Social Drivers of Health (SDOH) Coding Infographic



	LOINC	ICD-10-CM	SNOMED-CT	СРТ	HCPCS Level II
what are these codes?	Logical Observation Identifiers Names and Codes Also referred to as 'laboratory codes'	International Classification of Diseases, Tenth Revision, Clinical Modification Also referred to as 'diagnosis codes'	SNOMED Clinical Terms	Current Procedural Terminology Also referred to as 'procedure codes'	Healthcare Common Procedure Coding System Level II
who develops & maintains hese codes?	Regenstrief Institute, a non-profit medical research organization associated with Indiana University Free for use	CDC's National Center for Health Statistics under authorization by the World Health Organization Free for use	SNOMED International, a not-for-profit organization Free for use	American Medical Association (AMA) Use of any CPT code requires an organizational or individual license from AMA	Centers for Medicare and Medicaid Services (CMS) Free for use
why are these codes used?	Federally mandated terminology standard/coding system for capturing: Health measurements and observations Vital signs, lab tests and results, questions and responses for validated screening and assessment tools (e.g., PRAPARE®, PHQ, etc.) Document types Consult notes, discharge summaries, progress notes, procedures notes, etc.	Federally mandated terminology standard/coding system for capturing diseases, illnesses, injuries and health conditions	Federally mandated terminology standard/coding system for capturing all health-related concepts (e.g., clinical findings, diagnostic procedures, etc.), Includes codes that represent concepts and relationships between concepts with more specificity	Federally mandated terminology standard/coding system for billing services provided or rendered to a patient	Federally mandated terminology standard/coding system for describing services, equipment and supplies used in various health care setting that are not part of the CPT code set. Code Set Categories include: Services (i.e., Ambulance, Medical, Behavioral Health, Dental) Supplies Durable Medical Equipment (DME) (i.e., orthotics, prosthetics)
HOW are these codes used?	Facilitate the aggregation and exchange of health measurements, observations, and documents	Insurance claims submission and processing Tracking public health conditions and assisting with population health management Identifying care gaps Clinical research	Allows the meaning of information recorded in clinical information systems (e.g., EHRs, etc.), health data & analytics platforms and interoperability solutions to be processed SNOMED-CT, together with ICD-10-CM, is the accepted standard for SDOH Assessment, Goals, and Interventions in <u>USCDIv3</u> and will be required for use before Jan 1, 2026, through the <u>ONC's HTI-1 final rule</u> .	Insurance claims submission and processing Utilization review and comparison Identifying care gaps (i.e., indicated by the lack of a CPT code) Can be leveraged to establish clinical protocols and outreach processes	Insurance claims submission and processing by Medicare, Medicaid, and other insurers for those services, supplies, and equipment not identified by CPT. Billing to Medicare for qualifying FQHC services and care management services under the Prospective Payment System (PPS) system of "G codes". Utilization review and comparison
SDOH Example	PRAPARE® (full assessment instrument): 93025-5 "What is your housing situation today?": 71802-3 "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)": LA30190-5 See PRAPARE® LOINC Codes for full code set	Unsheltered homelessness: Z59.02 See CMS SDOH Z Code Infographic and PRAPARE® Z Code Quick Sheet for full code set, Z55-Z65 (also referred to as 'Z codes')	Patient identified as experiencing unsheltered homelessness: 611141000124105 Goal established for the patient to be stably housed: 611221000124108 Intervention provided through a referral to housing support program: 472161000124106 See PRAPARE® Data Documentation and Codification File for full code set	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes: 99401 See next page for full code set	When patient has unmet SDOH needs that interfere with establishing a diagnosis or treatment plan goals, administration of a standardized, evidence-based SDOH risk assessment tool, 5-15 minutes, not more than every 6 months: G0136 Provided with the following services: E/M visit Behavioral health office visits Annual Wellness Visit (AWV)

and the reason why an intervention was provided

assess for social risk factors is valid findings (less detail) Captures the provision of SDOH Captures the provision of SDOH assessments, for assessments and social risk interventions patients with unmet SDOH needs, within an office visit



	СРТ	Description	Tips for Using*	
SDOH	96156	Health behavior assessment (e.g., health-focused clinical interview, behavioral observations, validated rating scales) by a qualified healthcare professional, initial assessment	This code is used for the initial assessment of health behaviors, including screening for SDOH. It involves conducting a comprehensive interview, behavioral observations, and using validated rating scales to assess various health-related behaviors, including social drivers of health.	
Assessment	96160	Administration of patient-focused health risk assessment instrument (e.g., health hazard appraisal) with scoring and documentation, per standardized instrument.	This code is used for the administration and scoring of a patient-focused health risk assessment instrument, such as a standardized questionnaire or survey that includes SDOH screening. It involves assessing multiple health risks, including social drivers of health, and documenting the results.	
Addressing	97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes		
Food Insecurity	97803	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes		
	97804	Medical nutrition therapy; group (2 or more individuals), each 30 minutes		
	99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes		
	99402	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes	These codes used for counseling and interventions aimed at promoting health, preventing illness, and reducing risk factors. They can be used to address specific needs identified through SDOH screening Should be reported together with an ICD-10-CM Z-code(s), which demonstrates the link or need for the preventive medicine counseling Cannot be reported in addition to preventive medicine service codes 99381–99385 and 99391–99395 for comprehensive preventive medicine evaluation and management of an individual (overlapping services)	
Addressing	99403	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes		
Identified Social Risks	99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes		
	99411	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes		
	99412	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 60 minutes		

*Use of any CPT code requires an organizational or individual license from AMA.

^{*}Reimbursement for services will vary by state and payor. See NACHC Community Health Integration (CHI) and Principal Illness Navigation (PIN) Tip Sheets for Medicare reimbursement opportunities related to SDOH services.