Connecticut Department of Social Services
Medical Assistance Program **Provider Bulletin 2015-61**
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TO: All Providers

RE: Claims Processing Guidance for Implementing ICD-10 Codes

For dates of service on and after October 1, 2015, entities covered under the Health Insurance Portability and Accountability Act (HIPAA) will be required to use the ICD-10 code sets in standard transactions adopted under HIPAA. The ICD-10 consists of two parts:

- ICD-10-CM for diagnosis codes
- ICD-10-PCS for inpatient procedure codes. This will impact only Inpatient Hospital claims.

The Department of Social Services (DSS) is issuing guidance to providers enrolled in the Connecticut Medical Assistance Program (CMAP) that claims (including electronic and paper) will no longer be accepted with ICD-9 codes according to the following guidelines:

- Professional claims with FROM date of service on or after October 1, 2015;
- Institutional Claims with THROUGH date of service on or after October 1, 2015.

Please Note: ICD-10 codes may only be used for services provided on or after October 1, 2015. A claim cannot contain both ICD-9 codes and ICD-10 codes.

Date of Service logic for claims processing for the use of ICD-10 Diagnosis Codes and Surgical Codes: Claims must be billed with all codes from the same code set - either ICD-9 code set or ICD-10 code set - based on the date of service. Claims processing will employ the following date logic for the use of ICD-10-CM and ICD-10-PCS codes.

- **Inpatient and Institutional Medicare Part A Crossover** claim types will use Header Through Date Of Service (TDOS). If the Header TDOS is 10/1/2015 or later, the entire claim must be billed using ICD-10 codes.

  Example: An Inpatient or Institutional Medicare Part A Crossover claim with dates of service from 9/29/2015 to 10/2/2015 should be submitted with ICD-10 codes as the Header TDOS is after the ICD-10 implementation date of 10/1/2015.

- **Home Health, Long Term Care, and Outpatient** claim types will use Header From Date of Service (FDOS).

  Example: A Home Health, Long Term Care, or Outpatient claim with dates of service from 9/29/2015 to 10/2/2015 should be submitted with ICD-9 codes as the Header FDOS is prior to the ICD-10 implementation date of 10/1/2015.

- **Outpatient Medicare Crossover** claim type will use Header FDOS with one exception noted below.

  Example: An Outpatient Medicare Crossover claim with dates of service from 9/29/2015 to 10/2/2015 should be submitted with ICD-9 codes as the Header FDOS is prior to the ICD-10 implementation date of 10/1/2015.

  Exception: Outpatient Medicare Crossover claim with a Type of Bill beginning with 32 will use Header TDOS. (See the example under Inpatient and Institutional Medicare Part A Crossover claim types above)

- **Professional, Medicare Part B Crossover and Dental** claim types will use Header FDOS.

  Example: A Professional, Medicare Part B Crossover or Dental claim with dates of service from 9/29/2015 to 10/2/2015 with two details:

  - Detail 1 with FDOS 9/29/2015 and TDOS 9/29/2015
  - Detail 2 with FDOS 10/1/2015 and TDOS 10/1/2015

  This claim should be submitted with ICD-9 codes as the Header FDOS is prior to the ICD-10 implementation date of 10/1/2015.

- **Pharmacy and Compound Drug** claim types will use dispense date. Providers will be required to use ICD-9 codes for claims with a dispense date through 9/30/2015 and use ICD-10 codes on all claims with a dispense date 10/1/2015 and later.

Are you impacted by the transition to ICD-10?

The following provider types or provider types/specialties that bill on the professional claim format to CMAP do not require a diagnosis code to be submitted on the claim. However, if a diagnosis code is submitted on the claim, it is subject to the ICD-10 guidelines.

- Durable Medical Equipment/Medical Supply Dealer (Provider Type 25)
- Transportation (Provider Type 26)
- Radiology (Provider Type 29)
- Connecticut Home Care/Access Agency/Connecticut Home Care Billing Provider (Provider Type/Specialty 57/541)
- Connecticut Home Care/Connecticut Home Care Service Provider (Provider Type/Specialty 57/544)
- Community First Choice (Provider Type 50)

The following claim types have limited use of diagnosis codes in CMAP:

- Pharmacy and compound claims require diagnosis codes for certain circumstances
- Currently, CMAP does not require a diagnosis code on dental claims unless the submitted procedure code is D9920 (Behavior Management).
- For Personal Care Services/Personal Care Agency (Provider Type/Specialty 36/361), the following services DO NOT require a diagnosis code:

  1286A- Tier A Case Management
  1286Z- Case Management Services
  1286C- Tier C Case Management
  1288Z- Initial Assessment
  1291Z- Status review
  1292Z- In Hospital status review
  1293Z- Nursing Home status review
  1300Z- Reassessment

These provider types are urged to review their current claims submission processes to determine whether they are currently submitting diagnosis codes on their claims and make appropriate adjustments for the transition to ICD-10 to avoid any claim denials.