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Medicaid Alert

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TO: All Providers, Except Hospital **– For Action**
Health Maintenance Organizations **– For Information Only**

SUBJECT: ICD-10 Billing Procedures

EFFECTIVE: Claims with service dates on or after October 1, 2015

PURPOSE: To notify providers of important billing procedures for reporting ICD-10-CM (International Classification of Diseases, 10th Edition, Clinical Modification) diagnosis codes on professional and non-hospital institutional claims.

BACKGROUND: ICD-10-CM shall impact diagnosis codes reported on all Direct Data Entry (DDE), paper and Health Insurance Portability and Accountability Act (HIPAA) 837I and 837P claim transactions. Hospitals also report inpatient surgical procedure codes on claims using the ICD-10-PCS (Procedure Coding System) code set. For additional information regarding ICD-10, please see the Medicaid Newsletter Volume 23, No. 10, dated June 2013.

The NJ FamilyCare (NJFC)/Medicaid Program shall process, but deny any DDE, paper or HIPAA claim not reporting a valid ICD-10-CM diagnosis code for service dates ending on or after October 1, 2015. 'Service Date Through' is a recognized field in the HIPAA transaction set.

ACTION: Frequently asked questions (FAQs) regarding the implementation of ICD-10-CM on October 1, 2015.

Common ICD-10-CM Terminology:

***Unspecified* –** means a valid ICD-10-CM code that is reported when clinical information does not provide a definitive documented diagnosis. The term 'unspecified' is not intended to be reported when a surgical procedure has been performed or a diagnostic determination has been made involving a specific body part (i.e. left arm, right arm, etc.).

***Valid ICD-10-CM Code* -** means an ICD-10-CM code composed of 3, 4, 5, 6 or 7 characters. Codes with three characters (1st character alpha,/2nd character numeric/3rd character numeric) are included in ICD-10-CM as the heading of a category of codes that may be further subdivided by the use of a 4th character (etiology); a 5th character (anatomical site); a 6th character (severity); and a 7th character (extension). A three-character code is used ONLY if it is not further subdivided.

***Family of Codes* –** means the same as the ICD-10-CM three-character heading of a category. Codes within a category are clinically related. For example, the category or family H25 (Age-Related Cataract) contains a number of more specific codes composed of 4, 5, 6 or 7 characters that capture information on the type of cataract as well as information on the eye involved, such as H25.031 (Anterior subcapsular polar age-related cataract, right eye).

1. On July 7, 2015, the Centers for Medicare and Medicaid Services (CMS) issued a Medicare Provider Letter announcing guidance regarding ICD-10 flexibilities related to reporting ICD-10 code sets on Medicare claims on or after October 1, 2015. What impact does this guidance have on the processing of NJFC/Medicaid fee-for-service (FFS) claims?

Response: The guidance issued by CMS has no impact on the processing of NJFC/Medicaid FFS claims. The guidance applies to Medicare services only, providing Medicare providers additional flexibility in the CMS claims auditing and quality reporting processes. NJFC/Medicaid providers are required to report ICD-10-CM diagnosis codes at the level of specificity required for claims processing purposes.

2. Will psychiatric and other mental health professionals need to submit ICD-10-CM diagnosis codes? Currently, diagnosis information is obtained from the Diagnostic and Statistical Manual (DSM) of Mental Disorders.

Response: Yes. All providers must report ICD-10-CM diagnosis codes on claims with dates of service/date of discharge on/after October 1, 2015.

The ICD-10 classification system is designed to meet the needs of all types of health care professionals. Mental health providers will not need to use most of the codes in the classification system; in fact, they generally will only need to use a subset of ICD-10-CM codes that largely come from Chapter 5: Mental and Behavioral Disorders. Other chapters of relevance may include:

- Chapter 6: Diseases of the Nervous System.
- Chapter 18: Symptoms, Signs and Abnormal Clinical and Laboratory Findings.
- Chapter 21: Factors Influencing Health Status and Contact with Health Services.

For quick reference, ICD-10-CM codes can be found in parentheses within the diagnostic criteria box for each disorder. There is a listing of ICD-10 codes found in the "DSM-5 Classification" in the front of the DSM-5 Manual, as well as alphabetical and numerical listings in the DSM appendices. For further information, please visit http://www.apapracticecentral.org/business/legal/icd-10-questions.aspx for frequently asked questions regarding the ICD-10 implementation prepared by the American Psychiatric Association.

3. When are providers required to report specific ICD-10-CM diagnosis codes to the NJFC/Medicaid Program?

Response: The NJFC/Medicaid requirement to report specific diagnosis codes on claims for certain services shall not change. Providers must report a 'valid' ICD-10-CM diagnosis code that is HIPAA-compliant for claims with dates of service on or after October 1, 2015. ICD-9-CM diagnosis codes will be reported for claims with dates of service prior to October 1, 2015.

4. When is it appropriate for a provider to 'split' a professional claim?

Response: Providers must ensure that the appropriate ICD code set is reported on claims based on the date of service. When a mix of ICD-9-CM and ICD-10-CM diagnosis codes are required to properly report diagnosis codes for billed services, providers are required to 'split' the claim so that all ICD-9-CM diagnosis codes remain

on one claim with dates of service through September 30, 2015; and all ICD-10-CM diagnosis codes are reported on the other claim with dates of service on or after October 1, 2015.

5. How should a supplier of durable medical equipment (DME) bill a capped rental claim or a claim for monthly supplies that span the ICD-10 compliance date?

Response: Generally, the 'Through' date reported on a claim is used to determine the appropriate ICD code set for reporting a diagnosis. For DME claims that span the ICD-10 compliance date, the 'From' date reported on the claim shall be used to determine the appropriate ICD code set to be reported. For example, if a DME claim has a 'From' date of September 15, 2015 and a 'Through' date of October 15, 2015, the 'From' date of September 15, 2015 shall be used to determine that the ICD code set to be reported on this claim must be ICD-9-CM since the 'From' date is prior to October 1, 2015.

6. Is the State of New Jersey responsible for providing an ICD-10-CM diagnosis code that replaces or 'maps' to an ICD-9-CM diagnosis code that would have been reported prior to October 1, 2015?

Response: No. The selection of appropriate ICD-10-CM diagnosis codes by providers is based on clinical information that is unavailable to the State of New Jersey. ***Molina Medicaid Solutions shall decline a provider's request for information concerning the mapping of an ICD-9-CM diagnosis code to an ICD-10-CM diagnosis code.***

7. What are the ICD-10 rules regarding the definition of a 'valid' ICD-10-CM code?

Response: All claims with service dates on or after October 1, 2015 must report a **valid** ICD-10-CM diagnosis code. ICD-9-CM diagnosis codes shall be processed but denied for service dates on or after October 1, 2015. ICD-10-CM is composed of codes with 3, 4, 5, 6 or 7 characters. Codes with 3 characters are included in ICD-10-CM as the 'heading' of a category of codes that may be further subdivided by the use of 4th, 5th, 6th or 7th characters to provide greater specificity to the reported diagnosis.

A 3-character 'heading or header code' may be reported as a 'valid' ICD-10-CM diagnosis code only if the category is not further subdivided. However, in the majority of reporting situations, a 'valid' ICD-10-CM code will consist of code values with a greater number of characters to identify a diagnosis with the highest level of 'specificity.'

See the following example:

M87.0 Idiopathic aseptic necrosis of bone
M87.00 Idiopathic aseptic necrosis of unspecified bone
M87.01 Idiopathic aseptic necrosis of shoulder
Idiopathic aseptic necrosis of clavicle and scapula
M87.011 Idiopathic aseptic necrosis of right shoulder
M87.012 Idiopathic aseptic necrosis of left shoulder
M87.019 Idiopathic aseptic necrosis of unspecified shoulder

- ✓ ICD-10 code M87.00 is a **valid** ICD-10 code **because the category is not further subdivided.**

- ✓ ICD-10 code M87.01 is a subcategory, but an **invalid** ICD-10 code **because there are more detailed codes beneath it,** including M87.01**1**, M87.01**2** and M87.01**9**, in this example.

8. What on-line information is available for providers to select a valid ICD-10-CM diagnosis code?

Response: Many providers interchange the terms 'billable codes' and 'valid codes.' A complete list of the 2016 ICD-10-CM valid codes and code titles is posted at the CMS website at http://www.cms.gov/Medicare/Coding/ICD10/2016-ICD-10-CM-and-GEMs.html. The codes are listed in tabular order, in the same order as in the ICD-10-CM code book. This list is important to those providers unsure as to whether an additional 4th, 5th, 6th or 7th character is required to provide the code 'specificity' required by New Jersey Medicaid policy and procedures.

CMS also launched a new ICD-10 Clinical Concepts Series for provider specialties. The Series includes common ICD-10 codes and corresponding ICD-9 codes; clinical documentation tips; as well as other helpful information. The Series may be accessed at https://www.roadto10.org/

Information is also available on-line that could assist providers with the mapping process. For example, the American Academy of Professional Coders (AAPC) has a website which may serve as a good reference. The website has an online tool for mapping diagnosis codes (not PCS codes) in both directions (ICD-9 > ICD-10; or ICD-10 > ICD-9). The mapping tool may be found at https://www.aapc.com/icd-10/codes/.

9. **What is GEMS and how can accessing GEMS assist a provider with the ICD-10-CM implementation?**

Response: Mappings between ICD-9-CM and ICD-10-CM play a critical role in the successful transition to ICD-10-CM. CMS and the Centers for Disease Control and Prevention created the General Equivalence Mappings (GEMs) to ensure consistency within national data. GEMs act as a translation dictionary to bridge the language gap between the ICD code sets. GEMs can be accessed at: http://www.cms.gov/Medicare/Coding/ICD10/2016-ICD-10-CM-and-GEMs.html.

10. What is the difference between 'mapping' and 'coding?'
Response: Mappings simply provide a linkage between a code in one code set and its closest equivalent in another code set, without consideration of context or specific patient encounter information. Coding involves assigning the most appropriate code based on health record documentation; knowledge of other codes on the medical record; and applicable guidelines.

11. What changes are required to report the ICD-10-CM code set on HIPAA 837P transactions?

Response: Providers should visit the New Jersey Medicaid HIPAA Companion Guide Version 5010 on the Molina Medicaid Solutions Website at www.njmmis.com for information regarding ICD-10 qualifiers that must be reported on HIPAA claims on or

after October 1, 2015. To access the Guide: select 'Forms and Documents'; key: 'Provider'; and then key: 'HIPAA'; select the 837/835/277P HIPAA Companion Guide (Version 5010).

12. What changes to UB-04 and 1500 paper claims are required to report ICD-10-CM diagnosis codes?

Response: Effective for UB-04 and 1500 paper claims submitted on or after October 1, 2015, providers are required to report the ICD version indicator value of '0' for ICD-10 code sets. For claims with service dates prior to October 1, 2015, providers must report the ICD version indicator value of '9' for ICD-9 code sets. The ICD Version Indicator on the 1500 paper claim form is identified as Form Locator 21 and as Form Locator 66 on the UB-04 paper claim.

13. Are there FFS Error Codes that address ICD-10-CM reporting issues?

Response: The NJ Medicaid Management Information System (NJMMIS) required the reporting of certain ICD-9-CM diagnosis codes on claims for certain NJFC/Medicaid-covered services. These requirements have not changed. As part of the transition to ICD-10-CM, the NJMMIS has been updated with ICD-10-CM diagnosis codes that replace ICD-9-CM codes required for reporting purposes. NJMMIS Error Codes that previously denied claims when the incorrect diagnosis code was reported will continue to post, now requiring the appropriate ICD-10-CM code.

FFS Error Codes related to the ICD-10 transition include the following:

Error Codes	Description	Denial Explanation
0166	Invalid/Missing Diagnosis Code	• The format for the ICD code set submitted is incorrect • the qualifier/ICD Version indicator value reported on the claim is incorrect
0296	Diagnosis Code Not On File	• Invalid heading code (additional subcategories exist for this header code) • Reported qualifier/version indicator code value does not match code set reported • Inappropriate code set reported for service date
1416	ICD Version Mismatch	• No ICD version reported in version indicator field • Mixture of ICD-9 and ICD-10 codes reported

14. Are providers able to continue submitting ICD-10-CM test claims to Molina Medicaid Solutions?

Response: Yes, testing is always available for providers to test their ICD-10-CM claims utilizing the Molina Medicaid Solutions EDI Proof System. The Molina EDI Proof System is a self-serve testing environment that enables all providers and submitters to test their ICD-10 claims on their own schedule and enable them to consult the Molina EDI Department (609-588-6051) to rectify any problems encountered. The following is

an excerpt from the Medicaid Newsletter, Volume 24, No. 12, dated September 2014, that provides testing instructions.

- Create a test file reporting the appropriate ICD-10-CM diagnosis codes or the appropriate ICD-10-PCS procedure codes for the healthcare services provided.
  - ✓ In the header specification, change the ISA 15 field value to a "T" to represent your file as a "test" file.
  - ✓ Limit the number of claims submitted in the test file to **no more than** 100 FFS claims or **less than 1000** HMO encounter claims.
  - ✓ Use Version 5010 HIPAA standards, which have been required since January 1, 2012 and accommodate ICD-10-CM diagnosis codes and ICD-10-PCS procedure codes.
  - ✓ **DO NOT** report both ICD-9 and ICD-10 codes **within the same claim**. The same test file may contain a combination of claims reporting only ICD-9 codes or only ICD-10 codes.
  - ✓ ICD-10 coding must be at the most granular level possible and will be edited accordingly by the "Proof" system.
- Login to the NJFC/Medicaid website @t www.njmmis.com; select HIPAA claims; sign in using your Use Name and Password; submit your created test file.
- Submitted test files will be processed the following morning. At approximately 9:00 AM on the day after your submission, proceed to the download page to retrieve detail and summary reports, as well as a HIPAA 835 Remittance File for all submitted test claims.

If you have any questions concerning this Medicaid Alert, please contact Molina Medicaid Solutions Provider Relations at 1-800-776-6334.

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