOH on treatment was formally added to the list of elements for medical decision making (MDM) for evaluation and management (E/M) codes for office and other outpatient settings in 2021. Those same SDOH elements were added in the CPT 2023 code set for inpatient observation care, emergency departments, nursing facilities, and home or residence services.

Reporting Scenario 2

With the recognition of SDOH, more comprehensive information is considered:

Diabetic education was completed, and ICD-10-CM Z codes were reported on subsequent claims, when applicable. The patient is unemployed and has no health insurance and has recently applied for Social Security Disability Insurance (SSDI), which lead the patient to administer their insulin prescription below the prescribed dosage due to the high cost of the insulin and an inability to pay for it.

Additional ICD-10-CM diagnosis codes that reflect the effect of SDOH:

- Z59.7, *Insufficient social insurance and welfare support*
- Z56.0, *Unemployment, unspecified*
- Z91.120, *Patient's intentional underdosing of medication regimen due to financial hardship*

The CPT code selection that reflects the effect of SDOH increased to:

- 99214, *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.*

MDM elements considered:

- Risk: Moderate (increased with diagnosis or treatment significantly limited by SDOH)

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HCPCS Code G0136 – Assessment for SDOH

HCPCS Code G0136: Assessment for SDOH (effective 1/1/24)

G0136 – "Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment, 5-15 minutes, not more often that every 6 months"

- This assessment can be done on the same day as an E/M service and may also be used/billed with discharge visits from an inpatient stay

- **The 2024 Final Rule further states the following regarding assessment tools:**
  - "Administration of a standardized, evidence-based SDOH risk assessment tool that has been tested and validated through research, and includes the domains of food insecurity, housing insecurity, transportation needs, and utility difficulties"
  - "Possible evidence-based tools include the CMS Accountable Health Communities (AHC) tool, the Protocol for Responding and Assessing Patients' Assets, Risks and Experiences (PRAPARE) tool, and instruments identified for Medicare Advantage Special Needs Population Health Risk Assessment" – p 346

- CMS does not require that care management services be provided, however, they expect the patient to be referred to relevant resources (requires follow-up)

[23]https://www.cms.gov/priorities/innovation/files/worksheets/ahcm-screeningtool.pdf
[24]CMS-1784-F | CMS
[25]https://prapare.org/
[26]https://public-inspection.federalregister.gov/2023-24184.pdf
[27]MLN9201074 - Health Equity Services in the 2024 Physician Fee Schedule Final Rule

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HCPCS Code G0136: Assessment for SDOH (effective 1/1/24)

You may choose a tool or ask additional questions that also include other areas if prevalent or culturally important to your patient population. Some tools you may consider that are standardized and evidence-based include the CMS Accountable Health Communities Tool, Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences (PRAPARE), and instruments identified for Medicare Advantage Special Needs Population Health Risk Assessment.

Note: G0136 is also added to telehealth services on a permanent basis.

Health Equity Services in the 2024 Physician Fee Schedule Final Rule — MLN Booklet

Social Determinants of Health Risk (SDOH) Assessment

We finalized a new stand-alone G code, G0136, to pay for administering an SDOH risk assessment, no more than once every 6 months:

G0136: Administration of a standardized, evidence-based SDOH assessment, 5–15 minutes, not more often than every 6 months.

You may provide this service with:

- An evaluation and management (E/M) visit, which can include hospital discharge or transitional care management services
- Behavioral health office visits, such as psychiatric diagnostic evaluation and health behavior assessment and intervention
- The Annual Wellness Visit (AWV)

SDOH risk assessments that you furnish as part of an E/M or behavioral health visit isn't a screening. It may be medically reasonable and necessary as part of a comprehensive social history, when you have reason to believe there are unmet SDOH needs that are interfering with the practitioner's diagnosis and treatment of a condition or illness or will influence choice of treatment plan or plan of care. In these circumstances, patient cost sharing will apply, just as it does for any medical service. The risk assessment wouldn't usually be administered in advance of the visit.

[27] MLN9201074 - Health Equity Services in the 2024 Physician Fee Schedule Final Rule

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CMS AHC Health-Related Social Needs Screening Tool

The Accountable Health Communities Health-Related Social Needs Screening Tool

What's the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool?

We at the Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (CMMI) made the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool to use in the AHC Model.[1] We're testing to see if systematically finding and dealing with the health-related social needs of Medicare and Medicaid beneficiaries has any effect on their total health care costs and makes their health outcomes better.

Why is the AHC HRSN Screening Tool important?

Growing evidence shows that if we deal with unmet HRSNs like homelessness, hunger, and exposure to violence, we can help undo their harm to health. Just like with clinical assessment tools, providers can use the results from the HRSN Screening Tool to inform patients' treatment plans and make referrals to community services.

What does the AHC HRSN Screening Tool mean for me?

Screening for HRSNs isn't standard clinical practice yet. We're making the AHC HRSN Screening Tool a standard screening across all the communities in the AHC Model. We're sharing the AHC HRSN Screening Tool for awareness.

AHC HRSN Screening Tool Core Questions

If someone chooses the underlined answers, they might have an unmet health-related social need.

Living Situation

1. **What is your living situation today?[3]**
   - ☐ I have a steady place to live
   - ☐ I have a place to live today, but **I am worried** about losing it in the future
   - ☐ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

2. **Think about the place you live. Do you have problems with any of the following?[4]**
   CHOOSE ALL THAT APPLY
   - ☐ Pests such as bugs, ants, or mice
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Lack of heat
   - ☐ Oven or stove not working
   - ☐ Smoke detectors missing or not working
   - ☐ Water leaks
   - ☐ None of the above

Food

Some people have made the following statements about their food situation. Please answer whether the statements were OFTEN, SOMETIMES, or NEVER true for you and your household in the last 12 months.[5]

3. **Within the past 12 months, you worried that your food would run out before you got money to buy more.**
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

[28]The AHC Health-Related Social Needs Screening Tool

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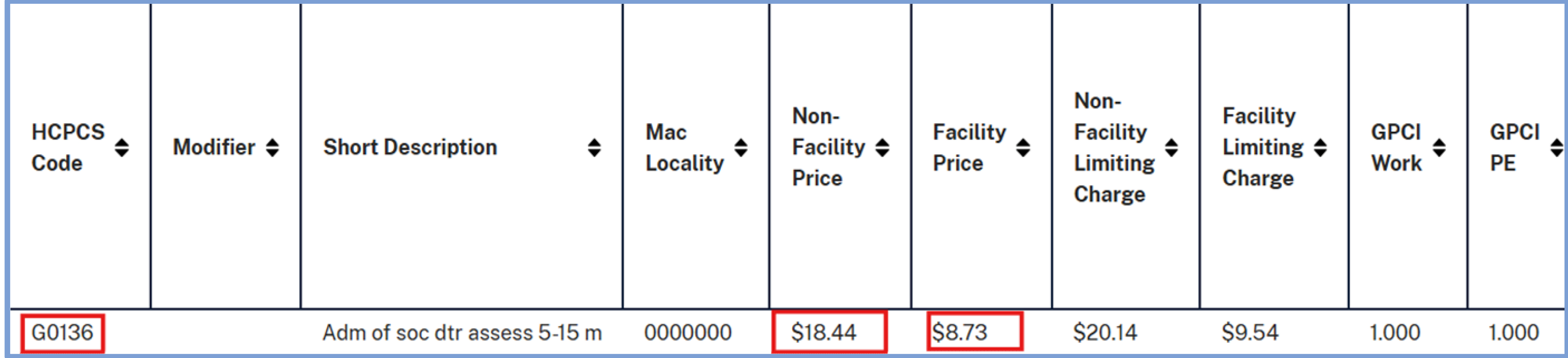
PRAPARE SDOH Screening Tool

[29] PRAPARE

HCPCS Code G0136: CMS Reimbursement



HCPCS Code	Modifier	Short Description	Mac Locality	Non-Facility Price	Facility Price	Non-Facility Limiting Charge	Facility Limiting Charge	GPCI Work	GPCI PE
G0136		Adm of soc dtr assess 5-15 m	0000000	$18.44	$8.73	$20.14	$9.54	1.000	1.000

[30] Search the Physician Fee Schedule | CMS

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Clinical Coding Examples

Clinical Coding Example #1

A young male patient with a knee injury presents to his PCP for an initial evaluation

The PCP documents "Recommend an MRI to rule out a suspected meniscus tear & then refer him to Orthopedics. Unfortunately, he has a low-paying job and no health insurance, so he is refusing both the MRI & the referral"

Provider's perspective: management decisions are now more complicated & there's a higher level of risk associated with this patient

Z59.71 Insufficient Health Insurance Coverage (no health insurance coverage)

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Clinical Coding Example #2

66-year-old patient returns to the office today for a refill of her medications for HTN & DM

Documentation states "Millie lives alone and has missed her last 2 appointments due to difficulties with transportation. She has no family nearby to help her with transportation"

Documentation also states "Patient has been out of her medications for 2 weeks because she couldn't pay for them. She was waiting for her social security check"

Z59.82 Transportation Insecurity/Lack of Transportation

Z59.6 Low Income

Z60.2 Problems related to living alone

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Summary and Tips

Summary and Tips

- SDOH is considered "**Moderate**" in the Risk element of MDM
  - **Coders/Auditors:** Do not miss these dx codes! Be sure to page through the ICD-10 manual to familiarize yourself with these codes (Z55-Z65).
    - *Work with your providers & ensure they document them in their notes.*
    - *Make sure they are aware that appropriate codes exist to reflect their patient's clinical situation!*
  - **Providers**: **Document social issues affecting your patients as these factors can influence their care plans & outcome and can affect the level of service provided.** This will soon become a standard requirement in outpatient settings
- SDOH reporting is ***mandatory*** to CMS in the inpatient world as of January 2024
- SDOH reporting will be ***mandatory*** in the outpatient world as of CY2026
- Reporting requirements will have an impact on us all … extra time to collect data, patient inquiries and queries to providers!

Stay up-to-date & **ONLY use authoritative guidance!**

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Veradigm Provider Engagement Resources

Our Mission

At Veradigm we are transforming health, *insightfully*

Veradigm is a healthcare technology and analytics company spanning across the **THREE PILLARS** of healthcare—

Veradigm and the Veradigm Network are **DIFFERENT** because of our connectivity, scale, and expertise which provide a uniquely comprehensive scope and depth of interconnected resources, so our clients can drive improved health outcomes for the patients they serve.

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Veradigm Payer | Purpose and Mission

OUR PURPOSE is to empower high-value healthcare partnerships

OUR MISSION is To re-imagine data to help people live healthy and independent lives through sophisticated analytics, predictive techniques, efficient administrative and financial workflows, and advanced interoperability solutions.

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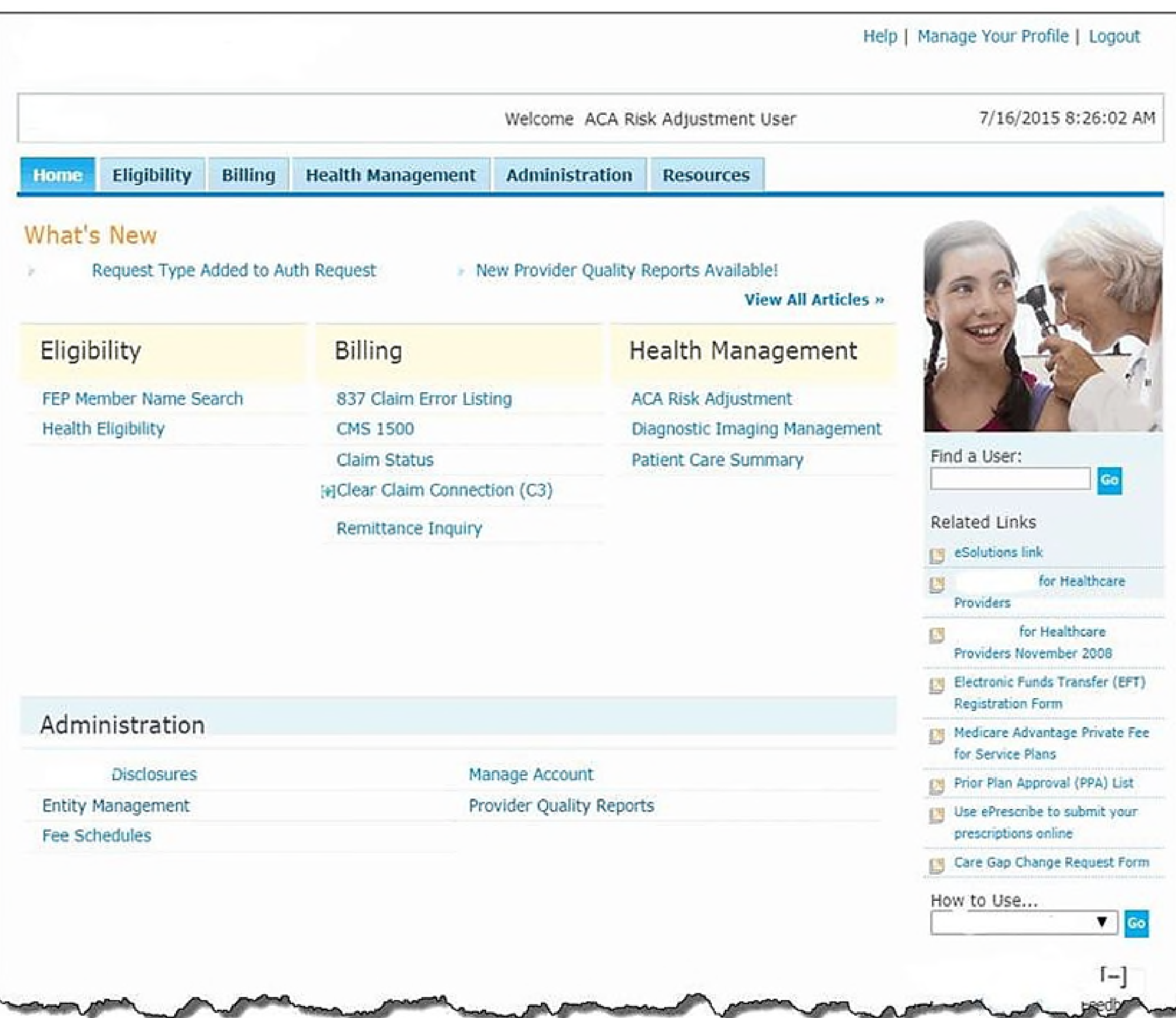
Accessing the Collaborate Portal



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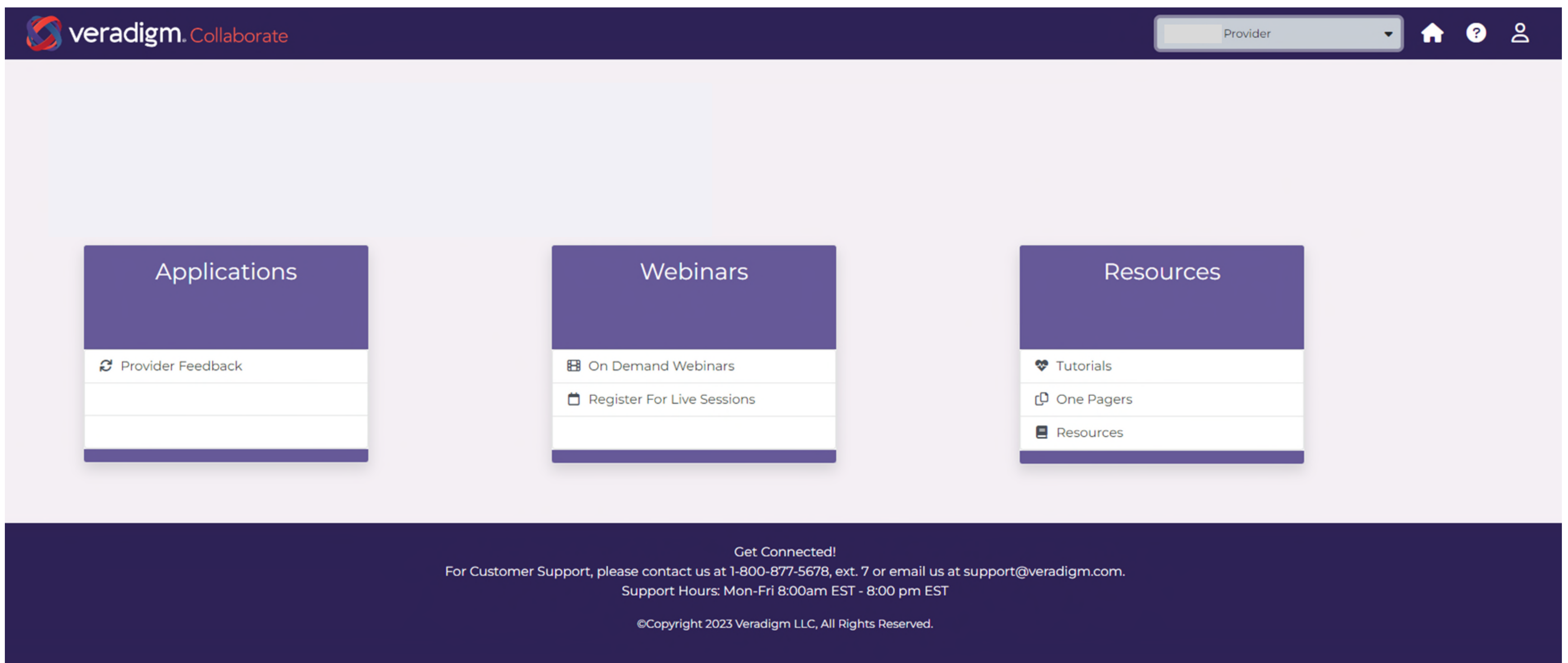
Veradigm Collaborate Portal

Collaborate has resources available to you and your support personnel 24/7



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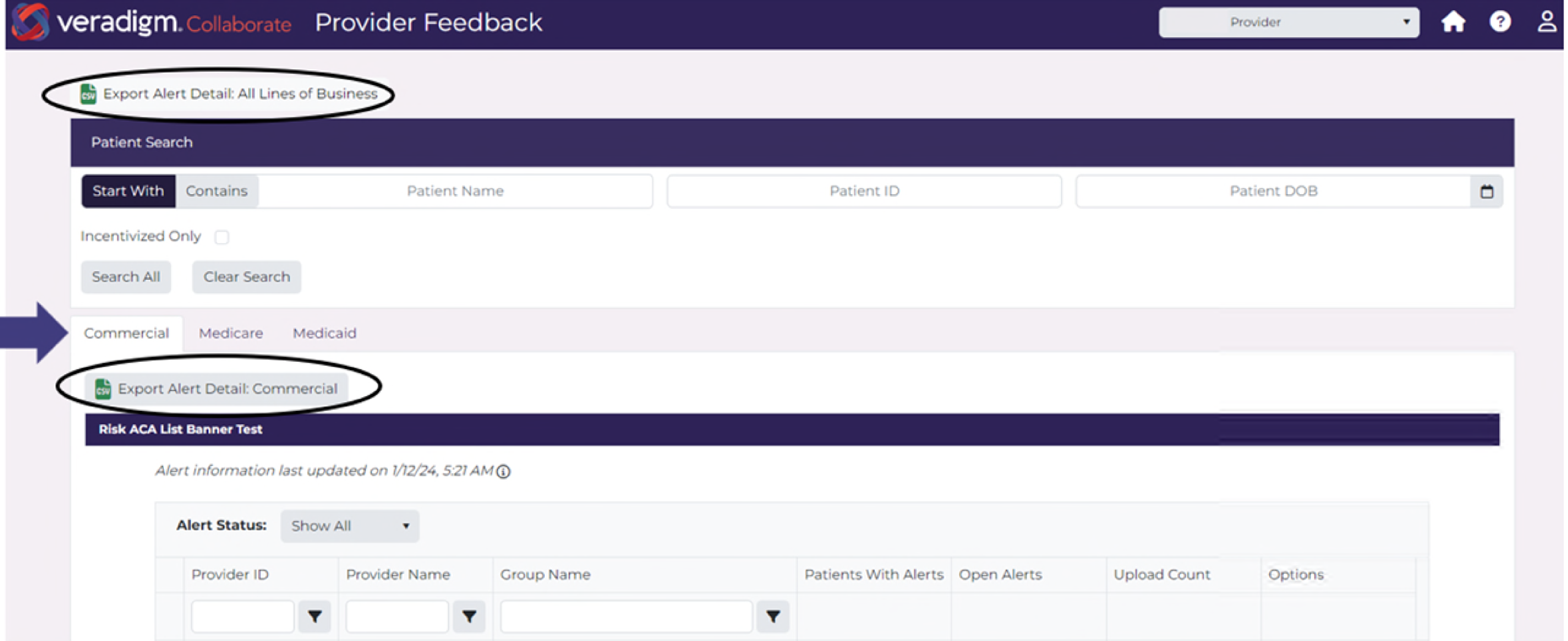
Provider Feedback Application



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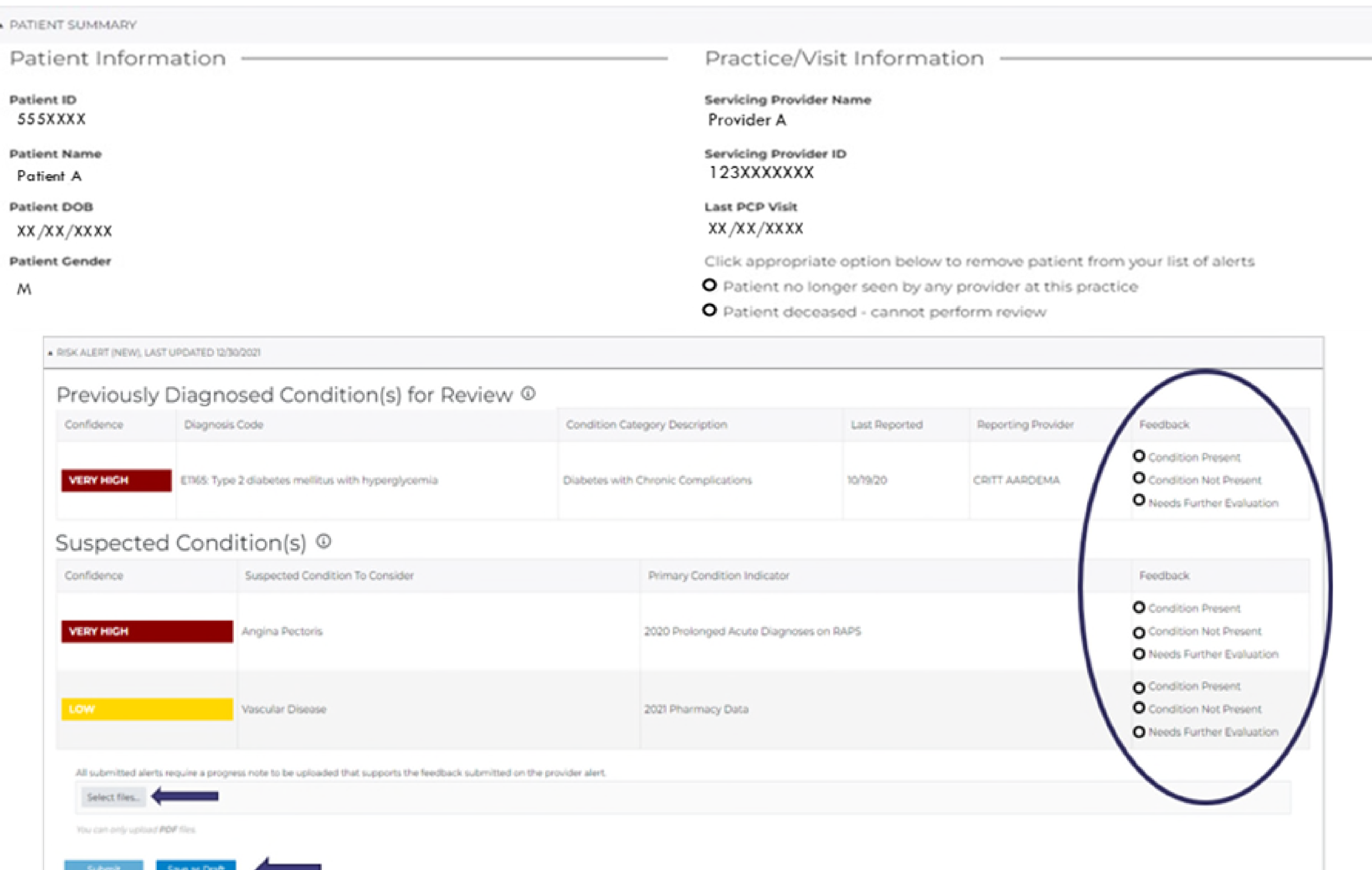
Provider Alerts



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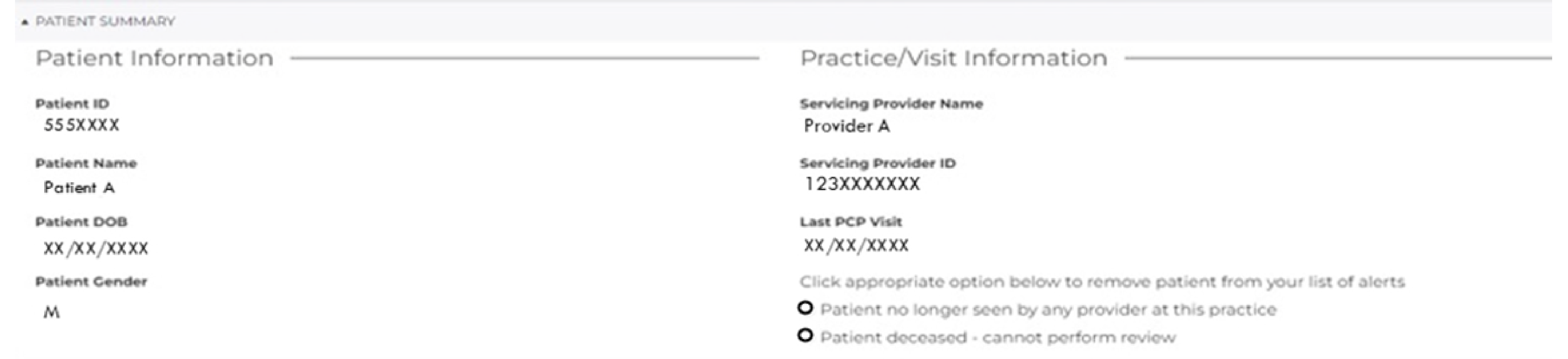

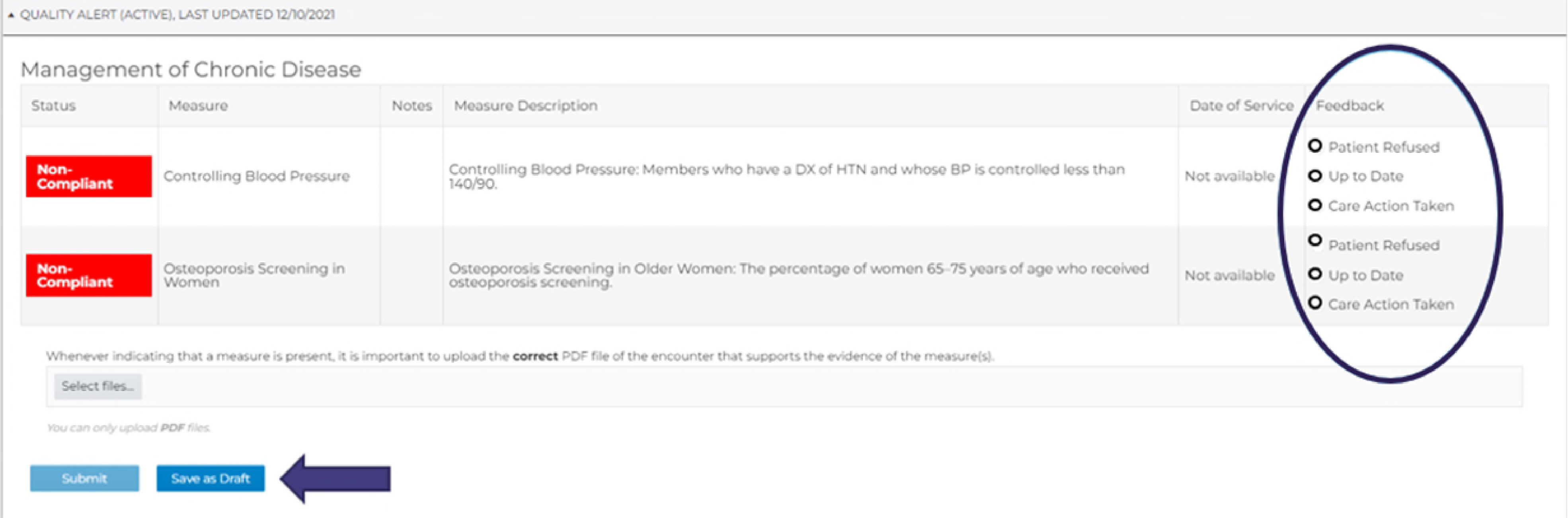

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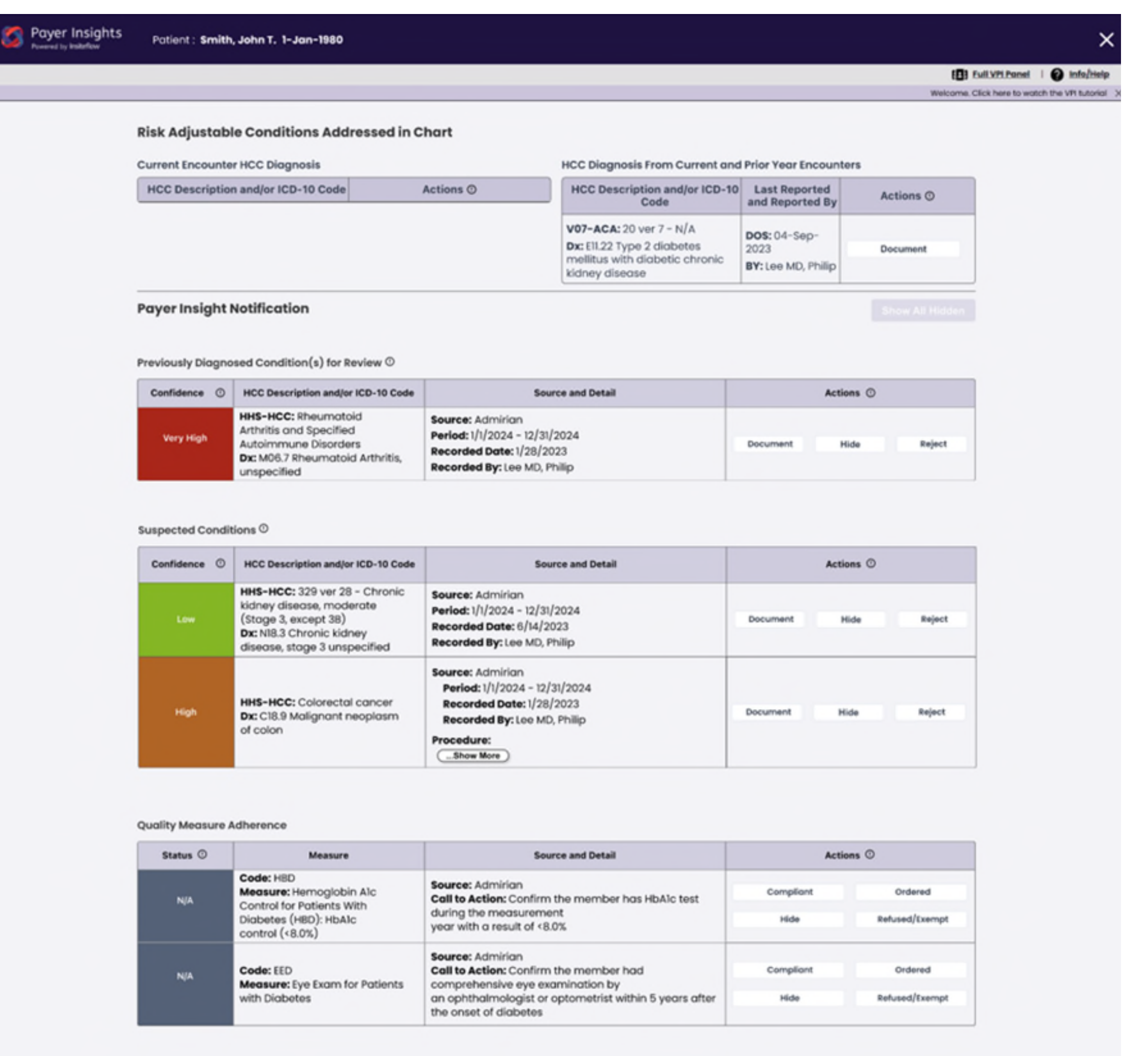
Veradigm Payer Insights Overview

- Point-of-care module to review care gaps from Veradigm's Payer partners
- Engages clinical staff within the EHR in real time
- Facilitates pre-visit planning
- Captures suspecting and persisting diagnoses
- Collects supporting "MEAT" documentation



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UPCOMING WEBINARS

January: 2025 Coding Updates: New Year, New Codes!

February: The A, B, C's of Coding for Common Pediatric Conditions

March: Health Equity: Ensuring You Are Properly Coding and Documenting for SDOH Disparities

April: Setting the Stage for Coding and Documentation for Chronic Kidney Disease

May: Inhale the Facts of Coding and Documentation for Common Pulmonary Conditions

June: Pulse Check: Accurate Coding and Documentation for Cardiovascular Conditions

July: The Sweet Spot: Coding for Diabetes and Complications

August: Don't Let Coding Get Under Your Skin….Coding and Documentation for Dermatology Disorders

September: Making Connections: Proper Coding and Documentation for Neurological Conditions

October: Arm Yourself: Battling Through Coding and Documentation for Cancer

November: Fill Your Plate with Knowledge: Coding and Documentation for Gastroenterology

December: Ease Your Mind: Coding and Documentation for Behavioral Health and Substance Use Disorders

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On Demand Webinars

Narrow it Down: Documentation and Coding for Vascular Disorders

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State of Mind: Documentation and Coding for Depression and other Behavioral Health Disorders

Open your mind to specific documentation and coding of Major Depressive Disorders, Schizophrenia, and Bipolar Disorders.

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Calm your Nerves: Coding and Documentation for Neurological Conditions

Join us to review accurate documentation and coding for diseases of the central and peripheral nervous systems such as Epilepsy, Generalized Seizure Disorders, Chronic and Acute pain, Migraines, Alzheimer's disease, and pain management in your patient population.

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Get with the Flow: Coding and Documentation for Genitourinary Conditions

Learn about specific documentation and coding related to Genitourinary Conditions such as Nephritis, Nephropathy, and infections of the kidneys. Gain insight into proper coding for Chronic Kidney Disease and all the associated stages and complications.

WATCH NOW | TAKE TEST | MATERIALS

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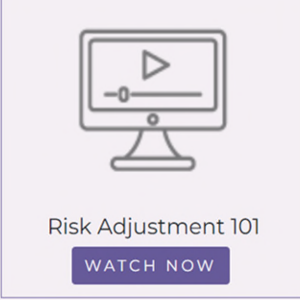
Collaborate Resources

Tutorials



Risk Adjustment 101

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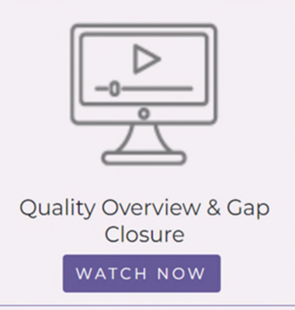

Quality Overview & Gap Closure

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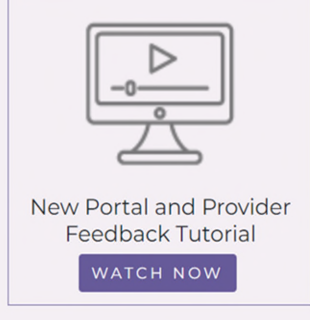

New Portal and Provider Feedback Tutorial

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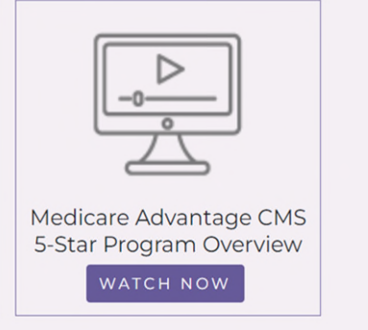

Medicare Advantage CMS 5-Star Program Overview

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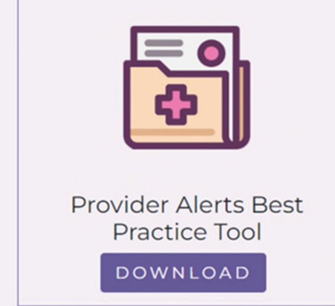
One Pagers

Risk Adjustment



Provider Alerts Best Practice Tool

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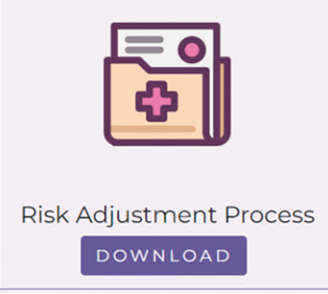

Risk Adjustment Process

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The Most Common Risk Adjustment Conditions

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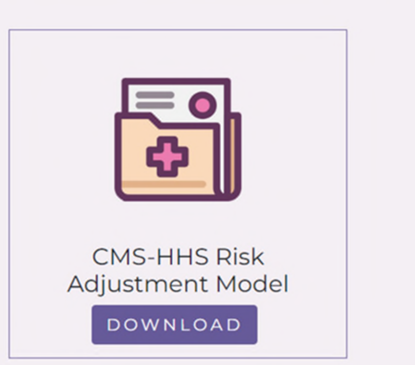

CMS-HHS Risk Adjustment Model

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References

1. Social Determinants of Health (SDOH) | About CDC | CDC
2. Social Determinants of Health | Advocacy
3. Health Equity Terminology and Quality Measures | The Measures Management System
4. U.S. Department of Agriculture. (September 2021). Food Security in the U.S. Key Statistics & Graphics. Retrieved from: https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/key-statistics-graphics.aspx#foodsecure
5. U.S. Department of Housing and Urban Development. Office of Policy Development and Research. (July 2021). Worst Case Housing Needs 2021 Report to Congress. Retrieved from: https://www.huduser.gov/portal/sites/default/files/pdf/Worst-Case-Housing-Needs-2021.pdf
6. Doran, K., et al. (October 2020). Homeless Shelter Entry in the Year After an Emergency Department Visit: Results from a Linked Data Analysis. Health Policy/Brief Research Report. Volume 76, Issue 4, 462-467. Annals of Emergency Medicine. Retrieved from: https://www.annemergmed.com/article/S0196-0644(20)30180-3/fulltext
7. U.S Department of Transportation: https://www7.transportation.gov/mission/health/connectivity
8. Coding Clinic, 4Q, 2021, pages 33-37
9. FY 2025 IPPS Final Rule Home Page | CMS
10. CMS-1809-FC | CMS
11. Data Tools | CMS
12. USING Z CODES
13. Social determinants of health and medical coding: What to know | American Medical Association
14. 2025 CPT manual
15. Use of note templates for documenting medical information | American Medical Association
16. About AMA Debunking Medical Practice Regulatory Myths Learning Series | AMA Debunking Medical Practice Regulatory Myths Learning Series | Ed Hub
17. AMA Simplified Outpatient Documentation and Coding Toolkit.pdf
18. Resource on ICD-10-CM Coding for Social Determinants of Health | AHA
19. AHA Coding Clinic, 4Q 2023, pages 83-85
20. AHA Coding Clinic, 1Q 2023, page 8
21. AHA Coding Clinic, 4Q 2021, pages 93-95
22. CPT Assistant Bulletin 2023
23. https://www.cms.gov/priorities/innovation/files/worksheets/ahcm-screeningtool.pdf
24. CMS-1784-F | CMS
25. https://prapare.org/
26. https://public-inspection.federalregister.gov/2023-24184.pdf
27. MLN9201074 - Health Equity Services in the 2024 Physician Fee Schedule Final Rule
28. The AHC Health-Related Social Needs Screening Tool
29. PRAPARE
30. Search the Physician Fee Schedule | CMS

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Q&A

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