California Food is Medicine Documentation and Coding Guide:

Supporting Community Health Centers in Addressing Food and Nutritional Needs for Patients with Diabetes and Hypertension

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Executive Summary

WHO SHOULD USE THIS GUIDE:

- **Documentation and coding specialists** - for proper claim submission
- **Clinicians** - for documentation requirements
- **IT staff** - for Electronic Health Record (EHR) configuration
- **Administrator**s - for program implementation

HOW IS THIS GUIDE STRUCTURED?

- First we provide an overview of food insecurity terminology as developed by The Gravity Project and the types of codes used in specific contexts
- Second, we offer details on the codes used during each stage of the terminology workstream, from screening to diagnosis, interventions, and billing.
- Finally, we describe the quality measurement and reporting requirements related to food insecurity.
- Note: All acronyms are included in the acronym appendix.

Food insecurity affects millions of Americans and poses significant challenges for managing chronic disease, particularly diabetes and hypertension.[1,2] This policy brief provides California Community Health Centers (CHCs) with comprehensive guidance on implementing standardized documentation and coding practices for food security screening, assessment, and intervention activities in an effort to positively impact the Social Determinants of health SDOH (the conditions in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes).[3]

The integration of food security assessments into routine clinical care represents a critical step toward addressing social determinants of health.[4] Building on a brief first published in 2018, this brief describes the latest evidence-based frameworks for screening, diagnosis documentation, intervention coding, and billing strategies that enable CHCs to systematically address food insecurity for patients and populations and align with federal data standard initiatives, while maintaining financial sustainability.[5]

This brief serves as a comprehensive resource for standardized documentation and optimized reimbursement for screening and interventions (social care) for food insecurity in the context of diabetes and hypertension management. The primary audience for this guide is CHC documentation and coding specialists, and secondarily, CHC clinicians, administrators,

Section I: Introduction and Context

FOOD IS MEDICINE AND CHC KEY PERFORMANCE INDICATORS

Food is Medicine strategies enhance CHCs' approach to whole-person care, specifically social care and chronic condition care. Food is Medicine supports the achievement of multiple Healthcare Effectiveness Data and Information Set (HEDIS) Measures, a widely used set of standardized performance measures developed and maintained by the National Committee for Quality Assurance.[6] For example, these two HEDIS measures can be directly linked to improvements in food security:

- Controlling High Blood Pressure: Percentage of 18-to 85-year-old people with hypertension whose blood pressure was adequately controlled (<140/90 mm Hg).
- Comprehensive Diabetes Care: Percentage of 18-to 75-year-old people with diabetes whose hemoglobin A1c was not under control (>9.0%).

For many CHC patients, diet is influenced by a variety of factors, including knowledge of a healthy diet, food preparation skills and capacity, physical, social, and emotional factors, and access to healthy food or food security. For patients experiencing both food insecurity and a diet-related disease, a robust care plan will require addressing both food security and food behaviors.

INTRODUCTION TO SOCIAL RISK ASSESSMENT AND INTERVENTIONS

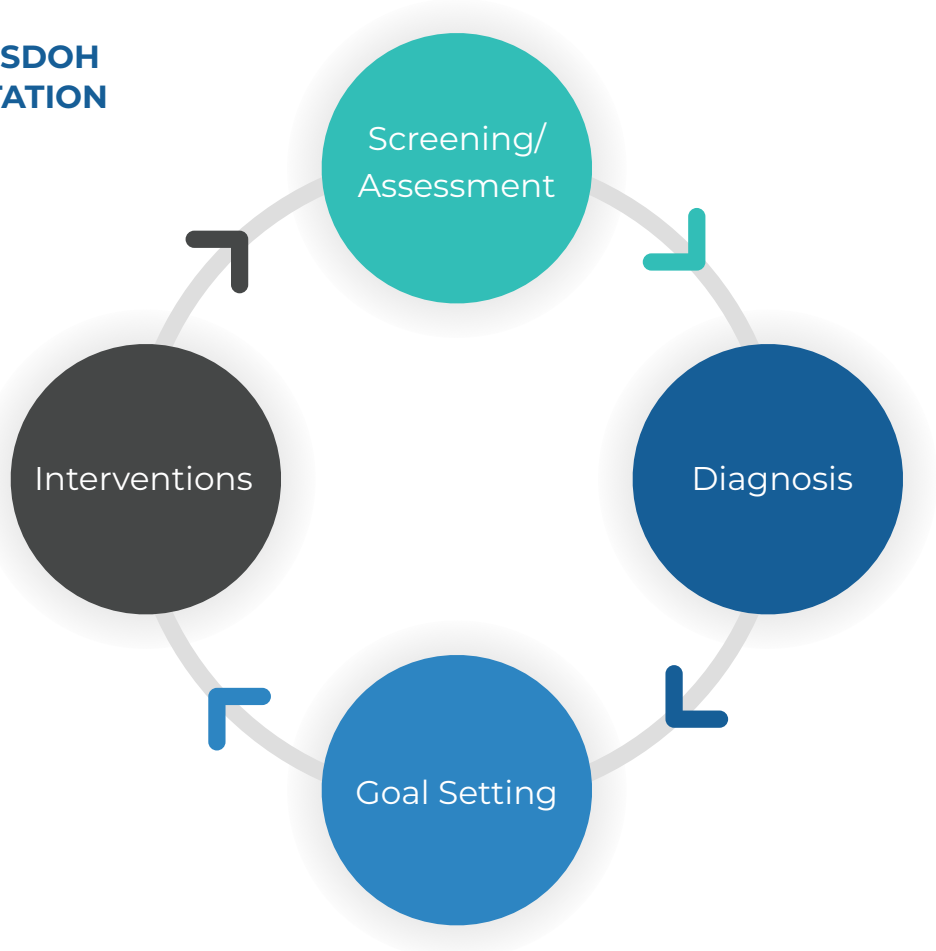
A general framework for social risk assessment and interventions provides a useful guide for properly documenting and billing for food insecurity assessments. The assessment and intervention framework is as follows:[7]

- Assess social risks (i.e., food insecurity) with standardized instruments, followed by patient interviews
- Document patient confirmed social risks relevant to the encounter as diagnoses or problems
- Set goals related to the social risk (e.g., sufficient meals and snacks daily)
- Establish interventions to address identified risks
- Measure outcomes to track progress
- Gather aggregate data for population health management and quality reporting

Mirroring the SDOH assessment and intervention workflow, these activities can be translated into discrete, interoperable codes for documentation (Figure 1):

- Standardized assessment instruments can be mapped to LOINC (Logical Observation Identifiers Names and Codes) codes for clinical observations (e.g., screening) in patient records.
- Social risks, like food insecurity, can be coded using International Classification of Diseases and Related Health Problems (ICD)-10-CM (clinical modification) codes (diagnosis codes) and Systematized Nomenclature of Medicine Clinical Term (SNOMED CT) codes (clinical terminology)
- Goals are documented with SNOMED CT.
- Interventions can be coded with three different types of codes: SNOMED-CT for specific programs and types of procedures, and CPT® (Current Procedural Terminology) and HCPCS (Healthcare Common Procedure Coding System) for interventions that are eligible for reimbursement by payers.[8]
- Outcomes are tracked through various methods, leveraging the terminology above as needed, depending on the measurement's goals. These include: changes between two applications of the same standardized instrument (e.g., lower score on the same United States Department of Agriculture (USDA) instrument after intervention), remission or resolution of a social risk (e.g., food insecurity to food security), attainment of goals (sufficient meals and snacks daily), or interventions completed.

FIGURE 1. GRAVITY* FHIR®** SDOH CLINICAL CARE IMPLEMENTATION GUIDE SCOPE[9 10]



* The Gravity Project builds and promotes consensus-driven SDOH data standards for interoperability and use across multi-stakeholders in health and social care. The mission of the Gravity Project is to serve as an open, public collaborative advancing the standardization of health and social data for health equity.

** FHIR® (Fast Healthcare Interoperability Resources) is an international standard for exchanging healthcare information electronically. It uses modern web technologies to allow different healthcare systems to share data in a standardized way, modify electronic health records (EHRs), and improve interoperability by ensuring data consistency across various platforms.

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Proper coding and documentation serve multiple critical functions beyond reimbursement. These activities support quality improvement initiatives, enable risk adjustment calculations, facilitate data sharing through Qualified Health Information Organizations (QHIOs), and support future value-based payment models. To learn more about the California Qualified Health Information Organizations, visit: https://dxf.chhs.ca.gov/for-participants/. Even when immediate reimbursement may not be available, consistent coding practices establish the foundation for future payment opportunities and quality measurement. In addition, coding offers immediate opportunities for analysis, providing insights into populations and supporting quality improvement. For example:

- Social risk data can provide insights into population needs that inform opportunities for healthcare Community-Based Organization partnerships and community needs analysis.
- Combining intervention and outcomes data can provide insights into which interventions are most effective at addressing the identified health-related social need, such as food insecurity.

Section II:
Coding for Food Insecurity Assessment (screening)

The implementation of validated assessment tools represents the cornerstone of effective food security screening in clinical settings. The Hunger Vital Sign™ (HVS) has emerged as the gold standard for initial screening, offering a brief yet validated assessment that can be easily integrated into routine clinical workflows. The HVS has been extensively validated in Community Health Center settings and provides reliable identification of food insecurity with minimal administrative burden.[11]

Several comprehensive screening instruments incorporate the HVS while providing additional SDOH assessment capabilities. The Accountable Health Communities Health-Related Social Needs Screening Tool, developed by the Centers for Medicare & Medicaid Services, provides a standardized approach to addressing multiple health-related social needs, including food insecurity, housing instability, transportation barriers, utility needs, and personal safety concerns.[12] The American Academy of Family Physicians Social Needs Screening Tool provides similar comprehensive assessment capabilities with particular attention to primary care integration.[13]

For diagnostic purposes, the United States Department of Agriculture Food Security Survey module remains the gold standard for comprehensive food security assessment. The 18-item Household Food Security Survey Module provides the most comprehensive assessment, comprising a 10-item adult assessment and an additional 8 child-focused items for households with children. Abbreviated versions, including the 6-item short form, offer efficient alternatives for clinical settings.[14] The 8-item Abbreviated Child and Adolescent Food Security Survey adds two questions to the 6-item tool to assess food security in households with children, addressing unique pediatric food security considerations.[15]

All USDA instruments are crafted as scales, with questions about mild forms of food insecurity first, progressing to more severe forms at the end. This allows for assessment of severity. The Hunger Vital Sign™ is structured as a highly sensitive initial screener for risk of food insecurity, identifying the mildest forms, and is recommended to be followed by a further assessment with the USDA instruments or a direct patient interview to confirm findings and establish severity, risk, and triage next steps for food insecurity interventions.

FIGURE 2.

Note: dimensions listed in order of least to most severe

Dimensions of Food Insecurity Represented in USDA Aligned Validated Assessment Instruments

- Worry that food will run out before there is money to buy more
- Food not lasting and there is no money to buy more
- Not able to afford eating balanced meals
- Adults cutting sizes of meals because there isn't enough money for food
- Adults eating less than they should because there isn't enough money for food
- Adults skipping meals because there isn't enough money for food
- Adults eating less than they felt they should because there isn't enough money for food
- Adults hungry but not eating because there isn't enough money for food
- Adults losing weight because there isn't enough money for food
- Adults not eating for a whole day because there isn't enough money for food
- Relying on low-cost foods for children because of running out of money
- Not being able to afford balanced meals for children
- Children not eating enough because there isn't enough money for food
- Cutting the size of children's meals because there isn't enough money for food
- Children skipping meals because there isn't enough money for food
- Children hungry but you can't buy more food because there isn't enough money for food
- Children not eating for a whole day because there isn't enough money for food

Although it has not been validated against the gold standard methodology, many CHCs utilize the NACHC-authored PRAPARE® Questionnaire. This instrument is currently under revision, and access requires licensing. The questionnaire includes one question regarding food insecurity that asks about being "unable to get (food)." As with the HVS, a screening protocol can be designed to cascade into the USDA diagnostic method if desired. But the question is not directly aimed at worry, balance, or quality, thus it may be a less sensitive initial screen. Of note, it is best practice to confirm all findings from standardized questionnaires with direct patient interviews before assigning diagnostic codes.

LOINC CODING FOR ASSESSMENT ACTIVITIES

As noted above, the activities of social care (i.e., food insecurity screening and interventions) can be translated into discrete, interoperable codes for documentation. When an assessment is used in the context of a clinical visit, its questions and answers can be coded using the LOINC® (Logical Observation Identifiers Names and Codes) system. Gravity Project curates sets of valid LOINC-encoded food security instruments within the open National Library of Medicine (NLM) Value Set Authority Center (VSAC). Links are also noted below. "LOINC is a common language (set of identifiers, names, and codes) for identifying health measurements, observations, and documents."[16]) LOINC® is predominantly used to document lab results, and is increasingly used for validated screening and assessment tools. LOINC® assigns valid instruments an alphanumeric code that is interoperable, i.e., able to be shared across all EHRs. This means

users can both use LOINC® to craft internal follow-up for screening question responses and communicate these needs in referrals or orders; it also means that the standardized data can be aggregated across health systems for research and population health initiatives. If your health system is not currently capturing screening processes in LOINC® terminology, you can advocate within your system to incorporate this terminology.

USDA HOUSEHOLD FOOD SECURITY SURVEY METHOD

- USDA
  - » 18-item (LOINC codes) Gold standard comprehensive assessment of food security
  - » 10-item (LOINC codes) Adult full assessment

INSTRUMENTS FULLY VALIDATED AGAINST THE USDA METHOD

- Hunger Vital Sign™ (LOINC codes)
  - » Accountable Health Communities (AHC) Health-Related Social Needs Screening Tool (CMS AHC Screening Tool)
  - » American Academy of Family Physicians AAFP Social Needs Screening Tool
- USDA 6-item (LOINC codes) Abbreviated adult assessment
- Abbreviated Child and Adult Food Security Scale (ACAFSS): abbreviated assessment for households with children (LOINC codes)

OTHER FOOD INSECURITY SCREENING TOOLS:

As of October 2025, PRAPARE is currently under revision to become PRAPARE 2.0. There may be LOINC updates that align with this. Current LOINC representation for the original instrument is represented here (LOINC codes).

Disease-Specific Screening Considerations

The American Diabetes Association Standards of Care explicitly recommend routine assessment of SDOH, including food insecurity, during clinical encounters for patients with diabetes.[17] Growing evidence suggests that food insecurity has a significant impact on glycemic control and diabetes self-management capabilities. For patients with hypertension, food security assessments take on particular importance given the critical role of dietary sodium restriction and the DASH (Dietary Approaches to Stop Hypertension) dietary pattern in blood pressure management.[18]

Section III: Documentation and Coding for Food Insecurity Risk (Diagnosis)

Social risks, such as food insecurity, are documented using the same methods as clinical conditions, such as diabetes. They can be documented in encounters through the International Classification of Diseases and Related Health Problems (ICD)-10-CM (clinical modification) codes that designate the risk in claims to payers and through surveillance methods. They can also be placed on problem lists with Systematized Nomenclature of Medicine

Clinical Term (SNOMED CT) terminology that maps to ICD-10-CM. Problem list placement (includes concerns relevant to patients over time) allows for evaluation over time and sharing problems across settings through interoperability initiatives. Curated sets of ICD-10-CM and SNOMED CT codes relevant to food insecurity are available in the NLM VSAC.

ICD DOCUMENTATION

ICD codes are used in nearly all areas of healthcare to indicate diagnoses and support billing. They are attached to orders, such as lab results or x-rays, to explain why tests or procedures are necessary and to help guide the interpretation of the results. They are typically referenced in the patient's electronic bill for an office visit or on an order to trigger billing. ICD codes are maintained internationally by the World Health Organization (WHO).[19] In the US, the National Center for Health Care Statistics (NCHS) is responsible for ICD. NCHS has developed a "clinical modification" of the international ICD code — ICD-10-CM.[20] Although ICD-10-CM codes, in general, conform to the WHO ICD conventions, there are subtle differences in the available codes between the versions.

To diagnose food insecurity with ICD-10-CM, health providers can use code Z59.41 "Food insecurity", which effectively replaced code Z59.4 "Lack of adequate food and safe drinking water" as part of a larger update to the SDOH Z codes, which became effective on October 1, 2021.[21] Patient nonadherence (also known as noncompliance) driven by food insecurity to a dietary regimen can be documented using two codes: "Z91.A10 Caregiver's noncompliance with patient's dietary regimen due to financial hardship" or "Z91.110 Patient's noncompliance with dietary regimen due to financial hardship". These codes capture the clinical scenario where patients are unable to follow dietary recommendations, especially for specific conditions, such as diabetes, due to financial limitations rather than lack of understanding or motivation.[22] It is important to note that clinicians and patient-facing staff should actively address the use of ICD codes (i.e., Z59.41 'Food insecurity') with patients during the encounter to prevent perceptions of stigma and to clearly define the role of ICD codes in linking them to necessary services.

DISEASE-SPECIFIC DOCUMENTATION

Diabetes management in the context of food insecurity requires careful documentation that captures both the primary medical condition and the social risk factor. For example, uncomplicated type 2 diabetes **(E11.65)** should be documented alongside food insecurity (Z59.41) to provide a complete clinical picture that supports care planning and resource allocation decisions. (For a full list of possible

ICD-10-CM to document diabetes, please refer to the CDC guidance.) Essential hypertension **(I10)** requires documentation alongside food insecurity (Z59.41) when dietary restrictions are compromised by limited food access. This dual coding approach ensures that care teams understand the complex interplay between medical conditions and SDOH.

SNOMED CT DOCUMENTATION

The Systematized Nomenclature of Medicine Clinical Term (SNOMED CT) codes are an international, clinically based vocabulary for healthcare providers to document care delivery. In the US, they are predominantly used to describe clinical observations and findings, and are contained in a patient's EHR Problem List. A Problem List includes concerns relevant to patients over time. While ICD diagnoses can change from visit to visit, the Problem List is a place in every patient's EHR where chronic concerns are documented. Health care providers are required to regularly update the Problem List. SNOMED CT is considered more granular than ICD, but with the growing breadth and specificity of ICD-10-CM, there is greater equivalence between the code sets.

Food insecurity **(SNOMED CT code 733423003)** serves as the primary SNOMED CT code for problem list documentation, enabling consistent terminology across healthcare systems. Combination codes for diabetes mellitus with food access problems and hypertension with nutritional factors provide more granular documentation options that capture the specific clinical relationships between chronic diseases and food security challenges.

If CHCs are using valid food insecurity assessment methods that can categorize levels of food insecurity, they can document these levels using the aligned severity concepts (Figure 3) This can be helpful due to the established difficulty of fully resolving mild dimensions of food insecurity (worry and running out) and the critical need to address severe forms of food insecurity such as skipping meals or not eating for a whole day and common food insecurity coping strategies, like reducing the quality and safety of foods.[23]

CONCEPT/DIMENSION	SNOMED CT CODE	ICD-10 CODE	CLINICAL INDICATORS
Food insecurity	**733423003**	**Z59.41**	
Mild food insecurity on the United States Household Food Security Survey Module (finding)	470911000124109	Z59.41	Anxiety about food sufficiency, worry about running out
Moderate food insecurity on the United States Household Food Security Survey Module	470941000124108	Z59.41	Reduced quality/variety, compromised diet quality
Severe food insecurity on the United States Household Food Security Survey Module	470951000124105	Z59.41	Reduced intake/missed meals, weight loss

NOTE: The scoring and interpretation methods can be found in the USDA documentation for each instrument.

Flow of Food Insecurity Documentation and Coding in an Office Visit

SCREEN

HUNGER VITAL SIGN™ **88121-9**

Screening Questions:

1) "Within the past 12 months we worried whether our food would run out before we got money to buy more." **88122-7**

2) "Within the past 12 months the food we bought just didn't last and we didn't have money to get more." **88123-5**

Answers to one or both questions

AT RISK for Food Insecurity

Answers: "Often True" or "Sometimes True"

LA28397-0 / LA6729-3

AT RISK for food insecurity **LA19952-3**

NOT AT RISK

Answers: Never True" or "Don't Know/Refused"

LA28398-8 / LA15775-2

LA1998:8-8 *Rescreen at next interval or Food Insecurity*

DIAGNOSE

Additional LOINC Food Insecurity Screening Tools Validated Against USDA measures:

LOINC CODE	LONG COMMON NAME
107617-3	Abbreviated Child and Adult Food Security Scale [ACAFSS]
96777-8	Accountable health communities (AHC) health-related social needs screening (HRSN) tool
99593-6	American Academy of Family Physicians Social Needs Screening Tool
95353-9	U.S. Adult Food Security Survey [U.S. FSS]
95361-2	U.S. Household Food Security Survey - Six-Item Short Form [U.S. FSS]
95246-5	U.S. Household Food Security Survey [U.S. FSS]

ASSESS AND DIAGNOSE

After verifying diagnosis with the patient and patient consent

SNOMED CT Codes

- Add SNOMED CT code: Food Insecurity **733423003** to Problem List

ICD-10-CM Codes

- Diagnose with **ICD-10-CM Z59.41**

Noncompliance codes:

Z91.A10 Caregiver's noncompliance with patient's dietary regimen due to financial hardship

Z91.110 Patient's noncompliance with dietary regimen due to financial hardship

Figure 3. Dimensions of Food Insecurity (aligned with USDA scoring)

CONCEPT/DIMENSION	SNOMED CT	IDC-10	CLINICAL INDICATORS
Food insecurity	**733423003**	**Z59.41**	Low or very low food security
Mild food insecurity on USDA HFSSM	**470911000124109**	**Z59.41**	Anxiety about food sufficiency, worry about running out
Moderate food insecurity on USDA HFSSM	**470941000124108**	**Z59.41**	Reduced quality/variety, compromised diet quality
Severe food insecurity on USDA HFSSM	**470951000124105**	**Z59.41**	Reduced intake/missed meals, weight loss

AFTER ASSESSMENT — DOCUMENT INTERVENTIONS

INTERVENE

Note: Several SNOMED CT codes are available in the Gravity Project-approved value sets for standardized documentation. While this is not an exhaustive list of interventions, some of the most common examples are included below.

Adjustment

- Adjustment of clinical plan to accommodate social risk - SNOMED CT **1269404007**

Coordination

- Coordination of resources to address food insecurity - SNOMED CT **1004110005**

Referral Activities

- Patient referral for socioeconomic factors - SNOMED CT **41920009**
- Referral to WIC program - SNOMED CT **464111000124106**
- Referral to SNAP - SNOMED CT **464101000124108**
- Referral to Community Action Agency program - SNOMED CT **464111000124106**

Provsion-Based Interventions

CONCEPT/DIMENSION	SNOMED CT
Provision of food (procedure)	**710925007**
Provision of produce (procedure)	**951381000124109**
Provision of medically tailored meals (procedure)	**464431000124105**
Provision of healthy groceries aligned with Dietary Guidelines for Americans (procedure)	**951411000124107**

GENERATE E-BILL

ICD-10-CM

- Z59.41 Food insecurity
- Plus applicable additional E/M code

CPT Codes

- CPT 96160 / 96161 (if validated, standardized screen)
- Plus applicable additional E/M code

Traditional CPT Codes

CPT 99401-99406	Preventive Medicine Counseling (time-based)
CPT 97802-97804	Medical Nutrition Therapy

Note: not contained by office visit complexity e/m

HCPCS Codes

G0019 / G0022	Community Health Integration
G0023 / G0024	Principal Illness Navigation
G0140 / G0146	Principal Illness Navigation - Peer Support

Section IV: Coding for Food Insecurity Interventions (Broad and Specific Interventions)

Following assessment and diagnosis, documenting interventions and actions to address food insecurity is critically important not just for providing high-quality patient care and follow-up, but also for evaluating which interventions help patients achieve better health outcomes. These data can help an individual clinic or entire health system make the case for investing time and resources in screening and intervening to address food insecurity.

GRAVITY PROJECT INTERVENTIONS FRAMEWORK APPLICATION

The Gravity Project Interventions Framework[24] (Figure 4) provides a systematic approach to coding social care interventions across multiple domains.[25] The framework categorizes interventions into nine primary types: adjustment, assistance, coordination, counseling, education, eligibility evaluation, evaluation and assessment, provision, and referral activities. These primary intervention types are then matched to every core food security program in the country for consistent documentation in patient encounters and care teams, and for research and outcomes analysis. This standardized framework ensures consistent documentation of food security interventions while supporting interoperability between healthcare and social service organizations. The adoption of Gravity Project standards facilitates care coordination and enables measurement of intervention effectiveness across diverse provider settings. Given the breadth of concepts for representing interventions, a partial list is provided below.

#	GRAVITY TERM	GRAVITY DEFINITION
1	Adjustment	Adjustment of clinical plan to accommodate social risk.
2	Assistance/Assisting	To give support or aid to; help.
3	Coordination	Process of deliberately organizing activities and sharing information to achieve safer and more effective care aligned with patient preferences.
4	Counseling	Psychosocial procedure that involves listening, reflecting, etc., to facilitate recognition of course of action/solution.

#	GRAVITY TERM	PROCESS OF DETERMINING ELIGIBILITY BY EVALUATING EVIDENCE.
5	Education	Procedure that is synonymous with those activities such as teaching, demonstration, instruction, explanation, and advice that aim to increase knowledge and skills, change behaviors, assist coping and increase adherence to treatment.
6	Evaluation of eligibility (for <x>)	Process of determining eligibility by evaluating evidence.
7	Evaluation/ Assessment	Determination of a value, conclusion, or inference by evaluating evidence.
8	Provision	To supply/make available for use.
9	Referral	The act of directing someone to a different place or person for information, help, or action.
10	Promotion	An activity that supports or encourages a cause or goal.

Adjustment

The general term Adjustment of clinical plan to accommodate social risk **(SNOMED CT code 1269404007)** was crafted to align with the NASEM report.[26] This code can represent the many times that care plans are altered in the presence of food insecurity or other social needs.

Coordination, Education, Assistance, and Referral Activities

Gravity builds general concepts for coordination and referral **(1004110005** |Coordination of resources to address food insecurity; Patient referral for socioeconomic factors **(SNOMED CT code 41920009)**. In addition, all core USDA, Older Americans Act, and regional food programs and social care organizations and professions (e.g. Referral to Community Action Agency program, **464111000124106**; Referral to Special Supplemental Nutrition Program for Women, Infants and Children) have specific SNOMED CT codes to describe the activities of connecting to services. Referrals to the Special Supplemental Nutrition Program for WIC program represent a critical intervention for eligible populations, particularly pregnant women and families with young children. Assessment and referral for Supplemental Nutrition Assistance Program (SNAP) eligibility (**464101000124108**) provides a connection to the nation's primary federal food assistance program. Community resource connections require systematic documentation to enable outcome tracking and care coordination. The integration of community health workers and social services coordination enhances the effectiveness of medical interventions while addressing underlying health-related social needs.

Provision-Based Interventions

Direct food provision (without referral) can also be documented. Food prescription program referrals represent an emerging intervention model that connects medical providers with community food resources through structured prescription-like processes. Medically tailored meal prescriptions represent an innovative intervention that provides therapeutic nutrition interventions for patients with specific medical conditions. Produce prescription programs offer targeted interventions that increase access to fresh fruits and vegetables while supporting chronic disease management. Emergency food assistance coordination provides immediate intervention for acute food insecurity situations.

Counseling Interventions

Food education, guidance, and counseling activities use their own set of SNOMED CT codes (Note: several SNOMED CT codes are available in the Gravity Project-approved value sets for standardized documentation). Diabetes nutritional counseling that incorporates food security components addresses both clinical nutrition needs and practical challenges related to food access. Similarly, hypertension dietary counseling that addresses food access barriers provides comprehensive care, acknowledging social determinants while maintaining a focus on clinical outcomes.

PROVISION-BASED INTERVENTIONS	
Concept	**SNOMED CT Code**
Provision of food (procedure)|	710925007 |
Provision of produce (procedure)|	951381000124109 |
Provision of medically tailored meals (procedure)|	464431000124105 |
Provision of healthy groceries aligned with Dietary Guidelines for Americans (procedure)|	951411000124107 |

Section V:
Coding for Food Insecurity Reimbursement (Billing)

Many strategies can be used to address food insecurity-related activities. This is a general overview. We suggest that clinics and providers work with regional coding specialists for comprehensive details on reimbursement procedures and options. For a general overview of reimbursement considerations and ethical implications, HealthBegins led a webinar on this topic that you can access here.[27] When implementing system wide billing processes it is important to analyze effects on under and uninsured patients within the legal requirements of billing for services.

BILLING AND REIMBURSEMENT CODES TO SUPPORT STANDARDIZED SCREENING

The existing codes for the utilization of standard instruments are CPT codes 96160 for patient-focused assessments and 96161 for caregiver-focused assessments. These codes provide reimbursement for structured assessment activities that extend beyond basic screening to include comprehensive evaluation and care planning components. Use of these concepts is best coordinated as a system.

BILLING TO SUPPORT DIAGNOSTIC COMPLEXITY

In 2021, the American Medical Association updated its evaluation and management (e/m) coding guidelines to allow SDOH to be a factor in determining the complexity of medical decision-making for reimbursement. Complexity of Medical Decision making is determined based on: the number and complexity of the problem(s) addressed, the amount and/or complexity of the data to be reviewed and analyzed (medical records, tests, and any other information needed for the encounter), and risk of complications and/or morbidity or mortality of patient management decisions. SDOH can be factored into the risk of complications and/or morbidity. If a patient's treatment is limited or significantly impacted by SDOH, this immediately increases the complexity of the visit and the corresponding billed amount.

BILLING TO SUPPORT INTERVENTION

Medicare Billing Opportunities

The Centers for Medicare & Medicaid Services (CMS) introduced significant new reimbursement opportunities for SDOH activities in the 2024 Physicians Fee Schedule. Community Health Integration concepts "cover community health integration services to address your needs and help your health care provider diagnose or treat your medical conditions."[28] "Principal illness navigation is a type of care management that helps patients understand their medical condition or diagnosis and guides them through the health care system," and it includes how social needs like food insecurity weigh into management."[29]

BILLING CODE	DESCRIPTION
G0019 Community Health Integration	This code supports the first 60 minutes per calendar month for addressing upstream SDOH during an initial E/M visit and includes a person-centered assessment, care coordination, and health education. Services can be provided by Community Health Workers, Health Coaches, Social Workers, Registered Dieticians, Nurses, and other staff with applicable training.
G0022 Community Health Integration	This code supports an additional 30 minutes per calendar month of Community Health Integration
G0023 Principal Illness Navigation	This code supports the first 60 minutes of navigation for patients with high-risk conditions under the direction of a physician or other practitioner. Services include person-centered planning, care coordination and health system navigation, referral to supportive services and community-based resources, and patient self-advocacy skill promotion. If this navigation is performed under the direction of a physician or other practitioner, these services can be provided by Community Health Workers, Health Coaches, Navigators, Social Workers, Registered Dieticians, Nurses, and other staff with applicable training.
G0024 Principal Illness Navigation	An additional 30 minutes per month of navigation
G0140 Principal Illness Navigation -Peer Support	60 minutes of peer-provided Principal Illness Navigation
G0146 Principal Illness Navigation- Peer Support	30 minutes of peer-provided Principal Illness Navigation

CHCs that are billing for Community Health Integration services can bill concurrently for care management for the same patient in the same service period.[30] Additional detailed information on CPT Evaluation and Management (E/M) guidelines is available.[31]

TRADITIONAL CPT CODES

Preventive Medicine Counseling codes **(CPT 99401-99406**) offer time-based reimbursement for individual and group counseling activities related to health promotion and disease prevention. These codes support extended counseling sessions that address behavioral factors related to food security and chronic disease management.

California Medicaid Considerations

California's Medicaid program has implemented specific provisions to support SDOH assessment and intervention activities. Medi-Cal Managed Care Plans have been directed to promote the use and reporting of priority SDOH Z codes, creating alignment between documentation practices and payment incentives.[32]

Contracted Enhanced Care Management (ECM) providers can provide ECM services to eligible members with complex needs, a benefit that provides members with a single lead care manager to help coordinate their physical, mental, and dental care as well as social services.[33] Through ECM, a member can be connected to Community Supports that can help address members' health-related social needs. Community Supports that help address food and nutrition insecurity include medically tailored meals and medically supportive food, among other "Food is Medicine" interventions. Managed Care Plans are expected to reimburse contracted ECM providers per their contract stipulations.

Medical Nutrition Therapy codes **(CPT 97802-97804)** provide reimbursement for qualified nutrition professionals to deliver individualized nutrition counseling and intervention services. These codes are particularly relevant for patients with diabetes, hypertension, and other conditions in which nutrition therapy is a core component of medical management. Note: Medicare only covers medical nutrition therapy for diabetes, chronic kidney disease, and renal transplant, while Medicaid coverage varies by state.[35]

Medi-Cal reimburses Community Health Worker services through the Community Health Worker State Plan Amendment when delivered as part of covered benefits. This reimbursement structure supports integrating health-related social needs screening and referral activities into comprehensive care delivery models. However, Federally Qualified Health Centers and Rural Health Clinics are not authorized as supervising providers for Community Health Workers.

The Federally Qualified Health Center Alternative Payment Methodology Program provides additional opportunities for enhanced reimbursement based on quality performance and population health outcomes, creating incentives for systematic SDOH assessment and intervention activities.[36] Payments linked to quality under the Alternative Payment Model include the Comprehensive Diabetes Care and the Controlling High Blood Pressure HEDIS Measures, which can be directly affected by the identification and management of food insecurity.

Section VI: Quality Measurement and Reporting Related to Food Insecurity

CMS QUALITY REPORTING REQUIREMENTS

CMS previously implemented comprehensive SDOH reporting requirements across multiple healthcare settings. CMS mandated SDOH screening for inpatient admissions, with required assessment of five domains: food insecurity, housing stability, transportation access, utility security, and personal safety.[37] The mandatory nature of these requirements created systematic incentives for healthcare organizations to develop standardized screening and documentation processes. However, in 2025, CMS changed course and issued a final rule that updates Medicare payment policies and rates for inpatient and long-term care hospitals under the Medicare hospital Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital Prospective Payment System (LTCH PPS) for fiscal year (FY) 2026, which resulted in the removal of these measures beginning with the CY 2024 reporting period/FY 2026 payment determination.[38] [39]

Note: health-related social needs screening is still included the Medicare Physician Fee Schedule across outpatient initiatives and models.

OUTPATIENT QUALITY MEASURES

The National Center for Quality Assurance has three relevant measurement areas that apply in this HEDIS domain. The Social Needs Screening and Intervention (SNS-E) measure is a national quality measure that assesses screening and intervention for food, housing, and transportation insecurity, using Gravity-aligned instruments and interventions. There are also disease-specific HEDIS measures for Diabetes and Hypertension. [40]

Conclusion

The integration of food security assessment and intervention into routine clinical care represents a fundamental shift toward comprehensive healthcare that addresses both medical and social determinants of health. This policy brief provides California Community Health Centers with the tools and frameworks necessary to implement systematic approaches to food insecurity while maintaining financial sustainability through appropriate coding and billing practices. Ultimately, the long-term success of scaling comprehensive SDOH assessment and intervention models will remain acutely sensitive to shifting federal and state policy priorities regarding healthcare coding—especially billing —which may present either crucial new supports or significant barriers to sustaining progress.

Acronym Appendix

ACH - Accountable Communities for Health

CHC - Community Health Center

CMS - Centers for Medicare and Medicaid Services

CPT - Current Procedural Terminology

ECM - Enhanced Care Management

EHR - Electronic Health Record

FHIR® - Fast Healthcare Interoperability Resource

FIM - Food is Medicine

HCPCS - Healthcare Common Procedure Coding System

HEDIS - Healthcare Effectiveness Data and Information Set

HVS - Hunger Vital Sign™

IPPS - Inpatient Prospective Payment System

LOINC - Logical Observation Identifiers Names and Codes

LTCH PPS - Long-Term Care Hospital Prospective Payment System

PHMI - Population Health Management Initiative

PRAPARE - Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

QHIO - Qualified Health Information Organization

SDOH - Social Determinants of Health

SNAP - Supplemental Nutrition Assistance Program

SNOMED CT - Systematized Nomenclature of Medicine Clinical Term

SNS-E - Social Needs Screening and Intervention

USDA - United States Department of Agriculture

WIC - Special Supplemental Nutrition Program for Women, Infants, and Children

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This work was supported by a sub-award through Tufts University from the Kaiser Foundation Health Plan, and in collaboration with HealthBegins and the project team at the Food is Medicine Institute at the Friedman School of Nutrition Science and Policy at Tufts University.