Making the connections

Prenatal and postpartum care screening for social determinants of health

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Coding disclaimer

- The information in this presentation does not guarantee reimbursement, benefit coverage, or payment for services.
- Coding guidance in this presentation is not intended to replace official coding guidelines or professional coding expertise.
- Providers are required to ensure documentation supports all codes submitted for conditions and services.
- If you have questions regarding claims billed and reimbursement, call Provider Customer Services at **844-781-2343**.

Agenda

- **Part one:** Importance of prenatal and postpartum care
- **Part two:** Prenatal and Postpartum Care (PPC) HEDIS® measure
- **Part three:** Screening for social determinants of health (SDOH) needs
- **Part four:** Documentation and coding SDOH
- **Conclusion:** Resources

Note: This presentation was developed to improve maternal health by focusing on SDOH and reducing health disparities.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Part one

Importance of prenatal and postpartum care

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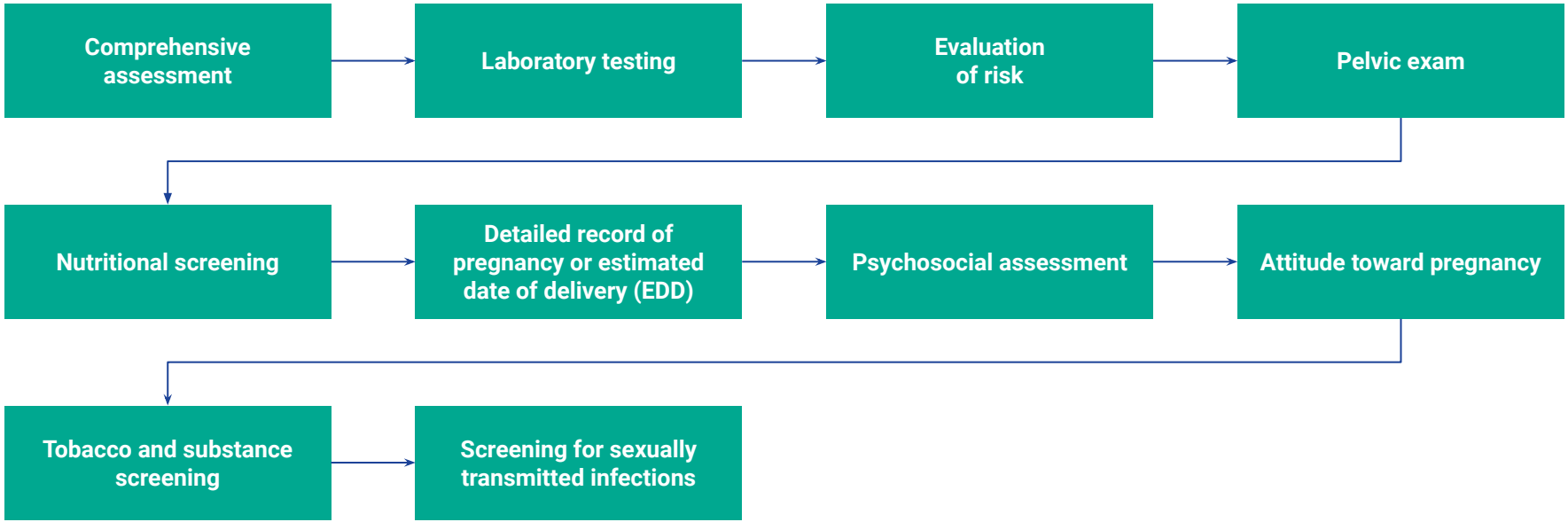
Initial prenatal visit

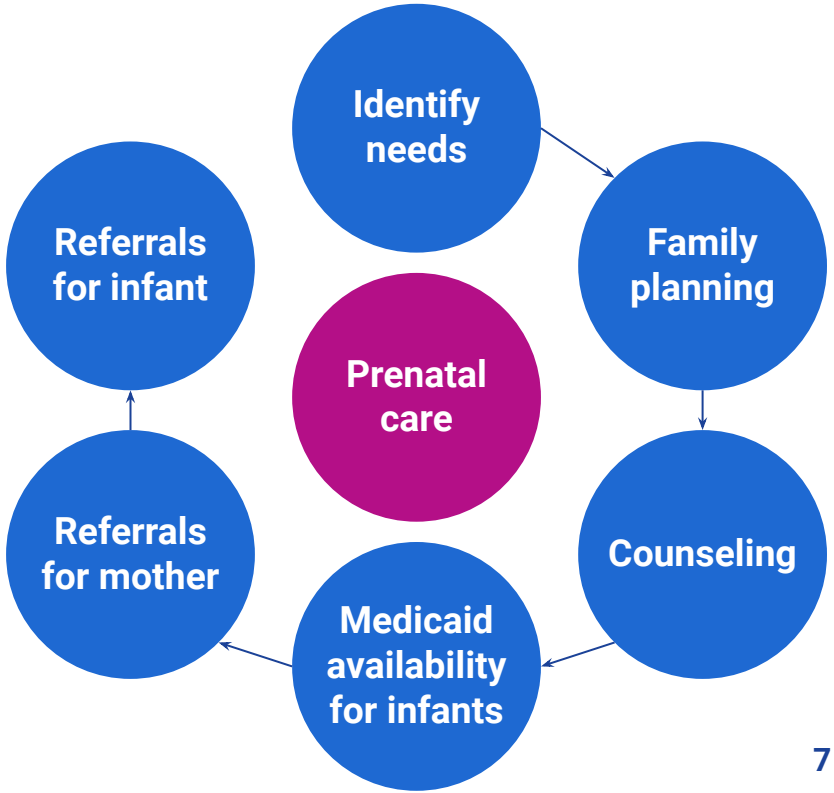


Prenatal care services

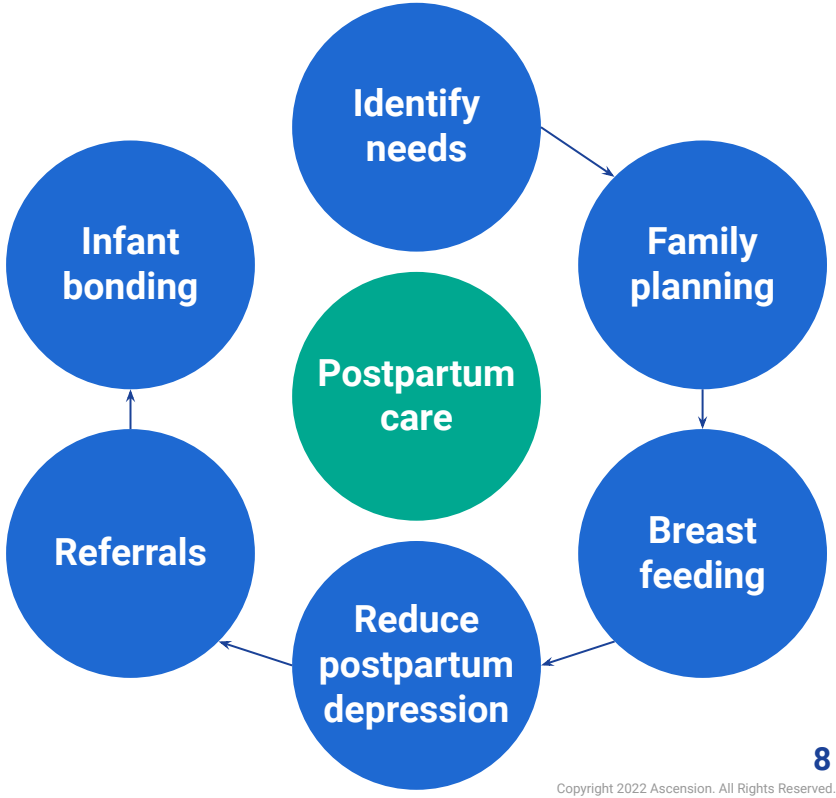
- HIV counseling and testing
- Immunizations
- Lead poisoning testing and management
- Ultrasound
- Screening for genetic disorders
- Several tests to assess fetal status
- Healthy Rewards
- Case Management
- Taking care of baby and me program
- Pregnancy classes
- Pregnancy and early parenting program
- My advocate

Prenatal care visits

Number of weeks	Frequency of prenatal visits
0 to 28 weeks of pregnancy	One visit every 4 weeks
29 to 36 weeks of pregnancy	One visit every 2 to 3 weeks
36 weeks and up until pregnancy	One visit per week



Postpartum care visits



Postpartum care plan

Element	Components
Postpartum visits	Ensuring patient knows the time, date and location for the appointment and has a contact office phone number.
Infant feeding plan	Intended method of feeding; resources for community support.
Reproductive life plan	Desired number of children and timing of next pregnancy.
Contraceptive plan	Method, instructions, effectiveness and potential adverse effects.
Pregnancy complications	Complications and recommended follow-up or test results.
Mental health	Recommendations for anxiety, depression, etc.
Postpartum problems	Management of postpartum problems.
Chronic health conditions	Treatment plan for ongoing conditions.

Part two

Prenatal and postpartum care (PPC) HEDIS measure

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Prenatal and postpartum care (PPC)

Understand the measure

Focus group

- Pregnant women whose deliveries resulted in live birth

Services

- Prenatal care visit
- Postpartum care visit

Frequency

- Prenatal visit within the first trimester or within 42 days or enrollment in the plan
- Postpartum visit on or between 7 and 84 days after delivery

PPC (cont.)

Description	CPT	CPT II	HCPCS
Prenatal visits	99202-99205, 99211-99215, 99241-99245 **With one of the following:** **OB panel:** 80055, 80081 **Prenatal ultrasound:** 76801, 76805, 76811, 76813, 76815-76821, 76825-76828		
Home visits for prenatal monitoring and assessment	99500	0500F, 0501F, 0502F	H1000-H1004

PPC (cont.)

Record your efforts—prenatal visits

Basic physical obstetrical examination	• Auscultation for fetal heart tone • Measurement of fundus height • Pelvic exam with obstetric observations
Prenatal care procedure (could be one of the following)	• Screening test/obstetric panel • TORCH antibody panel alone • Ultrasound/echography of a pregnant uterus

Home visits for prenatal monitoring and assessment	• Prenatal risk assessment and either:
	  ○ Counseling/education
	  ○ Complete obstetrical history

PPC (cont.)

Record your efforts—postpartum care

1. **Pelvic exam**
2. **Perineal or cesarean incision/wound check**
3. **Evaluation of weight, BP, breasts and abdomen**
    a. Notation of *breastfeeding* acceptable for evaluation of breasts component.
4. **Notation of postpartum care**
    a. PP care, PP check, 6-week check
    b. Postpartum care form
5. **Screenings**
    a. Depression, anxiety, tobacco use, substance use disorder or preexisting mental health disorders
    b. Glucose screening for women with gestational diabetes
6. **Documentation of:**
    a. Infant care or breastfeeding
    b. Resumption of physical activity, birth spacing or family planning
    c. Sleep/fatigue, attainment of healthy weight

PPC (cont.)

Postpartum care visits codes:

Description	CPT®codes	CPT II codes	ICD-10 codes
Postpartum care visit	57170, 58300, 59430, 99501	0503F	Z01.411, Z01.419, Z01.42,Z30.430, Z39.1, Z39.2

PPC (cont.)

Using CPT II codes can:

- Help reduce medical records requests.
- Identify additional information about the visit.
- Improve compliance rate with certain HEDIS measures.

PPC	
Initial prenatal care visit	0500F or 0501F—if prenatal care flow sheet documented in medical record by first prenatal visit
Subsequent prenatal care visit	0502F
Postpartum care visit	0503F—Make sure it is onor between 7 and 84 days after delivery.

PPC (cont.)

Helpful tips:

- Help reduce medical records requests.
- Schedule the postpartum visit prior to leaving the hospital after delivery.
- If the patient comes in one or two weeks after delivery for the removal of staples, educate her on the importance of coming back for postpartum visit.
- Make sure the postpartum checkup date is on or between 7 and 84 days after delivery.
- Call patients to schedule the postpartum visits or to remind them of their postpartum appointment if already scheduled.
- Follow up with patients who miss appointments to ensure that they reschedule within a 7 to 84 days time frame.

Part three

Screening for SDOH needs

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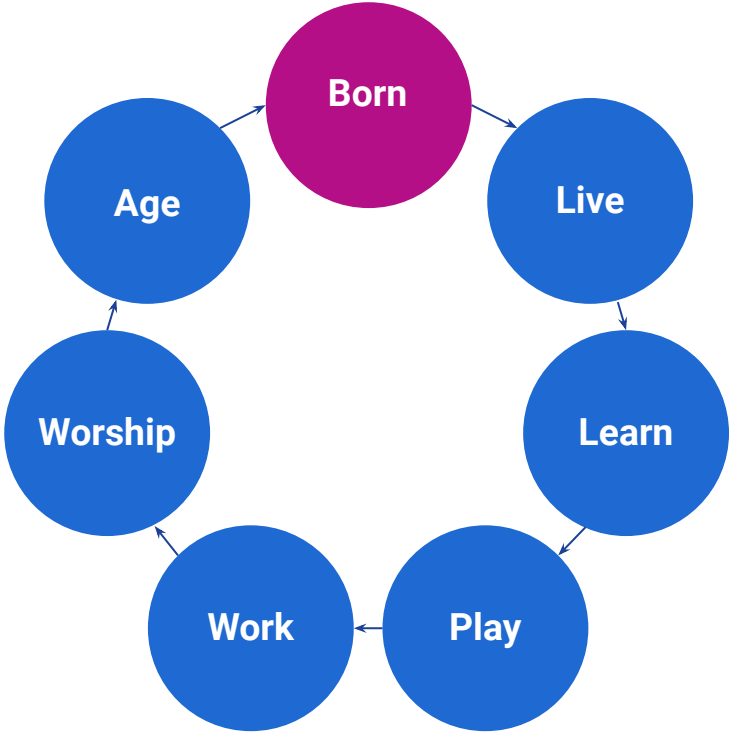
Introduction to SDOH:

SDOH are:

- Conditions in which people are born, live, learn, play, work, worship and age.
- Circumstances shaped by distribution of money, power and resources at global, national and local levels.
- Responsible for health inequities, which are avoidable differences in health status seen within and between groups.



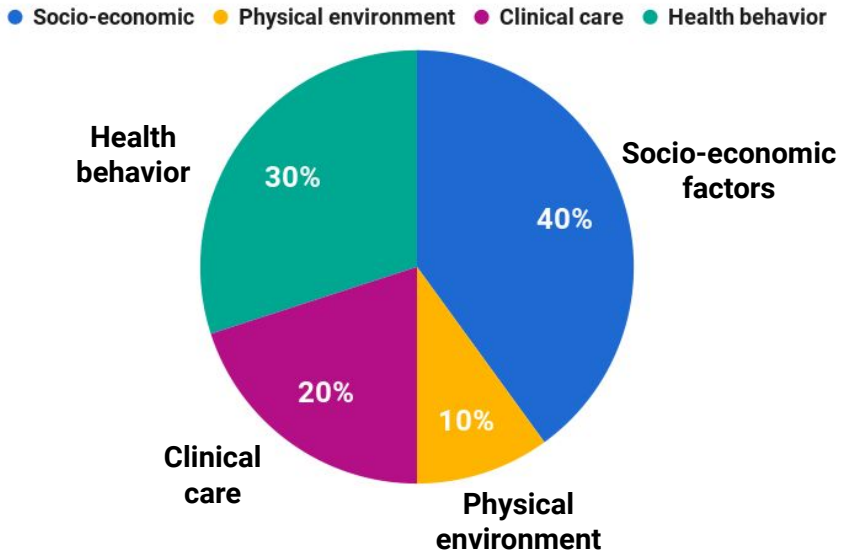
SDOH five key areas

Factors that influence health and outcomes include:

Economic stability	Education	Social and community context	Health and healthcare	Neighborhood and built environment
Employment	Early childhood education and development	Civic participation	Access to healthcare	Access to healthy food
Food security	High school education/graduation	Discrimination	Access to primary care	Crime and violence
Housing stability	Enrollment in higher education	Incarceration	Health literacy	Environmental conditions
Poverty	Language and literacy	Social integration		Quality of housing

Impact of health outcomes

Three nonclinical factors account for 80% of health outcomes



https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five/

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Addressing SDOH in primary care

What is your practice's approach to SDOH?

How does your practice currently identify and document SDOH, if at all?

↓

Whose responsibility is this?

↓

In what ways does your practice currently help address patients' SDOH?

↓

What systems do you have in place to ensure SDOH are addressed at patient visits?

Ask | **Identify** | **Act**

Identifying and capturing SDOH

Receptionist/medical assistant	• Make education materials available in waiting areas and exam rooms. • Distribute the SDOH screening tool when patient arrives. • Ask questions during the encounter.
Administrator	• Ensure adequate resources and staffing to screen. • Communicate to each staff member his or her responsibilities. • Provide training to staff.
Social workers and/or community health workers (if available)	• Determine resources available in your community. • Facilitate referrals to community resources based on patient needs. • Refer to case management and follow up between visits.

Addressing SDOH in primary care

PRAPARE (Protocol for Responding to and Assessing the Patients' Assets, Risks and Experiences) Tool

- There are two versions of the **PRAPARE** assessment configured in the Findhelp Community Resource link. One version is the **full PRAPARE** questionnaire, the second is a condensed version that includes just those questions that pertain to SDOH needs.

PRAPARE: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences

Family and home

1.What is your housing situation today?

☐	I have housing
☐	I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)
☐	I choose not to answer this question

2.Are you worried about losing your housing?

☐	Yes	☐	No	☐	I choose not to answer this question

Partnering with providers to tackle SDOH

Refer to the Case Management department:

- Case managers and care coordinators can help to find services and resources to assist eligible members for chronic complex conditions that may involve SDOH.

Providers can use:

- Findhelp.org (formerly Aunt Bertha) to find resources for patients: **https://www.findhelp.org**
- Dell Children's Health Plan community support: **DCHP.findhelp.com**
- Direct members to community resource(s) and make referrals for them whenever possible.

Community **Resources** **Health**

Part four

Documentation and coding SDOH

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SDOH: New guideline

Chapter 21: Factors influencing health status and contact with health services

Codes describing social determinants of health (DOH) should be assigned when this information is documented. For social determinants of health, such as information found in categories Z55 to 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.

SDOH: New guideline (cont.)

- 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

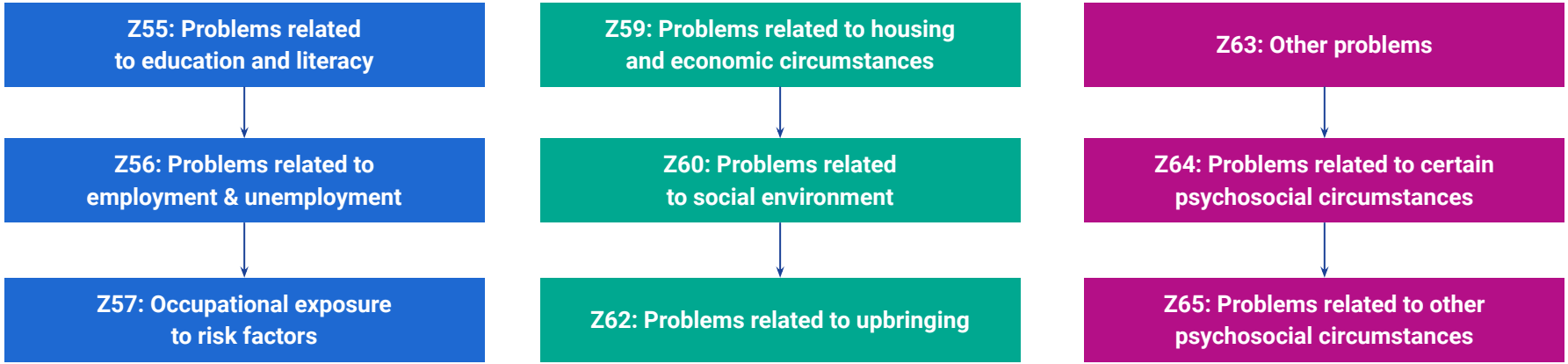
Revised guideline: Z codes, new SDOH section

- 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

New 2022 SDOH codes

- Z55.5: Less than a high school diploma
- Z58.6: Inadequate drinking-water supply
- Z59.00: Homelessness unspecified
- Z59.01: Sheltered homelessness
- Z59.02: Unsheltered homelessness
- Z59.41: Food insecurity
- Z59.48: Other specified lack of adequate food
- 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
- Z59.89: Other problems related to housing and economic circumstances

Documentation and coding for SDOH



- These codes are found in *Chapter 21* of the ICD-10-CM code set.
- They are acceptable to be billed just like any other diagnosis code.
- The medical record documentation should support all codes reported on the claim.

Documentation and coding for SDOH (cont.)

ICD-10-CM code examples:

Economic stability
Z59.4: Lack of adequate food
Z59.5: Extreme poverty
Z59.6: Low income

Education
Z55.0: Illiteracy and low-level literacy
Z55.1: Schooling unavailable and unattainable
Z55.2: Failed school examinations

Social and community context
Z60.2: Problems related to living alone
Z62.21: Child in welfare custody
Z63.4: Disappearance and death of family member

Health and healthcare
Z75.3: Unavailability and inaccessibility of health care facilities
Z75.4: Unavailability and inaccessibility of other helping agencies

Neighborhood and built environment
Z59.0: Homelessness
Z59.1: Inadequate housing
Z65.1: Imprisonment and other incarceration

Documentation and coding for SDOH (cont.)

Capture the complete picture

- Assess the patient's health condition and identify any social issues impacting health.
- Document any SDOH impacting the patient's health or ability to attain appropriate treatment.
- Report the appropriate diagnosis and E/M code.

Table 2 – CPT E/M Office Revisions
Level of Medical Decision Making (MDM)

Revisions effective January 1, 2021:
Note: this content will not be included in the CPT 2020 code set release

AMA AMERICAN MEDICAL ASSOCIATION

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making: Number and Complexity of Problems Addressed	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
99204 99214	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

Diagnosis or treatment significantly limited by social determinants of health

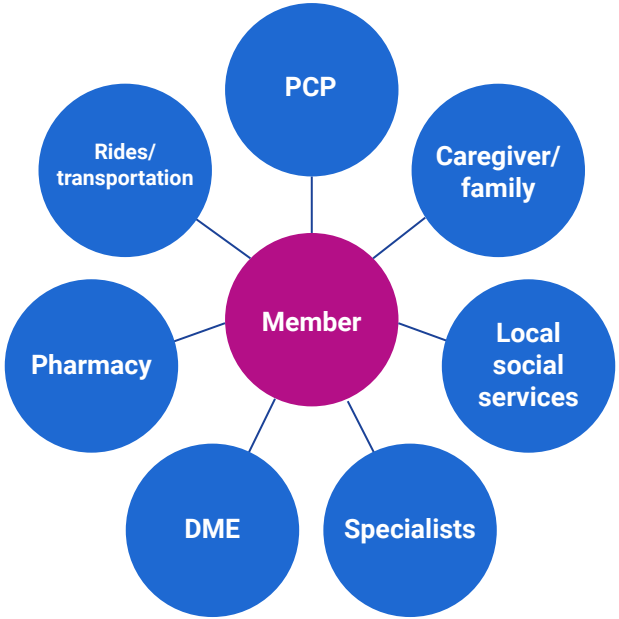
Documentation and coding for SDOH (cont.)

Helpful tips:

- Document the screening questions and results in each medical record encounter.
- Embed SDOH assessments in the electronic medical record systems.
- Set triggers to ensure questions are not left blank.
- Have members complete questionnaire while waiting to be seen, then discuss the
- responses during the encounter.
- Allow the member to divulge as much information as they care to share.
- Use ICD-10-CM diagnosis codes to report health risks related to SDOH.

Tip: We can also use this information to assist members and target outreach to support different areas!

Team-based approach to SDOH



Identifying SDOH example

Identifying SDOH example:

M. Smith (age 36)—female member

- Bipolar, noncompliant with medications and office visits due. She is a new mom with an infant and a 2-year old at home. She is currently unemployed and has been attending court hearings for late rent payments. She hasn't been eating regularly or doesn't have money to buy food or medications.

Ask	Identify	Act
Living situation—late payments, court hearing	Document SDOH in the medical record	Contact local legal aid regarding housing issues
Transportation—no car, no driver's license	Refer member to case management program to assist with medical needs	Educate member regarding behavioral health case management program services, WIC program and Findhelp link
Safety		

Coding for SDOH scenario

Z55: Problems related to education and literacy	Z59: Problems related to housing and economic circumstances	Z63: Other problems
Z56: Problems related to employment & unemployment	Z60: Problems related to social environment	Z64: Problems related to certain psychosocial circumstances
Z57: Occupational exposure to risk factors	Z62: Problems related to upbringing	Z65: Problems related to other psychosocial circumstances

What code categories from the list above apply to the scenario below?

M. Smith (age 36)—female member

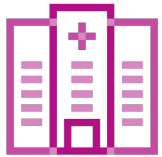
- Bipolar, noncompliant with medications and office visits due. She is a new mom with an infant and a 2-year old at home. She is currently unemployed and has been attending court hearings for late rent payments. She hasn't been eating regularly or doesn't have money to buy food or medications.

Coding for SDOH scenario (cont.)

What code categories for SDOH can be applied to the scenario?

- Z59.41: Food insecurity
- Z59.811: Housing instability, housed with risk of homelessness
- Z59.89: Other problems related to housing and economic circumstances
- Z56.0: Unemployment, unspecified

How can you help—next steps



- Implement/maintain a team-based approach to addressing SDOH.
- Assess opportunities where your staff/resources/workflows could better address SDOH.
- Leverage SDOH screening tools:
  - **PRAPARE Tool**
- Familiarize team with local health department and statewide
- resources that address SDOH.
- Establish/maintain workflows for referring patients to SDOH resources in the community/case management.

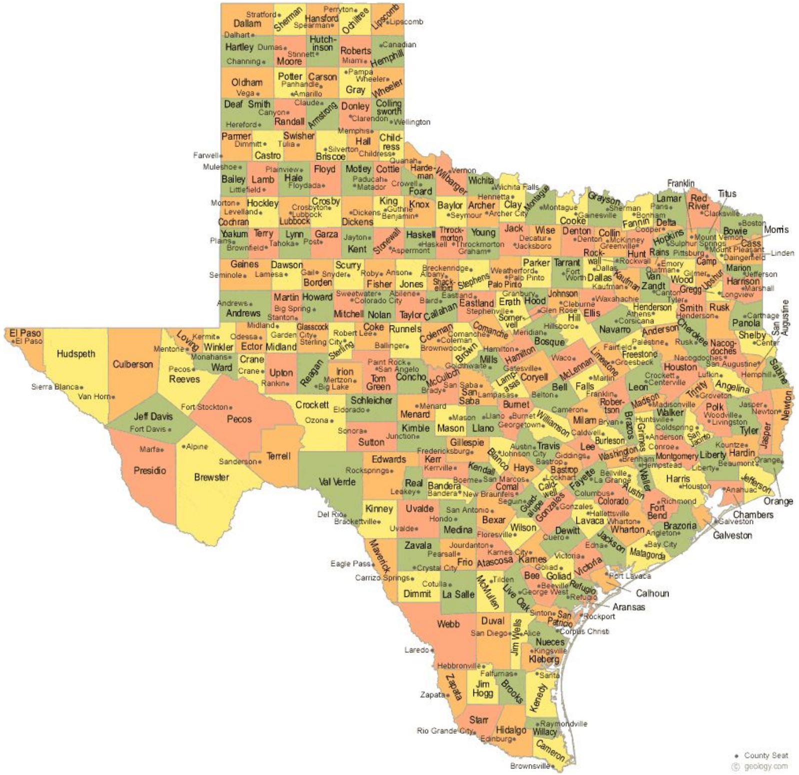
How can you help—next steps

- Guide members to the Findhelp website.
- Tell members to contact the customer care line to learn about value-added benefits including:
  - Any Baby Can classes
  - Personalized wellness programs

https://www.dellchildrens.net/health-plan/providers

Resources to help address SDOH

- Know your local city and county health departments.
- Use resources in patients’ communities that can help address SDOH.
- Collaborate with organizations to address SDOH and advance health equity.



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Resources to help address SDOH (cont.)

Resource locator

Coordinating entities	**Texas 2-1-1**: Connects people with free information on available community services. Individuals are connected to trained, bilingual contact center agents who provide information on services and referrals to programs aligned with the individual's specific needs. https://www.211texas.org/ **Texas Health and Human Services**: Energy Assistance, food assistance, disability services, medical assistance. https://www.hhs.texas.gov **Findhelp.org (formerly Aunt Bertha)**:Search for free or reduced cost services like medical care, food, job training and more. https://www.findhelp.org
Food insecurity	**Food pantries**: Find local pantries, soup kitchens, food shelves, food banks and other food help https://www.foodpantries.org/st/texas
Behavioral health	**Texas Health and Human Services**: Texas Health and Human Services offers mental health and substance use services for families and people of all ages. https://www.hhs.texas.gov/about-hhs/process-improvement/improving-services-texans/behavioral-health-services

Resources to help address SDOH (cont.)

Resource locator (cont.)

Housing	**Texas Department of Housing and Community Affairs**: Provide every Texas citizen the opportunity to have access to safe and affordable housing, no matter their community or income. **https://www.tdhca.state.tx.us/** **Texas Homeless shelters**: Many are emergency shelters along with general homeless shelters and some transitional housing opportunities listed by cities.**https://www.homelessshelterdirectory.org/state/texas**
Jobs	**Texas Workforce Commission**: Offers career assistance for job seekers, employment services for veterans and programs designed to assist with employment **https://www.twc.texas.gov/**
Child care	**Texas Child Care Center:** Offer assistance finding quality childcare, preschools and family resources. **https://childcarecenter.us/state/texas**

References

- American Academy of Family Physicians, The EveryONE Project, *Addressing Social Determinants of Health in Primary Care: Team-based Approach for Advancing Health Equity*
- Centers for Disease Control and Prevention (CDC) **https://www.cdc.gov/socialdeterminants/index.htm**
- CMS Center for Medicare and Medicaid Innovation (CMMI), *Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool*(2018)
- CPT® E/M Office Revisions Level of Medical Decision Making (MDM): **https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf**
- National Committee for Quality Assurance (NCQA) **https://www.ncqa.org/hedis/measures**

Thank you!

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*Findhelp is an independent company providing referral platform services on behalf of Dell Children's Health Plan.