Quick Guide for Clinical Teams:

Addressing Patient Barriers to Cardiac Rehabilitation Services & Coding for Social Determinants of Health (SDoH Z Codes)

QIN–QIO
Quality Innovation Network -
Quality Improvement Organizations
CENTERS FOR MEDICARE & MEDICAID SERVICES
iQUALITY IMPROVEMENT & INNOVATION GROUP

Quick Guide for Clinical Teams: Addressing Patient Barriers to Cardiac Rehabilitation Services & Coding for Social Determinants of Health (SDoH Z Codes)

Use this tool to ensure you are providing comprehensive care for patients with **Medicare Part B** who experienced any of the following cardiovascular events:

- A heart attack in the last 12 months
- Coronary artery bypass surgery
- Current stable angina (chest pain)
- A heart valve repair or replacement
- A coronary angioplasty (a medical procedure used to open a blocked artery) or coronary stent (a procedure used to keep an artery open)
- A heart or heart-lung transplant
- Stable chronic heart failure

Here are four easy steps to set your team up for success by increasing patient communication.

1. Work with patients who will benefit from cardiac rehabilitation services by documenting barriers and following solutions offered.
2. Address social determinants of health.
3. Document the appropriate Z codes for billing purposes.
4. Use appropriate resources to help patients start and complete a cardiac rehabilitation program.

Here are a few tips to help your patient succeed in completing their program:

1. Speak with the patient's health care team to determine their eligibility for cardiac rehab. Discuss with their primary care provider and cardiologist.
2. Talk to your patient about how cardiac rehab can improve their recovery progress. Check out Alliant's cardiac rehab resources.
    - Address any patient barriers using pages 4-6 of this booklet.
3. Provide your patient with a cardiac rehab program referral.
4. Confirm your patient's enrollment in a cardiac rehab program.
    - Use page 7 of this booklet to document referral information.
5. Document your patient's cardiac rehab attendance and program completion on page 7 of this booklet.
6. Advocate for the services your patient needs. Access the Million Hearts Cardiac Rehab Change Packet for additional resources.

Once the cardiac rehabilitation referral has been approved:

1. Confirm with the patient all details related to their first cardiac rehab session, such as time and location.

2. Discuss program enrollment with other colleagues involved in the patient's care, such as the primary care provider, cardiologist and cardiac rehab team.

3. Ask the patient about barriers that may impact their ability to participate in the cardiac rehab program regularly. Check out the What's Holding You Back From Going to Cardiac Rehab? one-page resource.

If the patient shares barriers to cardiac rehab participation:

1. Refer patient and care partner(s) to the discharge planning team, social work, case management, care coordination, and other patient services to help address barriers to CR.

2. Ensure the patient is screened and referred to resources for additional social needs related to Social Determinants of Health (SDoH).

Does the patient need transportation to attend cardiac rehab sessions?

YES
Ask colleagues and other care team members how you can help the patient arrange for medical transport services.

Ask case managers to share a list of transportation services in your area, considering costs and insurance coverage if applicable.

NO
Encourage the patient to share their transportation mode, travel route, transit time and plan for the day with their care partner(s) and companion(s).

Let them know they can ask you for help if their transportation plans fall through.

Is transportation a problem for the patient because their cardiac rehab program is too far, or there are no programs within a reasonable distance?

Z59.82 – Transportation insecurity

YES
Evaluate your patient's eligibility for a home-based or virtual cardiac rehabilitation program.

NO
Encourage your patient to prioritize their heart by attending all their cardiac rehab sessions.

Is the patient worried about scheduling conflicts related to their caregiver's responsibilities?

SDoH Code: Z63 – Other problems related to the primary support group, including family circumstances.

YES

1. Encourage patients to discuss prioritizing their health with their families.
2. Refer the patient to the appropriate care team member (discharge planning team, case manager, case coordinator or social worker) to guide them on how to find respite care services and community resources.

NO
Encourage the patient to create a feasible schedule with family members or respite services to ensure uninterrupted attendance to cardiac rehab sessions.

National Respite Locator Service
www.archrespite.org/respitelocator

Well Spouse Association
800-838-0879
info@wellspouse.org
www.wellspouse.org

Eldercare Locator
800-677-1116
eldercarelocator@n4a.org
https://eldercare.acl.gov

Centers for Medicare & Medicaid Services
800-633-4227
877-486-2048 (TTY)
www.cms.gov

Learn more about discussing FMLA with employers here:
https://www.dol.gov/agencies/whd/fmla

Is the patient worried about taking time off from work?

SDoH Code: Z56 – Problems related to employment and unemployment.

YES
Encourage your patient to discuss with their employer or HR representative if they are eligible for federal FMLA benefits and review their workplace policy.

NO
Encourage the patient to create a feasible schedule with supervisors and coworkers to ensure uninterrupted attendance to cardiac rehab sessions.

If the patient is concerned about insurance for cardiac rehab services, use the following information to help them understand coverage.

SDoH Code: *Z59 – Problems related to housing and economic circumstances.*

Medicare Part B (Medical Insurance) covers cardiac rehab services if your patient has at least one of these qualifying conditions:

- A heart attack in the last 12 months
- Coronary artery bypass surgery
- Current stable angina (chest pain)
- A heart valve repair or replacement
- A coronary angioplasty (a medical procedure used to open a blocked artery) or coronary stent (a procedure used to keep an artery open)
- A heart or heart-lung transplant
- Stable chronic heart failure

Part B also covers intensive cardiac rehabilitation programs, allowing for more education and lifestyle counseling. Medicare covers these services in a doctor's office or hospital outpatient setting (including a critical access hospital).

Your patient's costs in Original Medicare: Your patient may pay 20% of the Medicare-Approved Amount if they get these services in a doctor's office. In a hospital outpatient setting, they may also pay the hospital a co-payment. The Part B deductible applies.

Have a list of local financial and community resources to offer patients facing economic obstacles in participating in cardiac rehabilitation, including case managers, charities, hospital funds and faith-based organizations.

Patient Information and Attendance Record

Patient Name		Number	
Telephone 1		Telephone 2	
Emergency Contact		Telephone Emergency Contact	
Qualifying Dx		Referring Provider	
Primary Care Provider (PC)		PCP Contact info	
Cardiologist Name		Cardiologist Contact info	
Cardiac Rehab (CR) Program		CR Program Contact info	

Cardiac Rehabilitation Program Attendance					
Session	**Date Scheduled**	**Attended Y/N/ Rescheduled Date**	**Session**	**Date Scheduled**	**Attended Y/N/ Rescheduled Date**
1			19		
2			20		
3			21		
4			22		
5			23		
6			24		
7			25		
8			26		
9			27		
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Notes:

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USING SDOH Z CODES
Can Enhance Your Quality Improvement Initiatives

Health Care Administrators

Understand how SDOH data can be gathered and tracked using Z codes.

- Select an SDOH screening tool.
- Identify workflows that minimize staff burden.
- Provide training to support data collection.
- Consider EHRs that facilitate data collection and coding.
- Decide what Z code data to use and monitor.

Develop a plan to use SDOH Z code data to:

- Enhance patient care.
- Improve care coordination and referrals.
- Support quality measurement.
- Identify community/population needs.
- Support planning and implementation of social needs interventions.
- Monitor SDOH intervention effectiveness.

Health Care Team

Use a SDOH screening tool.

- Follow best practices for collecting SDOH data in a sensitive and HIPAA-compliant manner.
- Consistently document standardized SDOH data in the EHR.
- Refer individuals to social service organizations and appropriate support services through local, state, and national resources.

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Coding and Other Professionals

Follow the ICD-10-CM coding guidelines.[3]

- Use the CDC National Center for Health Statistics ICD-10-CM Browser tool to search for ICD-10-CM codes and information on code usage.[4]
- Assign all relevant SDOH Z codes to support quality improvement initiatives.

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

This list is subject to revisions and additions to improve alignment with SDOH data elements.

Resources: [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
[3] https://www.cms.gov/medicare/icd-10/2024-icd-10-cm
[4] https://www.cdc.gov/nchs/icd/icd-10-cm.htm

USING Z CODES:
The **Social Determinants of Health (SDOH)** Data Journey to Better Outcomes

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]

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USING Z CODES:

The **Social Determinants of Health (SDOH)** Data Journey to Better Outcomes, cont'd.

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.

What are Z codes

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.

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

www.quality.allianthealth.org

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