

Social Need Screening and Intervention (SNS-E) – HEDIS Measure



Improving Quality Outcomes

Line of Business: Medicaid, Marketplace ●●

SOCIAL NEED SCREENING AND INTERVENTION (SNS-E)

Measure Description

The percentage of persons who were screened using prespecified instruments, or assessed by a provider, for unmet food, housing and transportation needs at least once during the measurement period, and the percentage of persons with a positive screen or identified need for food, housing or transportation who received an intervention corresponding to the positive screen or identified need within 30 days.

The following age ranges applies:

- ≤17 years
- 18-64 years
- 65 and older

Identifiable Social Need Screenings and Interventions:

- Food Screening: percentage of members who were screened for food insecurity.
- Food Intervention: percentage of members who received a corresponding intervention within 30 days (1 month) of screening positive for food insecurity.
- Housing Screening: percentage of members who were screened for housing instability, homelessness, or housing inadequacy.
- Housing Intervention: percentage of members who received a corresponding intervention within 30 days (1 month) of screening positive for food insecurity.
- Transportation Screening: percentage of members who were screened for transportation insecurity.
- Transportation Intervention: percentage of members who received a corresponding intervention within 30 days (1 month) of screening positive for transportation insecurity.

Description	Codes*
Food Insecurity	CPT: 97802, 97803, 97804 HCPCS: G0136, S5170, S9470 ICD-10-CM: Z59.41, Z59.48
Homelessness	HCPCS: G0136 ICD-10-CM: Z59.00, Z59.01, Z59.02
Housing Inadequacy	HCPCS: G0136 ICD-10-CM: Z59.10, Z59.11, Z59.12, Z59.19
Housing Instability	ICD-10-CM: Z59.811, Z59.812, Z59.819, Z59.89
Transportation Insecurity	HCPCS: G0136

*Codes subject to change

Important note: Use the applicable ICD-10 Code for SDOH when billing with CPT/HCPCS codes.

SNOMED CODES				
Food Insecurity	Homelessness	Housing Instability	Inadequate Housing	Transportation Insecurity
1759002	308440001	308440001	49919000	308440001
61310001	710824005	710824005	308440001	710824005
103699006	711069006	711069006	710824005	711069006
308440001	1148446004	1148446004	711069006	1148446004
385767005	1148447008	1148447008	1148446004	1162436000
710824005	1148812007	1148812007	1148813002	1230338004
710925007	1148814008	1148814008	1148815009	461481000124109
711069006	1148817001	1148817001	1148823006	462481000124102
713109004	1148818006	1148818006	1162436000	462491000124104
1002223009	1162436000	1156869006	1230338004	464001000124109
1002224003	1162437009	1162436000	461481000124109	464011000124107
1002225002	1230338004	1162437009	462481000124102	464021000124104
1004109000	461481000124109	1230338004	462491000124104	464131000124100
1004110005	462481000124102	461481000124109	464001000124109	464161000124109
1148446004	462491000124104	462481000124102	464011000124107	464291000124105
1162436000	464001000124109	462491000124104	464021000124104	464301000124106
1230338004	464011000124107	464001000124109	464131000124100	464311000124109
441041000124100	464021000124104	464011000124107	464161000124109	464611000124102
441201000124108	464131000124100	464021000124104	464291000124105	470231000124107
441231000124100	464161000124109	464131000124100	464301000124106	470591000124109

SNOMED CODES for Social Health Needs (SNS-E) is a list of codes reflecting social services provided through a case manager, coordination of care, referrals, agency assistance, educational resources and more. For a complete list of LOINC/SNOMED Codes access the NCQA Store to download HEDIS Digital Measure Bundles at: <https://store.ncqa.org/hedis-quality-measurement.html>

Improving HEDIS Measure:

For HEDIS MY2026, NCQA has expanded the Social Need Screening and Intervention measure (SNS-E) to enhance data capture and improve health equity. The following updates should be reflected in documentation and coding practices:

- **HCPCS Code G0136** has been added as a valid screening indicator. This code should be used to document assessments for social needs, including food insecurity, housing instability, and transportation barriers.
- Continue to use **LOINC codes** for structured data capture when applicable. These codes remain valid for documenting responses to standardized screening instruments.
- **To ensure comprehensive documentation:**
 - Pair **G0136** or LOINC-coded screenings with the appropriate **ICD-10 “Z” codes** that reflect identified social needs (e.g., Z59.0 for homelessness, Z59.4 for lack of adequate food).
 - Include a corresponding **intervention code** (e.g., SNOMED, CPT, or administrative data) within 30 days of a positive screen to meet numerator compliance.
- Ensure the diagnosis code references the member’s **Social Need Screening and Intervention (SNS-E)** to capture the full scope of services already occurring.
- Interventions may include assistance, assessment, counseling, coordination, education, eligibility evaluation, provision, or referral.

Use of LOINC Codes – Eligible screening instrument with thresholds for positive findings

LOINC Codes for Food Insecurity		
Assessment Tool	Screening Code	Positive Finding
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	88122-7, 88123-5	LA28397-0, LA6729-3
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	88122-7, 88123-5	LA28397-0, LA6729-3
Health Leads Screening Panel **	95251-5	LA33-6
Hunger Vital Sign™1 (HVS)	88124-3	LA19952-3
Protocol for Responding to and Assessing Patients’ Assets, Risks and Experiences [PRAPARE] **	93031-3	LA30125-1
Safe Environment for Every Kid (SEEK) **	95400-8, 95399-2	LA33-6
U.S. Household Food Security Survey [U.S. FSS]	95264-8	LA30985-8, LA30986-6
U.S. Adult Food Security Survey [U.S. FSS]	95264-8	LA30985-8, LA30986-6
U.S. Household Food Security Survey–Six-Item Short Form [U.S. FSS]	95264-8	LA30985-8, LA30986-6
We Care Survey	96434-6	LA32-8
WellRx Questionnaire	93668-2	LA33-6

LOINC Codes for Housing Instability and Homelessness		
Assessment Tool	Screening Code	Positive Finding
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	71802-3	LA31994-9 LA31995-6
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	99550-6 71802-3	LA33-6 LA31994-9 LA31995-6

Children's Health Watch Housing Stability Vital Signs™ **	98976-4 98977-2 98978-0	LA33-6 ≥3 LA33-6
Health Leads Screening Panel®1	99550-6	LA33-6
Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences [PRAPARE]**	93033-9 71802-3	L133-6 LA30190-5
We Care Survey	96441-1	LA33-6
WellRx Questionnaire	93669-0	LA33-6

LOINC Codes for Housing Inadequacy

Assessment Tool	Screening Code	Positive Finding
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	96778-6	LA31996-4, LA28580-1, LA31997-2, LA31998-0, LA31999-8, LA32000-4, LA32001-2
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	96778-6	LA32691-0, LA28580-1, LA32693-6 LA32694-4, LA32695-1, LA32696-9 LA32001-2, LA31996-4, LA28580-1 LA31997-2, LA31998-0, LA31999-8 LA32000-4, LA32001-2
Norwalk Community Health Center Screening Tool [NCHC]	99134-9 99135-6	LA33-6, LA31996-4, LA28580-1, LA31997-2, LA31998-0, LA31999-8, LA32000-4, LA32001-2

LOINC Codes for Transportation Insecurity

Assessment Tool	Screening Code	Positive Finding
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	93030-5	LA33-6
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	99594-4	LA33-6, LA33093-8, LA30134-3
Comprehensive Universal Behavior Screen (CUBS)	89569-8	LA29232-8, LA29233-6, LA29234-4
Health Leads Screening Panel **	99553-0	LA33-6
Inpatient Rehabilitation Facility - Patient Assessment Instrument (IRF-PAI) version 4.0 [CMS Assessment]	93030-5	LA30133-5, LA30134-3
Outcome and assessment information set (OASIS) for m— version E— Discharge from Agency [CMS Assessment]	93030-5	LA30133-5, LA30134-3
Outcome and assessment information set (OASIS) form— version E — Resumption of Care [CMS Assessment]	93030-5	LA30133-5, LA30134-3
Outcome and assessment information set (OASIS) form—version E—Start of Care [CMS Assessment]	93030-5	LA30133-5, LA30134-3
Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences [PRAPARE]®**	93030-5	LA30133-5, LA30134-3

PROMIS®**	92358-1	LA30024-6, LA30026-1, LA30027-9
WellRx Questionnaire	93671-6	LA33-6

** Proprietary; may be cost or licensing requirement associated with use.

Improving the Collection of SDOH Data

Peach State Health Plan encourages our network providers to participate in EMR exchange of SDOH data. Achieving this goal takes coordination and alignment between providers, payers, and the community at large. We encourage you to leverage your staff and resources to improve patient and population health. Peach State is in this initiative with you, and we are here to support you with the necessary tools and webinars that speak to SDOH. Please visit our website for more resources at: www.pshpgeorgia.com.

Reminder:

- Addressing SDOH can lead to improving healthier outcomes.
- Member can complete assessments both in-office or remotely.
- Select the appropriate screening tool based on the needs of your member population.
- Connect members with SDOH needs for appropriate services.
- Always document the completion of SDOH assessments with applicable codes.

Commonly Used SDOH ICD-10-CM Codes	
ICD-10 -CM Codes	Description
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 circumstance
Z64	Problems related to certain psychosocial circumstance
Z65	Problems related to other psychosocial circumstances

Note: This is a range of ICD-10 codes for SDOH use most appropriate code for reporting

Community Resources:

Identify resources in the community to assist patients with social needs. Creating a high- quality referral system to locate resources.

- Call 211 | United Way or go to www.211.org
- Go to findhelp.org by findhelp – Search and Connect to Social Care