

CMHN Blue KC Social Determinants of Health (SDoH) Screening FAQ

The following FAQ was developed to address Blue KC's 2026 quality performance measure on 'Social Determinants of Health Screening' as part of the 2026 Blue KC / CMHN Medical Home Agreement. See the [Slide Deck Overview](#) of CMHN's Blue KC Medical Home Value Based Agreement for additional information.

Key Information to Inform SDoH Screening in Your Practice

What: Perform a SDoH screening at least once during the calendar year 2026 for all patients receiving primary care services. The SDoH screening must address at least **transportation, food insecurity, housing issues or concerns, and social environment**.

How: Screening should be implemented utilizing evidence-based screening questions derived from clinically validated screening tool(s). See examples of clinically validated survey tools in Question 13. Your practice can also leverage the comprehensive screening tool developed by CMHN in Appendix B.

In 2026, Blue KC is requiring CMHN to have a 5% or greater positivity rate to earn 50% of the incentive dollars. Be sure to code positive screens correctly in order to achieve compliance.

G9920: Screening Performed and Negative

G9919: Screening Performed and Positive and Provision of Recommendations

If a positive screening is identified and coded, **the appropriate ICD-10 diagnostic codes must be included on the date of the positive screen.** Interventions must be offered to the patient in follow up to any positive screen. An attestation is required to meet the measure.

Screening results and follow up action must be documented in the medical record. Blue KC may conduct chart reviews for evidence of screening and any necessary intervention. Substantial errors of fact may result in loss of Blue KC incentive payments or termination from the program.

(See Question 3 for ICD-10 codes expected to be used most frequently for positive screens).

How to Address Positive Screenings: If your patient screens positive, interventions must be offered and documented in the EMR. You can help provide interventions by:

- Refer the patient/family to a resource using Lift Up KC through InNote – a quick and easy way to connect patients to community-based organizations (CBOs) with just a few clicks.
 - Recommend or refer to “full-service” centers that can address many needs, such as food insecurity, housing insecurity, financial assistance, etc.
 - Recommend or refer to “no wrong door centers” that can help connect a patient to another organization if they are unable to help.
- Utilize a “super-user” in your practice, trained on Lift Up KC and local resources, to help connect the patient and family with a CBO.
- If the patient/family refuse your practice's help in facilitating a referral to a CBO on their behalf, you can provide the patient/family with liftupkc.org postcards to help access resources on their own. This option is only appropriate if the patient does not want your practice's help being connected.

See Appendix C for workflow diagram and recommended talking points.

Who: The SDoH screening can be completed by any member of the care team. In fact, parents or patients can complete the screening on paper or electronically while waiting for the visit. Practices also have the option of completing the social needs screening in advance of a patient's visit (see Question 7).

Why: Multiple studies have found that healthcare only impacts approximately 20% of a patient's health outcomes. As we transition toward value based models in which incentives are aligned to keep patients healthy and well, it becomes increasingly important and economically beneficial for practices to invest in the infrastructure to help address non-healthcare factors.

Question 1: How is the 'Social Determinants of Health Screening' measure defined? Specifically, how is Blue KC defining the eligible patients?

See **Appendix A** for the definition provided by Blue KC. The eligible population includes all attributed members (all ages) with at least one (1) primary care office visit claim (CPT codes 99381-99397 or E&M codes 99201-99215) within the 2026 calendar year.

The measure denominator does not include a 'continuous enrollment' requirement similar to HEDIS quality measures (i.e. no more than 1 gap in enrollment up to 45 days for the measurement year). However, patients will only be included in the SDoH Screening measure if:

- The patient has active Blue KC eligibility and attributed to CMHN both at the start of January 2026 and at the end of September 2026 (Blue KC freezes the measure denominator at this time for 2026 performance) **AND**
- The patient had a PCP visit (based on CPT codes 99381-99397 or E&M codes 99201-99215) during the calendar year.

Please note that both well visits and sick visits are included.

Question 2: For the SDoH Screening measure, is measure compliance based exclusively on claims for non-payable CPT codes G9920 and G9919 as noted in the Blue KC SDoH Coding Letter (Appendix A)?

Yes, screening compliance is based exclusively on claims containing one of these two codes. Supplemental data cannot be submitted for this measure. For quick reference, below are the two CPT codes used for screening.

G9920: Screening Performed and Negative

G9919: Screening Performed and Positive and Provision of Recommendations.

If a positive screening is identified and coded, **the appropriate ICD-10 diagnostic codes must be documented on the claim** indicating the applicable SDoH reason (**See Appendix A, page 9**). The screening HCPCS codes can be pointed or tied to any diagnosis code on the claim. CMHN recommends pointing the G9920 HCPCS code (negative SDoH screening) to the well visit or sick visit diagnosis and the G9919 (positive SDoH screening) to the applicable positive SDOH ICD-10 diagnosis code (see question #3). No modifier is needed for these codes since they don't carry any payment.



Tip/Insight: Blue KC has confirmed that the **ICD-10 Z code is required for compliance for positive screenings**.

Question 3: Is the list of ICD-10 diagnostic codes included in the Blue KC letter (Appendix A) an all-inclusive list of currently available codes that practices may use to identify the reason for a positive screen?

Yes, the ICD-10 diagnostic codes provided are an all-inclusive list of currently available codes. If Blue KC or CMHN becomes aware of additional codes, a communication will be sent to inform all CMHN practices.

ICD-10 codes that are expected to be used most frequently with a positive SDoH screening (CPT code G9919) based on the minimum screening requirements include:

- Transportation
 - Z59.82 – Transportation insecurity
- Food Insecurity
 - Z59.41 – Food insecurity
- Housing
 - Z59.00 – Homelessness, unspecified
 - Z59.81 – Housing instability, housed
 - Z59.811 – Housing instability, housed, with risk of homelessness
 - Z59.9 – Other problems related to housing and economic circumstances, unspecified
- Utilities
 - Z59.12 – Inadequate housing utilities
- Social Environment
 - Z60.4 – Social exclusion and rejection
 - Z60.9 – Problem related to social environment, unspecified



Tip/Insight: See **Appendix A, page 9**, for a complete list of ICD-10 diagnostic codes applicable for positive SDoH screenings.

Question 4: Do SDoH diagnosis codes (z-codes) impact the calculation of a patient's risk score (i.e. based on the Milliman MARA risk model)?

Currently, the following Social Determinant categories contribute to the MARA risk score:

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|--------------------------|--------------------------|
| Housing Disruption | Social Support |
| Family Member Disruption | Lifestyle Related Issues |

Later in 2023, Blue KC anticipates upgrading to MARA 4.62, which will expand to the following Social Determinant categories:

| | |
|-----------------------------|-----------------------------|
| Child/Parent-related Issues | Lifestyle Related Issues |
| Criminal-related Issues | Occupational-related Issues |
| Donor Status | Social Support |
| Education-related Issues | Social-related Issues |
| Housing Disruption | Unwanted Pregnancy |

*Please see Appendix A for a list of ICD-10 SDOH Categories and Z-codes.

Question 5: What are the minimal requirements to complete an SDoH screening?

CMHN practices have flexibility in how they administer an SDoH screening. According to Blue KC, screening must at least address **transportation, food insecurity, housing issues or concerns, and social environment**.

Practice screening tool must use standardized clinically validated questions.

- Practices cannot create their own screening questions. Questions must not be “adapted” from a validated tool, but must be worded exactly as is in the validated screener.
- Practices have flexibility in selecting a clinically validated screening tool and may even select questions from various validated screening tools.
- See Question 13 and Appendix B for clinically validated screening tool options your practice can leverage.

The name of the screening tool and the results of the screening tool must be documented in Electronic Health Record.

- Blue KC may conduct chart reviews for evidence of screening.

Practice must offer to facilitate follow up services for any patient that screens positive and record intervention in the patient's chart.

- See Appendix C for CMHN recommended workflow options for follow up.

Ensure you are coding appropriately to receive credit for the screening.



Tip/Insight: The social needs screening does not need to be completed by the provider. Parents or patients can complete the screening on paper or electronically while waiting for the visit. In fact, it has been found that screening responses are more accurate when not asked verbally.

Source: Gottlieb et al. <https://pdfs.semanticscholar.org/e11e/b3107fc9dba419d05b112497d751745f77e3.pdf>

Question 6: How should a practice code for screening when a patient declines to complete the SDoH screening? Do you submit the G code for a negative screening?

A practice should not submit a G code if a patient/family declines SDoH screening. The G codes (i.e. G9920, G9919) should only be used when a screening was successfully completed. As a result, a refusal to participate in screening will not impact measure compliance. It is understood that not all patients/families will want to participate in the SDoH screening, which is why 70% is considered the top performance target.

Question 7: Do CMHN practices have the option or the ability to complete the social needs screening in advance of the visit?

Blue KC has confirmed that it is acceptable to complete the social needs screening in advance of a patient's visit. However, the screening has to have occurred during the calendar year 2026 (i.e. the measurement year). If the screening is performed in advance, the results of the screening are expected to be reviewed at the visit and updated as applicable. The practice will then associate the applicable non-billable CPT code for SDoH screening (i.e. G9920, G9919) with the visit's standard billable services.

Question 8: What is Blue KC's justification for a 5% Positivity Rate?

Blue KC has monitored SDoH screening and positivity rates for almost two years and the CMHN reported Z-codes appear lower than expected based on what we know of the membership and nationwide studies about unmet SDoH. Blue KC believes moving to a tiered incentive for SDoH screening and data reporting will encourage providers to focus on drivers of low positivity rates for unmet SDoH. The 5% level of positivity that will allow a participating group to meet the higher incentive tier is still well below published SDoH prevalence data.

A review of the 100 most populous residential zip codes for CMHN attributed members showed 10% of members live in zip codes identified as having a high (greater than 50%) prevalence of households living at less than 200% of the Federal Poverty Level.

Blue KC's approach to Social Determinant of Health screening and expected positivity rates in pediatric populations is a step on the path to advancing SDoH and health equity measurements. It is essential that members have a full and complete Social Determinants of Health screening as part of the trusted health care provider-patient relationship, and the results of that screening be accurately recorded and submitted to Blue KC, and follow-up be offered to the member, when appropriate.

Question 9: How can CMHN practices increase true positive screens?

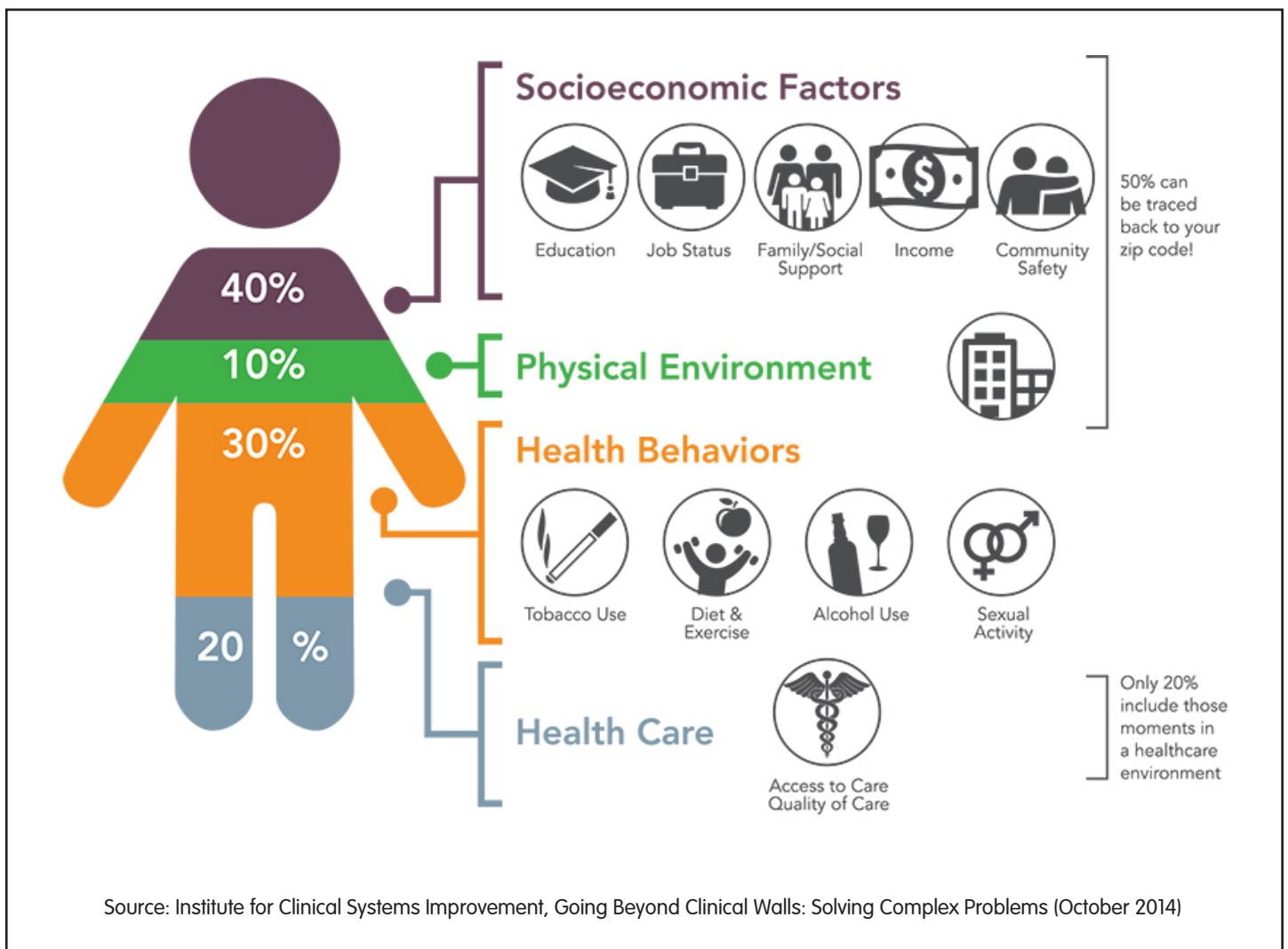
- Ensure that every patient is receiving an SDOH screen at each visit.
- Use clinically validated questions within your practice-specific screening tool.
- If patients receive an electronic screen before the visit, ensure there is a mechanism to catch any patients that fail to fill out the screen before the visit.
- Tailor the screening to your population by adding clinically validated questions that cover specific topics, such as financial needs, ability to pay for medication, social support, or bullying.
- When a screening is complete and positive, make sure you record the appropriate g-code and z-code(s).
- Implement a quick and easy workflow to follow up on positive screens (see Appendix C for recommendations).

Question 10: If screenings are performed by pediatric specialists, will those patients 'receive credit' for having completed a social needs screening?

Screenings performed by specialists will not count toward compliance for the SDoH screening measure. Credit for screenings will only occur for those patients screened by a primary care provider in Blue KC's medical home / value based program.

Question 11: Why is Blue KC requiring SDoH screening? Are other payers requiring SDoH screening?

Across the country, CMS (Center for Medicare & Medicaid Services) and other commercial payers are recognizing the importance of Social Determinants of Health on health outcomes. As shown in the diagram below, multiple studies have found that health care only impacts approximately 20% of a patient's health outcome. As we transition toward value based models in which incentives are aligned to keep patients healthy and well, it becomes increasingly important and economically beneficial for practices to invest in the infrastructure (e.g. screenings, social workers, relationships with community benefit organizations, etc.) to help address non-health care factors. Assuming the transition to value based care continues and practices are eventually paid a set amount for each patient (i.e. a capitated model), the investment in the infrastructure will help keep our patients healthy and well while also generating increased margins.



Question 12: What examples of “evidence-based” SDoH screening tools are available?

CMHN has developed a comprehensive screening tool based on the clinically validated Health Leads survey (**See Appendix B**). Additionally, practices can utilize any screening tool they choose or even select questions from various tools. Below are a few additional tools practices can utilize.

- PRAPARE – The Protocol for Responding to and Assessing Patients’ Assets, Risks and Experiences (<http://www.nachc.org/research-and-data/prapare/toolkit/>)
- The American Academy of Family Physicians Social Needs Screening Tool (https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/patient-long-print.pdf)
- American Academy of Pediatrics: Standardized Screening for Health-Related Social Needs in Clinical Settings (<https://nam.edu/wp-content/uploads/2017/05/Standardized-Screening-for-Health-Related-Social-Needs-in-Clinical-Settings.pdf>)
- Screening for Social Determinants of Health in Populations with Complex Needs: Implementation Considerations Center for Health Care Strategies, Inc. (https://www.chcs.org/media/VCU-Health-Social-Needs-Assessment_102517.pdf)
- CMS Accountable Health Communities Health Related Social Needs (<https://innovation.cms.gov/Files/worksheets/ahcm-screeningtool.pdf>)

Question 13: What should be done when a practice has already coded 12 or more diagnoses on a claim or our clearing house removes any identified ICD-10 Z code diagnoses?

Blue KC has stated that they understand that there will be times where the identified Z code will not fit on the claim due to a limitation of 12 diagnosis codes and other codes will take precedence. This is ultimately up to the provider to determine priority of filing claims and check with the clearing house. **An ICD-10 Z-code must accompany any positive SDoH screening in order to receive “credit” for the screening.**

Question 14: Can we submit a G code for screening if the parent completed the screening for another child in the family at a prior visit (on the same day or different day), or does the parent have to complete the screening for each child?

If a claim is being submitted, the expectation of Blue KC is that the screening is performed on each child/member.

Appendix A: Blue KC Social Determinants of Health (SDoH) Screening Measure Definition

Health-Related Social Needs (HRSN) Screening Measure– PY2026

Description:

At least 75% of attributed members aged 0-74 screened annually for unmet Health-Related Social Needs (HRSN) using standardized screening questions, for at least but not limited to, Transportation, Food Insecurity, Social Environment and Housing issues or concerns; AND if positive, the appropriate ICD-10-CM Z code or codes are submitted on the date of the positive screen, and interventions are offered to the member.

Denominator/Eligible Population:

All attributed members aged 0-74 at the beginning of the measurement period with at least one eligible encounter at the attributed Blue KC Primary Care First (PCF) Entity during the measurement period.

Denominator Criteria:

1. Attributed members aged 0-74 at the beginning of the measurement period, AND
2. An eligible Office (POS 11), Independent Clinic (POS 49), Federally Qualified Health Center (FQHC) (POS 50), Public Health Clinic (POS 71), Rural Health Clinic (POS 72) or Telehealth (POS 02) encounter at the attributed Blue KC PCF Entity during the measurement period: CPT 99381 – 99397 or E&M 99201 – 99215

Numerator:

Attributed members screened for AND if positive, the appropriate ICD-10 Z code or codes are submitted on the date of the positive screen.

Numerator Criteria:

1. Member is included in the denominator, AND
2. A claim for eligible Office or Telehealth encounter at the attributed Blue KC PCF Entity includes a Health-Related Social Needs CPT code:
 - a. G9920 - Screening performed and negative
 - b. G9919 - Screening performed and positive and provision of recommendations, AND
3. If the screening is positive and CPT G9919 is submitted, a corresponding ICD-10 Z code or codes are also submitted on the date of the positive screen. The Health-Related Social Needs ICD-10 Z codes for 2026 are listed on pages 3 -7.
4. If the initial screening is negative, but through further assessment other risk factors are identified, and an ICD-10 Z code(s) is on the same claim, this will count towards the HRSN screening positivity rate.

Definitions:

Measurement Period: Calendar Year 2026 (January 1, 2026, through December 31, 2026)

Screening: Completion of a Health-Related Social Needs (HRSN) assessment using age-appropriate and evidence-based screening questions, for at least but not limited to, Transportation, Food Insecurity, Social Environment and Housing issues or concerns. The results of the screening must be documented in the Electronic Health Record.

Reporting Type:

Claims Only

Coverage Evaluation:

The numerator and denominator are based on attributed membership that meet eligibility for inclusion and are not evaluated for continuous enrollment or gaps in coverage.

Social Determinants of Health (SDoH) Screening Measure – 2026

Highlighted code indicates new in 2026.

Problems related to education and literacy (Z55)

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| Z55.0 Illiteracy and low-level literacy |
| Z55.1 Schooling unavailable and unattainable |
| Z55.2 Failed school examinations |
| Z55.3 Underachievement in school |
| Z55.4 Educational maladjustment and discord with teachers and classmates |
| Z55.5 Less than a high school diploma |
| Z55.6 Problems related to health literacy |
| Z55.8 Other problems related to education and literacy |
| Z55.9 Problems related to education and literacy, unspecified |

Problems related to employment and unemployment (Z56)

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| Z56.0 Unemployment, unspecified |
| Z56.1 Change of job |
| Z56.2 Threat of job loss |
| Z56.3 Stressful work schedule |
| Z56.4 Discord with boss and workmates |
| Z56.5 Uncongenial work environment |
| Z56.6 Other physical and mental strain related to work |
| Z56.81 Sexual harassment on the job |
| Z56.82 Military deployment status |
| Z56.89 Other problems related to employment |
| Z56.9 Unspecified problems related to employment |

Occupational exposure to risk factors (Z57)

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| Z57.0 Occupational exposure to noise |
| Z57.1 Occupational exposure to radiation |
| Z57.2 Occupational exposure to dust |
| Z57.31 Occupational exposure to environmental tobacco smoke |
| Z57.39 Occupational exposure to other air contaminants |
| Z57.4 Occupational exposure to toxic agents in agriculture |
| Z57.5 Occupational exposure to toxic agents in other industries |
| Z57.6 Occupational exposure to extreme temperature |
| Z57.7 Occupational exposure to vibration |
| Z57.8 Occupational exposure to other risk factors |
| Z57.9 Occupational exposure to unspecified risk factor |

Problems related to physical environment (Z58)

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| Z58.0 Problems related to physical environment |
| Z58.6 Inadequate drinking-water supply |
| Z58.8 Other problems related to physical environment |
| Z58.81 Basic services unavailable in physical environment |
| Z58.89 Other problems related to physical environment |

Problems related to housing and economic circumstances (Z59)

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| Z59.00 Homelessness, unspecified |
| Z59.01 Sheltered homelessness |
| Z59.02 Unsheltered homelessness |
| Z59.10 Inadequate housing, unspecified |
| Z59.11 Inadequate housing environmental temperature |
| Z59.12 Inadequate housing utilities |
| Z59.19 Other inadequate housing utilities |
| Z59.2 Discord with neighbors, lodgers and landlord |
| Z59.3 Problems related to living in residential institution |
| Z59.41 Food insecurity |
| Z59.48 Other specified lack of adequate food |

Z59.5 Extreme poverty

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| Z59.6 Low income |
| Z59.7 Insufficient social insurance and welfare support |
| Z59.71 Insufficient health insurance coverage |
| Z59.72 Insufficient welfare support |
| Z59.81 Housing instability, housed |
| 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 |
| Z59.82 Transportation insecurity |
| Z59.86 Financial insecurity |
| Z59.861 Difficulty paying for utilities |
| Z59.861 Other financial insecurity |
| Z59.869 Unspecified financial insecurity |
| Z59.87 Material hardship |
| Z59.89 Other problems related to housing and economic circumstances |
| Z59.9 Other problems related to housing and economic circumstances, unspecified |

Problems related to social environment (Z60)

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| Z60.0 Problems of adjustment to life-cycle transitions |
| Z60.2 Problem related to living alone |
| Z60.3 Acculturation difficulty |
| Z60.4 Social exclusion and rejection |
| Z60.5 Target of (perceived) adverse discrimination and persecution |
| Z60.8 Other problems related to social environment |
| Z60.9 Problem related to social environment, unspecified |

Problems related to upbringing (Z62)

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| Z62.0 Inadequate parental supervision and control |
| Z62.1 Parental overprotection |
| Z62.2 Upbringing away from parents |
| Z62.21 Child in welfare custody |
| Z62.22 Institutional upbringing |
| Z62.23 Child in custody of non-parental relative |
| Z62.24 Child in custody of non-relative guardian |
| Z62.29 Other upbringing away from parents |
| Z62.3 Hostility towards and scapegoating of child |
| Z62.6 Inappropriate (excessive) parental pressure |
| Z62.8 Other specified problems related to upbringing |
| Z62.81 Personal history of abuse in childhood |
| Z62.810 Personal history of physical and sexual abuse in childhood |
| Z62.811 Personal history of psychological abuse in childhood |
| Z62.812 Personal history of neglect in childhood |
| Z62.813 Personal history of forced labor or sexual exploitation in childhood |
| Z62.814 Personal history of child financial abuse |
| Z62.815 Personal history of intimate partner abuse in childhood |
| Z62.819 Personal history of unspecified abuse in childhood |
| Z62.820 Parent-biological child conflict |
| Z62.821 Parent-adopted child conflict |
| Z62.822 Parent-foster child conflict |
| Z62.823 Parent-step child conflict |
| Z62.83 Non-parental relative or guardian-child conflict |
| Z62.831 Non-parental relative-child conflict |
| Z62.832 Non-parental guardian-child conflict |
| Z62.833 Group home staff-child conflict |
| Z62.89 Other specified problems related to upbringing |
| Z62.890 Parent-child estrangement NEC |
| Z62.891 Sibling rivalry |

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| Z62.892 Runaway [from current living environment] |
| Z62.898 Other specified problems related to upbringing |
| Z62.9 Problem related to upbringing, unspecified |

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| Other problems related to primary support group, including family circumstances (Z63) |
| Z63.0 Problems in relationship with spouse or partner |
| Z63.1 Problems in relationship with in-laws |
| Z63.31 Absence of family member due to military deployment |
| Z63.32 Other absence of family member |
| Z63.4 Disappearance and death of family member |
| Z63.5 Disruption of family by separation and divorce |
| Z63.6 Dependent relative needing care at home |
| Z63.71 Stress on family due to return of family member from military deployment |
| Z63.72 Alcoholism and drug addiction in family |
| Z63.79 Other stressful life events affecting family and household |
| Z63.8 Other specified problems related to primary support group |
| Z63.9 Problem related to primary support group, unspecified |

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| Problems related to certain psychosocial circumstances (Z64) |
| Z64.0 Problems related to unwanted pregnancy |
| Z64.1 Problems related to multiparity |
| Z64.4 Discord with counselors |

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| Problems related to other psychosocial circumstances (Z65) |
| Z65.0 Conviction in civil and criminal proceedings without imprisonment |
| Z65.1 Imprisonment and other incarceration |
| Z65.2 Problems related to release from prison |
| Z65.3 Problems related to other legal circumstances |
| Z65.4 Victim of crime and terrorism |
| Z65.5 Exposure to disaster, war, and other hostilities |
| Z65.8 Other specified problems related to psychosocial circumstances |
| Z65.9 Problem related to unspecified psychosocial circumstances |

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| Stress (Z73) |
| Z73.3 Stress, not elsewhere classified |
| Z73.4 Inadequate social skills, not elsewhere classified |
| Z73.89 Other problems related to life management difficulty |
| Z73.9 Problem related to life management difficulty, unspecified |

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| Problems related to medical facilities and other health care (Z75) |
| Z75.0 Medical services not available in home |
| Z75.1 Person awaiting admission to adequate facility elsewhere |
| Z75.3 Unavailability and inaccessibility of health care facilities |
| Z75.4 Unavailability and inaccessibility of other helping agencies |

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| Patient's and Caregiver's noncompliance (Z91) |
| Z91.1 Patient's noncompliance with medical treatment and regimen |

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| Z91.110 Patient's noncompliance with dietary regimen, due to financial hardship |
| Z91.11 Patient's noncompliance with dietary regimen |
| Z91.118 Patient's noncompliance with dietary regimen, for other reason |
| Z91.119 Patient's noncompliance with dietary regimen, due to unspecified reason |
| Z91.12 Patient's intentional underdosing of medication regimen |
| Z91.120 Patient's intentional underdosing of medication regimen, due to financial hardship |
| Z91.128 Patient's intentional underdosing of medication regimen, for other reason |
| Z91.13 Patient's unintentional under dosing of medication regimen |
| Z91.130 Patient's unintentional underdosing of medication regimen, for other reason |
| Z91.14 Patient's other noncompliance with medication regimen |
| Z91.141 Patient's other noncompliance with medication regimen, due to financial hardship |
| Z91.148 Patient's other noncompliance with medication regimen, due to financial hardship |
| Z91.15 Patient's noncompliance with renal dialysis |
| Z91.151 Patient's noncompliance with renal dialysis, due to financial hardship |
| Z91.158 Patient's noncompliance with renal dialysis for other reason |
| Z91.19 Patient's noncompliance with other medical treatment and regimen |
| Z91.190 Patient's noncompliance with other medical treatment and regimen, due to financial hardship |
| Z91.198 Patient's noncompliance with other medical treatment and regimen, for other reason |
| Z91.199 Patient's noncompliance with other medical treatment and regimen, due to unspecified reason |
| Z91.A Caregiver's noncompliance with patient's medical treatment and regimen |
| Z91.A1 Caregiver's noncompliance with patient's dietary regimen |
| Z91.A10 Caregiver's noncompliance with patient's dietary regimen due to financial hardship |
| Z91.A18 Caregiver's noncompliance with patient's dietary regimen for other reason |
| Z91.A2 Caregiver's intentional underdosing of patient's medication regimen |
| Z91.A20 Caregiver's intentional underdosing of patient's medication regimen due to financial hardship |
| Z91.A28 Caregiver's intentional underdosing of patient's medication regimen for other reason |
| Z91.A3 Caregiver's unintentional underdosing of patient's medication regimen |
| Z91.A4 Caregiver's other noncompliance with patient's medication regimen |
| Z91.A41 Caregiver's other noncompliance with patient's medication regimen due to financial hardship |
| Z91.A48 Caregiver's noncompliance with patient's medication for other reason |
| Z91.A5 Caregiver's noncompliance with patient's renal dialysis |
| Z91.A51 Caregiver's noncompliance with patient's renal dialysis due to financial hardship |
| Z91.A58 Caregiver's noncompliance with patient's renal dialysis for other reason |
| Z91.A91 Caregiver's noncompliance with patient's other medical treatment and regimen due to financial hardship |

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| Z91.A98 Caregiver's noncompliance with patient's other medical treatment and regimen for other reason |
| Z91.4 Personal history of psychological trauma not elsewhere classified |
| Z91.41 Personal history of adult abuse |
| Z91.410 Personal history of adult physical and sexual abuse |
| Z91.411 Personal history of adult psychological abuse |
| Z91.412 Personal history of adult neglect |
| Z91.413 Personal history of adult financial abuse |
| Z91.414 Personal history of adult intimate partner abuse |
| Z91.419 Personal history of unspecified adult abuse |
| Z91.42 Personal history of forced labor or sexual exploitation |
| Z91.49 Other personal history of psychological trauma not elsewhere classified |
| Z91.5 Personal history of self-harm |
| Z91.51 Personal history of suicidal behavior |
| Z91.52 Personal history of nonsuicidal self-harm |
| Z91.89 Other specified personal risk factors, not elsewhere classified |

A full HRSN screening can be conducted annually, and updates provided at each visit to resolve prior concerns or add new ones. These Healthcare Common Procedure Coding System (HCPCS) codes can be used when reporting: G9919 – Screening performed and positive and provision of recommendations. G9920 – Screening performed and negative.

American Hospital Association. ICD-10-CM Coding for Social Determinants of Health. Jan. 2022, www.aha.org/system/files/2018-04/value-initiative-icd-10-code-social-determinants-of-health.pdf

CMS. ICD-10-CM Official Guidelines for Coding and Reporting FY 2026 -- UPDATED October 1, 2025 <https://www.cms.gov/files/document/fy-2026-icd-10-cm-coding-guidelines.pdf>

CMS. IMPROVING THE COLLECTION OF Social Determinants of Health (SDOH) Data with ICD-10-CM Z Codes Sept 2023, <https://www.cms.gov/files/document/cms-2023-omh-z-code-resource.pdf>

ICD-10 Data.com Personal risk factors, not elsewhere classified Z00-Z99/Z77-Z99/Z75/Z91, 2025 <https://www.icd10data.com/ICD10CM/Codes/Z00-Z99/Z77-Z99/Z91->

American Academy of Professional Coders. ICD-10-CM Code for Insufficient health insurance coverage, 2024 <https://www.aapc.com/codes/icd-10-codes/Z59.71>

American Speech-Language-Hearing Association (ASHA) 2025 ICD-10-CM Codes Related to Social Determinants of Health: <https://www.asha.org/siteassets/reimbursement/icd-10-codes-sdoh.pdf>

CMS. The Accountable Health Communities Health-Related Social Needs Screening Tool, [The AHC Health-Related Social Needs Screening Tool](#)

CMS. Social Drivers of Health and Health-Related Social Needs, [Social Drivers of Health and Health-Related Social Needs | CMS](#)

Appendix B: CMHN Recommended Social Needs Screening Survey

SOCIAL NEEDS SURVEY






Our goal is to provide the best possible care for your child and family. Being a parent is not always easy, and we want to make sure that you know all the community resources that are available to you and your family. Many of these resources are free of charge.

Please complete and hand to your child's medical assistant at the beginning of the visit.

Thank you!

Name: _____ Phone Number: _____

Preferred Language: _____ Best Time to Call: _____

| | | |
|---|--|--|
|  | In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
|  | In the last 12 months, has your utility company shut off your service for not paying your bills? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
|  | Are you worried that in the next 2 months, you may not have stable housing ? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
|  | Do problems getting child care make it difficult for you to work or study? <i>(leave blank if you do not have children)</i> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
|  | In the last 12 months, have you needed to see a doctor, but could not because of cost ? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
|  | In the last 12 months, did you skip medications to save money ? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
|  | In the last 12 months, have you ever had to go without health care because you didn't have a way to get there ? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
|  | Do you ever need help reading hospital materials ? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
|  | Are you afraid you might be hurt in your apartment building or house? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
|  | Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you? Not at all <input type="checkbox"/> A little bit <input type="checkbox"/> Somewhat <input type="checkbox"/> Quite a bit <input type="checkbox"/> Very much <input type="checkbox"/> I choose not to answer this question <input type="checkbox"/> | |
|  | If you checked YES to any boxes above, would you like to receive assistance with any of these needs? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
|  | Are any of your needs urgent? For example: I don't have food tonight, I don't have a place to sleep tonight | Yes <input type="checkbox"/> No <input type="checkbox"/> |

Screening questions from the Health Leads Social Needs Screening and the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) Screening

Appendix C: Addressing a Positive Screen

If a patient screens positive for any of the needs identified in the SDOH screening, such as food insecurity or houselessness, ask them if they would like help with any of the identified concerns. Here is a sample of how you can talk to the patient about resources:

I appreciate your willingness to answer these screening questions to help with your care. You answered that you have a concern with having enough food to eat. Would you like me to connect you with a community organization that can help you with this need or would you like a way to do this yourself?

If the patient would like help you can:

- Refer patient/family to a resource using Lift Up KC through InNote – a quick and easy way to connect patients to community-based organizations (CBOs) with just a few clicks
- Recommend or refer to “full-service” centers that can address many needs, such as food insecurity, housing insecurity, financial assistance, etc.
- Recommend or refer to “no wrong door centers” that can help connect a patient to another organization if they are unable to help
- Utilize a “super-user” in your practice, trained on Lift Up KC and local resources, to help connect the patient and family with a CBO
- Provide the patient/family with [liftupkc.org](https://www.liftupkc.org) postcards so they can access resources and navigate their own care

CMHN can help provide recommendations of these organizations in your service area.

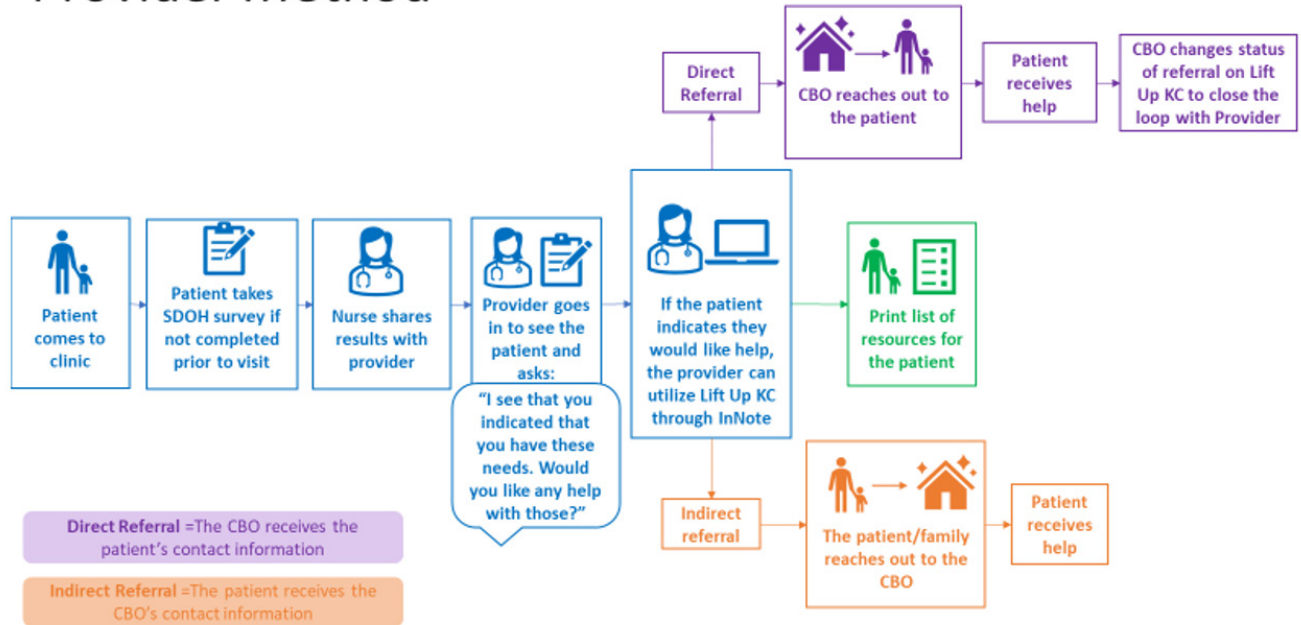
Additionally, CMHN can help facilitate a relationship between your practice and one “full service” CBO in your geographic area. This will allow your practice to refer all patients who screen positive for SDOH to one organization.

¹<https://www.cmics.org/cmhn/LoadImagesFiles/LoadFile?contentGUID=4DFD26B5-8C28-4B55-B9C0-1B9A96493FA6>

²Colvin, “Screening & Referring for Social Determinants of Health in General Pediatrics” September 29, 2021.

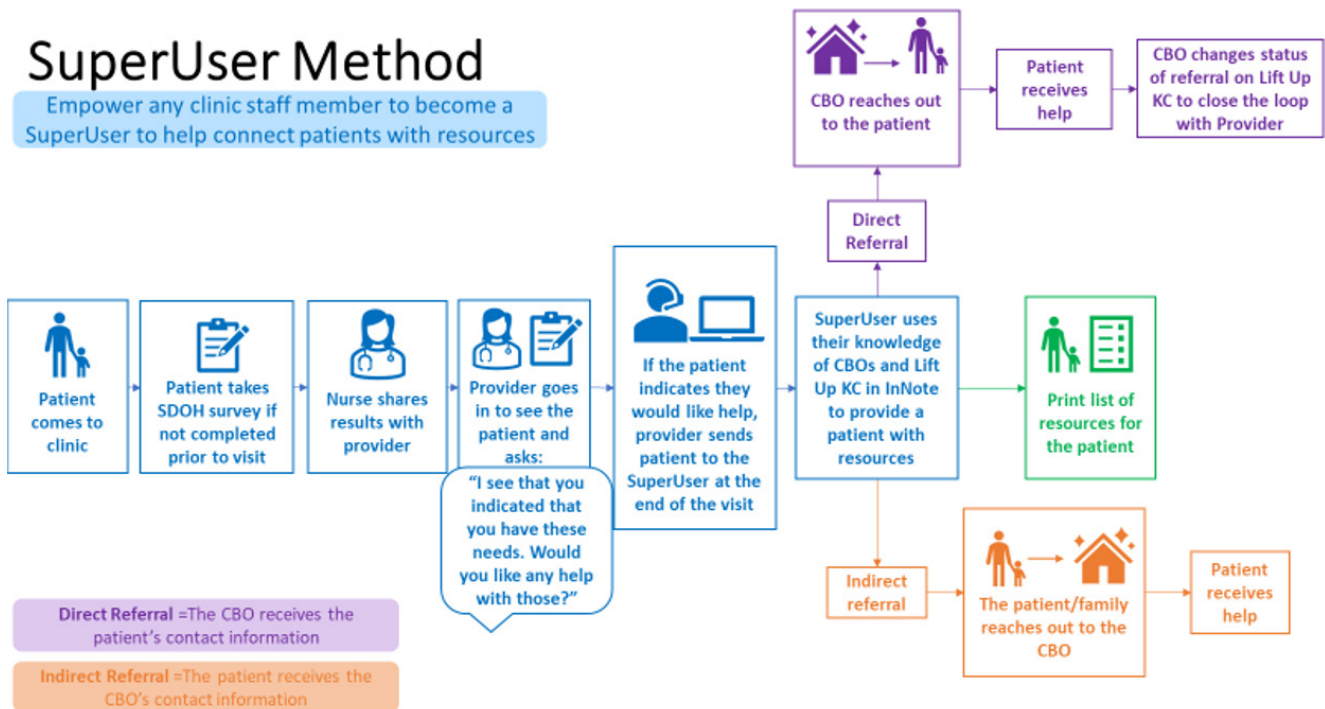
Recommended workflows for addressing positive screens:

Provider Method




SuperUser Method

Empower any clinic staff member to become a SuperUser to help connect patients with resources



Appendix D: Lift Up KC Referral Card Options for Patients / Families



Connecting your family with trusted community resources



www.liftupkc.org

Find food, transportation, housing, employment programs and more in seconds.

Zip

It's simple. It's free.

With just a zip code (no registration required) you can find hundreds of programs in your area and it takes less than 5 seconds.












Zip

Connecting your family with trusted community resources

Need a little help?

Find the resources you need quickly and easily

Find Programs | Connect to Services | Apply for Benefits | View Hours and Locations

-  Food
-  Housing & Goods
-  Transportation
-  Safety
-  Money & Employment
-  Health
-  Legal
-  Early Childhood
-  Education

www.liftupkc.org

Because everyone needs a little help sometimes.