

MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES SHORT-DOYLE/MEDI-CAL II SYSTEM



International Classification of Diseases, 10th Revision
(ICD-10), FAQ Sheet

I. 837 I and 837 P

- **Is the primary diagnosis code a required field on the 837 I and 837 P?**
 - The Primary Diagnosis Code (which currently contains ICD-9 values) is a REQUIRED field on the 837I and 837P which is why it is supplied 100 percent of the time.
- **Is the Secondary Diagnosis Code a required field on the 837?**
 - The Secondary Diagnosis Codes on the 837 are optional. Historically, the secondary diagnosis codes are provided on 837s approximately 20 percent of submitted claims (currently with ICD-9 values).
- **How many ICD-10 diagnoses can be submitted on the 5010?**
 - From a clinical point of view, there would be no prescribed limit on the number of diagnoses used; however, there is a limit of 25 diagnoses that can be submitted on the 5010 within SDMC.
- **Will counties have to split claims? Such that one 837 file contains only service dates before October 1, 2015, and other files contain claims with service dates October 1, 2015, and after?**
 - Yes.
- **Will SDMC II use ICD-10 PCS Procedure Codes for Specialty Mental Health inpatient claims?**
 - Yes.
- **Is it appropriate for a hospital to submit Treatment Authorization Request with Diagnostic and Statistical Manual of Mental Disorders (DSM), 5th Edition codes or should it only consists of DSM IV codes? Is it acceptable to intertwine the 2 versions?**

- ICD-9 codes should be provided for dates of service prior to October 1, 2015, and ICD-10 codes for dates of services on and after October 1, 2015.
- **How do we identify the discharge dates on claims per ICD-10 requirements?**
 - Inpatient discharges occurring on or after October 1, 2015, will use ICD-10-CM and ICD-10-PCS codes.
- **Per CMS info, ICD-10 diagnosis codes are reported on 837 I based on the Patient's date of discharge. In other words, ICD-10 diagnoses are used on Inpatient claims if the date of discharge is on or after October 1, 2015. There are potentially many different scenarios for this, both on Counties' Monthly and on Supplemental SDMC claims. For example, what diagnosis codes are sent if SDMC IP claims are for September dates of service for Clients discharged in October? Would the claim submission dates make a difference in the codes used for these services?**
 - In regards to the 837 I, the control date in Short-Doyle/Medi-Cal II system is the Statement Thru Date. Any service with a Statement Thru Date before Oct 1, 2015 will require a ICD-9 diagnosis. Any service with a Statement Thru Date on or after Oct 1, 2015, will require a ICD-10 diagnosis.
 - ✓ Example: For inpatient services, the date of discharge drives the code set used, regardless of when a patient is admitted. If the patient is discharged up to 11:59 pm on September 30, 2015, ICD-9 codes are reported. If the patient is discharged at 12:00am on October 1, 2015, and beyond, ICD-10 codes are reported.
- **Should clinicians base the diagnosis code on included versus excluded diagnosis codes?**
 - From the standpoint of the legal medical record and coding guidelines (which are covered under HIPAA), diagnosis codes should always reflect the patient's condition and should be reported in a sequence that is consistent with the Official Coding Guidelines. Clinicians should not be discouraged from reporting any and all complicating conditions and/or comorbidities that impact the treatment of the patient. Providers would still need to provide the diagnosis code that supports medical necessity for the services rendered.
- **Do the secondary and subsequent diagnosis codes have to be listed on the included diagnosis list?**
 - For the purposes of supporting medical necessity for the scope of services provided, you would only need to list the diagnosis codes that are required for claims

adjudication and reimbursement. From a standpoint of the legal medical record and coding guidelines (which are covered under HIPAA), diagnosis codes should always reflect the patient's condition and should be reported in a sequence that is consistent with the Official Coding Guidelines. Clinicians should not be discouraged from reporting any and all complicating conditions and/or comorbidities that impact the treatment of the patient. This doesn't mean that as a payer, you cannot enforce claims payment rules for the services rendered. In other words, providers would still need to provide the diagnosis code that supports medical necessity for the services rendered.

II. SHORT-DOYLE/MEDI-CAL II SYSTEM

- **When do you anticipate testing will start for the 5010 837P/837 I ICD-10 version?**
 - A test plan is currently under development. All ICD-10 testing will be communicated to all stakeholders in a future Information Notice. Testing activities are projected to commence in July 2015 and conclude in September 2015.
- **Will there be a system edit in Short-Doyle/Medi-Cal II to validate diagnosis codes on specialty mental health services and/or substance use disorder services claims?**
 - Currently, substance use disorder (SUD) claims are cross reference with valid diagnosis codes in table within SDMC. All SUD claims submitted with a date of service October 1, 2015, and thereafter will be cross-referenced to validate the supplied diagnosis code per an ICD-10 table within SDMC. Contrary, specialty mental health claims are not currently subjected to a diagnosis code validation check within SDMC; however, this is subject to change in the future.
- **What happens if an excluded ICD-10 code(s) is later determined it should have been included?**
 - If there is a determination that certain ICD-10 codes should have been allowable after claims have been denied, there will likely be an opportunity to resubmit the claims. This would need to be determined by policy.

III. CLAIMS (DATE of SERVICE)

- All claims with a date of service before October 1, 2015, should use the ICD-9 code set. Claims with a date of service before October 1, 2015, using ICD-10 (either primary/secondary diagnosis) codes will be rejected.
- All claims with a date of service on or after October 1, 2015, should use the ICD-10 code set. Claims with a date of service on or after October 1, 2015, with ICD-9 codes (either primary/secondary diagnosis) will be rejected.

IV. MHSUD ICD-10 CODES

- **Do you have a list of approved ICD-10 codes that are billable or payable by Medi-Cal for Mental Health and/or Substance Abuse?**
 - Yes, a list of approved ICD-10 codes are provided in attachments I (ICD-10 procedure codes for mental health services), attachment II (ICD-10 diagnosis codes for mental health services), and attachment III (ICD-10 diagnosis codes for SUD).
- **There is not an easy 1:1 mapping between DSM V and ICD-10. In some cases, DSM V is more specific and in some cases, ICD-10 is more specific. Will programs be allowed to diagnose using whichever diagnosis is most specific and then submit the ICD-10 dx on the claim?**
 - No. Clinicians use the DSM methodology to identify the diagnoses. Next, the clinician derives at the appropriate diagnosis using the decision tree. Finally, the diagnoses are coded using ICD-10 CM.

V. ICD-10 RESOURCES

- **Will all current mental health services and substance use disorder services reference materials be updated to include information on ICD-10?**
 - Yes, the Companion Guides for both mental health services and SUD services will be revised to reflect ICD-10. In addition, other resource materials including the Billing Manual and MedCCC website will be updated to reflect ICD-10 claiming activities.
- **Who do I contact if I have any ICD-10 questions?**
 - Questions regarding ICD-10 activities related to mental health services may be directed to the MHSD County Customer Services Section at: MedCCC@dhcs.ca.gov or (916) 650-6525.
 - Questions regarding ICD-10 activities related to SUD may be directed to SUD at: DMCSDMCII-HelpDesk@dhcs.ca.gov.
- **Where can I find additional information on ICD-10?**
 - You can find additional information on ICD-10 including videos on the Centers for Medicare & Medicaid Services' website located at: <http://www.cms.gov/Medicare/Coding/ICD10/index.html?redirect=/icd10/>
- What are some of the steps I can take to prepare for the ICD-10 implementation?

- **Providers** – Plan for medical records/coding, clinical, Information Technology, and finance staff activities to coordinate efforts and prepare for ICD-10.
- **Payers** – Review payment policies and business rules since the transition to ICD-10 will involve new coding rules.
- **Counties/MHPs:** Ask your software vendors about their readiness plans and timelines for product development, testing, availability, and training for ICD-10. Prepare and implement an Action Plan.
- **Software vendors, clearinghouses, and third-party billing services** – Work with clients to install and test ICD-10.

VI. ICD-10 TRAINING

- **Will training be provided to administrators, clinicians, billing/coders, and information technology employees?**
 - Yes, an Overview of ICD-10 will be provided at DHCS on May 5, 6, and 7, 2015. In addition, webinars and several Q&A forums are being planned to discuss the submission of claims for adjudication and a training class is being planned to discuss ICD-10 for Behavioral Health services.
- **Since the diagnosis codes have increased from 300 DSM codes to over 1,000 ICD-10 codes for MHSD, SUD, and dual diagnosis, will DHCS provide training to inform the clinicians of the changes?**
 - A forum and/or webinar should be provided to assist counties and trading partners with their transition to ICD-10.

VII. CLIENT & SERVICES INFORMATION SYSTEM

- **Will the Client & Services Information System (CSI) accept DSM-IV codes after October 1, 2015?**
 - Effective October 1, 2015, counties are instructed to report only ICD-10 codes for those services starting October 1, 2015. DHCS will no longer be accepting DSM-IV and ICD-9 codes, and will not be accepting any DSM codes in the CSI System for services provided on and after this date.
- **Up to how many ICD diagnosis codes can be reported to CSI?**
 - CSI will accept up to 5 diagnoses with the first diagnosis related to mental health services being the principal and the second diagnosis related to mental health services being the secondary.

- **Any "primary" and "secondary" diagnosis indicators required?**
 - No, CSI will not require "primary" and "secondary" indicators.

- **What are the validation rules amongst diagnoses being reported? (Current rules such as if "No Diagnosis" or "Deferred Diagnosis" is reported, their relative "position" in the CSI report is required and there is also restriction on other diagnoses being report at the same time.)**
 - DHCS/MHSD is currently working on the validation rules which will be incorporated in associated revised pages of the CSI Data Dictionary. Below are the main rules:
 - ✓ Diagnosis codes in Diagnosis fields 1 through 5 should not be the same codes (Example: diagnosis 1 (principal) should not equal diagnosis 2 (secondary) unless diagnosis 1 (principal) and diagnosis 2 (secondary) are deferred/no diagnosis)
 - ✓ S-09.0 Principal diagnosis and S-10.0 Secondary diagnosis must be a valid ICD-10 mental health diagnosis or deferred/no diagnosis
 - ✓ S-11.0 Additional 3 mental or physical health diagnosis must be a valid ICD-10 code

- **What is the new record layout to be used?**
 - DHCS/MHSD is currently working on the record layout which will be incorporated in associated revised pages of the CSI Data Dictionary. Below is the new record layout:
 - ✓ ADDED: S-09.0 Principal
 - ✓ ADDED: S-10.0 Secondary
 - ✓ ADDED: S-11.0 Additional 3 mental or physical health diagnosis

- **What is the test plan?**
 - Counties can submit files to QA ITWS for testing. DHCS ITSD will work with counties on timing and data submission. Counties will receive information on testing activities at a future date.

- **Since not all diagnoses data can be updated overnight, any recommendation of mapping current axis-based diagnoses into the new reporting? And disposition of non-diagnosis code such as the "General Medical Condition Code"?**
 - Only service records with service date (S-16 From/Entry Date for Mode 5, S-23.0 Date of Service for Mode 10 and 15) on or after October 1, 2015, report ICD-10 with new layout. Service records before the cutoff date will not be affected by ICD-10.

- The multi-axial conditions of the DSM-IV will no longer be applicable, and the following CSI fields will no longer be available:
 - REMOVED: S-28.0 Axis I Diagnosis
 - REMOVED: S-29.0 Axis I Primary (this field will no longer be available because this is an indicator to identify if S-28.0 is a primary diagnosis)
 - REMOVED: S-30.0 Additional Axis I Diagnosis
 - REMOVED: S-31.0 Axis II Diagnosis
 - REMOVED: S-32.0 Axis II Primary (this field will no longer be available because this is an indicator to identify if S-31.0 is a primary diagnosis)
 - REMOVED: S-33.0 Additional Axis II Diagnosis
 - REMOVED: S-34.0 Axis III General Medical Condition
 - REMOVED: S-36.0 Axis-V/GAF (Global Assessment of Functioning) Rating

- **Can county and vendor get a preview of CSI reporting error messages on ICD-10 codes, and the condition(s) that caused the errors? Vendor can add business rules to the system to minimize these occurrences, and county staff can prepare to handle these issues.**
 - We are working on finalizing the validation rules which will help build the error codes. Once they are reviewed and approved we can share this as part of the business requirements/associated revised pages of the CSI Data Dictionary.

- **After October 1, 2015, will the CSI system accept DSM IV with “Service Dates” before October 1, 2015?**
 - Yes, CSI will accept DSM-IV/ICD-9 for records with service dates prior to October 1, 2015.

- **Will the CSI system reference the service date on the record to determine which DX is valid, DSM-IV or ICD-10?**
 - Yes, CSI will reference the service date on the record to determine which DX is valid. For services dates before October 1, 2015, CSI will accept DSM-IV/ICD-9. For services dates on or after October 1, 2015, CSI will accept ICD-10.

- **Can ICD-10 records and DSM-IV records be included in the same upload file to the state, Information Technology Website Services? Or two separate files?**
 - Both ICD-10 records and DSM-IV/ICD-9 records can be included in the same batch upload file to the state. CSI will determine which code set to validate against based on the service date.

- **For “error correction” of records with service dates before October 1, 2015, will the CSI system accept DSM-IV after October 1, 2015, until the service years are archived?**
 - Yes, records submitted to CSI on or after October 1, 2015, with service dates prior to October 1, 2015, will be validated against the DSM-IV/ICD-9 code set.

- **Will the CSI online system be updated to accept both ICD-10 for services after October 1, 2015, and ICD-9 for corrections for services before October 1, 2015?**
 - Yes, CSI Online System will be updated to accept both ICD-10 for services after October 1, 2015, and ICD-9 for corrections for services before October 1, 2015.

VIII. ICD-10 CLAIM SUBMISSION REQUIREMENTS

ICD-10	CLAIM SUBMISSION REQUIREMENTS												
ICD-10 Guidelines	<ul style="list-style-type: none"> ▪ ICD-9-CM codes will not be accepted for services provided on or after October 1, 2015. ▪ ICD-10 codes will not be accepted for services provided prior to October 1, 2015. ▪ If the value of the date field is on or after October 1, 2015, use ICD-10. <table border="0" data-bbox="625 646 1328 951"> <thead> <tr> <th style="text-align: left;">Claim Type</th> <th style="text-align: left;">Claims</th> <th style="text-align: left;">Date Field To Be Used For Determining ICD Code Version</th> </tr> </thead> <tbody> <tr> <td>3</td> <td>Inpatient</td> <td>Through date</td> </tr> <tr> <td>4</td> <td>Outpatient</td> <td>From date</td> </tr> <tr> <td>5</td> <td>Medical</td> <td>From date</td> </tr> </tbody> </table>	Claim Type	Claims	Date Field To Be Used For Determining ICD Code Version	3	Inpatient	Through date	4	Outpatient	From date	5	Medical	From date
Claim Type	Claims	Date Field To Be Used For Determining ICD Code Version											
3	Inpatient	Through date											
4	Outpatient	From date											
5	Medical	From date											

ICD-10	CLAIM SUBMISSION REQUIREMENTS
ICD-10 PCS	<ul style="list-style-type: none"> ▪ Modifiers are not used with ICD-10 PCS codes. ▪ The only requirement is that providers are able to submit an ICD-10 PCS and the system can do the same front end edits as they will do with the diagnosis codes. Entries on the ICD-10 field on claim should be completed if a procedure was endured and valid. ▪ If procedures were not performed, then the claim should not have an ICD-10 PCS code on the claim. ▪ Claims are reimbursed in Short Doyle using revenue codes on claims and not ICD-10 codes. ▪ ICD-10-PCS uses 7 alphanumeric characters. ▪ ICD-10 PCS code that is not 7 characters is invalid. ▪ ICD-10 procedure codes must be used for all hospital inpatient procedures when reported by the hospital. ICD-10 procedure codes are not reported by professional providers rendering care to a patient in the hospital.

ICD-10	CLAIM SUBMISSION REQUIREMENTS
<p>ICD-10 CM</p>	<ul style="list-style-type: none"> • ICD-10-CM is composed of codes with 3, 4, 5, 6 or 7 characters. • Codes with three characters are included in ICD-10-CM as the heading of a category of codes that may be further subdivided by the use of fourth, fifth, sixth or seventh characters to provide greater specificity. • A three-character code is to be used only if it is not further subdivided. • A code is invalid if it has not been coded to the full number of characters required for that code, including the 7th character, if applicable. • A code that has an applicable 7th character is considered invalid without the 7th character. • The ICD-10-CM utilizes a placeholder character “X”. The “X” is used as a placeholder at certain codes to allow for future expansion. If the code is 4 characters, and a 7th character is required, then there would be two “X” placeholders assigned as the 5th and 6th characters. If the code is 5 characters, then one “X” placeholder would be assigned as the 6th character. • It is up to the provider who is reporting the code to assign the placeholder. The ICD-10 manual does not include the placeholders in the list of codes. The provider has to know when there is a 7th character requirement and how to assign the placeholder. • The character “X” is also used as a leading character in ICD-10 as well as in other positions when there is no 7th character requirement. • Placeholders are only applicable to diagnosis codes. • Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a diagnosis has not been established (confirmed) by the provider. • All electronic transactions must use Version 5010 standards. • Each unique ICD-10 CM code may be reported only once for an encounter. This applies to bilateral conditions when there are no distinct codes identifying laterality or two different conditions classified to the same ICD-10 CM diagnosis code.