



**TO: All Providers**

**RE: Implementation of the ICD-10 Code Sets**

**Per Act H.R 4302 signed by President Obama on April 1, 2014, the ICD-10 Implementation has been postponed till October 1, 2015.**

This bulletin provides important information regarding the Department of Social Services' (DSS) implementation of the International Classification of Diseases, 10<sup>th</sup> Revision (ICD-10) Code Sets in the Connecticut Medical Assistance Program (CMAP). ICD-10 consists of two parts:

- ICD-10-CM clinical modification for diagnosis codes
- ICD-10-PCS procedure coding system for inpatient procedure codes. (Inpatient Hospital claims only).

**It is important to note that HIPAA rules mandate ICD-10 Code Sets be used for any services rendered for dates of service October 1, 2014 forward.** Providers should take steps to learn and use the ICD-10 Codes appropriately. Documented below is a summary of the changes related to ICD-10 implementation in CMAP.

**1) Are your claims impacted by ICD-10 Changes in CMAP?** Claims which require a diagnosis code for dates of service October 1, 2014 forward are required to be submitted with ICD-10 codes and will be denied if submitted with ICD-9 codes.

As noted above, ICD-10-PCS impacts only Inpatient Hospital claims. ICD-10-CM, on the other hand, has a much wider impact. Noted below are the select few claims and/or provider types in CMAP that do not require diagnosis codes.

Currently, CMAP does not require a diagnosis code on dental claims unless procedure code is D9920 (Behavior Management)

The following provider types or provider types/specialties that bill on the professional claim format do not require a diagnosis code to be submitted on the claim:

- DME/Medical Supply Dealer (Provider Type 25)
- Transportation (Provider Type 26)
- Radiology (Provider Type 29)

- CHC/Access Agency/CHC Billing Provider (Provider Type/Specialty 57/541)
- CHC/CHC Service Provider (Provider Type/Specialty 57/544)

**2) 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 similar date logic as reported by CMS in the Medicare Learning Network (MLN) Matters publications MM7492 and SE1325 (links below).

[MM7492](#)

[SE1325](#)

Providers can also access these publications from the [www.cms.gov](http://www.cms.gov) Web site by entering the publication number in the search field.

**Please note:** MM7492 was published referencing the original ICD-10 implementation date of October 1, 2013. CMS revised the article to include a reference to the revised ICD-10 implementation date of October 1, 2014. All other information remains unchanged.

**3) Billing Changes Non-Pharmacy Claims:** Noted below are billing changes required for billing with ICD-10 Code Sets. The changes for the 837 transactions are noted in the Implementation Guide for the different claim types. The Web Claim Submission Instructions and Chapter 8 of the Provider Manual for all provider types will be updated with the billing instructions.

**Global 837 Changes:** The ICD-10 Code Sets should be submitted with the appropriate ID Code Qualifiers.

For ICD-10-CM:

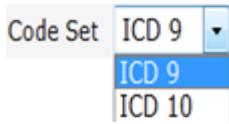
- ABK – Primary Diagnosis
- ABJ – Admit Diagnosis (Institutional)
- ABN – Ecode Diagnosis (Institutional)
- ABF – Other Diagnosis
- APR – Visit Diagnosis (Institutional)

For ICD-10-PCS:

- BBR – Principal Procedure Code (Institutional)
- BBQ – Other Procedure Code (Institutional)



**Global Web Claim Changes:** Diagnosis panels currently have a drop down list to select either the ICD-9 or ICD-10 Code Set.



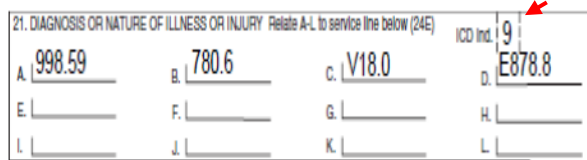
*Please Note:* For Institutional claims, in addition to selecting the Code Set for Diagnosis tab, providers will have to select the Code Set for Cause of Injury and Reason for Visit diagnosis tabs. Inpatient and Inpatient crossovers will need to select the Code Set for Surgical Procedure.

**Professional Paper Claim Changes:** DSS has transitioned to the revised CMS-1500 Form (version 02/12) in order to accommodate the ICD-10 changes. Providers were notified of the key billing changes for the revised CMS-1500 form via bulletin PB 2013-83 and the billing instructions for the new form are viewable in the appropriate Chapter 8 for your type/specialty. The specific ICD-10 changes are noted below:

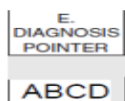
**Item Number 21 Diagnosis or Nature of Illness or Injury:** Providers will enter the applicable ICD indicator to identify which version of ICD codes is being reported.

- 9 for ICD-9-CM
- 0 for ICD-10-CM

No more than 12 ICD-9-CM or ICD-10-CM diagnosis codes can be listed.



**Item Number 24E Diagnosis Pointer:** Providers will enter the diagnosis code reference letter (pointer) as shown in Item Number 21 on the new (version 02/12) claim form. When multiple services are performed, the primary reference letter for each service should be listed first. The reference letter(s) should be A – L or multiple letters as applicable. Alpha characters only are accepted.

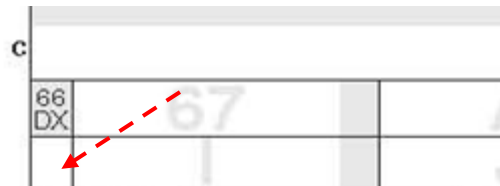


**Institutional Paper Claim Changes:** The current version of the UB-04 paper claim form will continue to

be used. However, the following ICD-10 related changes are targeted to be implemented April, 1<sup>st</sup> 2014.

**Item Number 66 DX:** Providers will enter the applicable ICD indicator to identify which version of ICD codes is being reported.

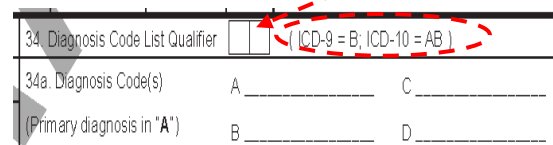
- 9 for ICD-9-CM
- 0 for ICD-10-CM



**Dental Paper Claim Changes:** The current version of the ADA paper claim form will continue to be used. However, the following ICD-10 related changes are targeted to be implemented April 1<sup>st</sup>, 2014.

**Item Number 34 Diagnosis Code List Qualifier:** Providers will enter the applicable ICD indicator to identify which version of ICD codes is being reported.

- B for ICD-9-CM
- AB for ICD-10-CM



**Claims with Abortion Procedure Codes:** Abortion services will require a condition code for professional, outpatient and inpatient claims with dates of service October 1, 2014 forward.

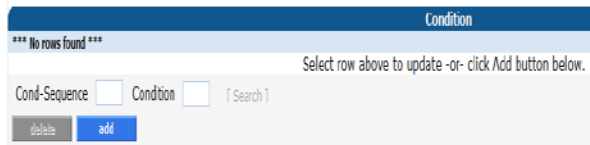
The use of Condition Codes is new to Professional claims in CMAP. Currently, Condition Codes are designed to allow the collection of information related to the patient, particular services, service venue and billing parameters which impact the processing of an Institutional claim. These codes are integral to both the paper UB-04 and the electronic 837I institutional claim.

In agreement with the National Uniform Billing Committee (NUBC), requirements for the creation of a subset of the Condition Codes for use in the professional claim were developed and license granted by NUBC for publication of the subset of codes by the National Uniform Claim Committee (NUCC). Due to legal ramifications and rules for federal financial participation (FFP) with state Medicaid programs, the NUCC approved the Condition Codes for abortion and

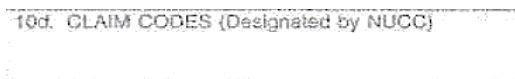


sterilization as part of the NUCC data set and the X12 Claims workgroup voted to add these codes to the claim level starting with version 004050 of the 837 Professional Health Care Claim.

Professional Web Claims have also been enhanced to add a Condition Code Panel.



The Condition Codes may be reported in field 10d (Claim Codes) of the 1500 Claim Form version 02/12.



The following Condition Codes can be used when submitting claims for abortion procedure codes:

- AA - Abortion Performed due to Rape
- AB - Abortion Performed due to Incest
- AC – Abortion Performed due to Genetic Defect, Deformity, or Abnormality
- AD - Abortion Performed due to Life Endangering Physical Condition
- AE – Abortion Performed due to Physical Health of Mother that is not Life Endangering
- AF – Abortion Performed due to Emotional/Psychological Health of the Mother
- AG – Abortion Performed due to Social or Economic Reasons
- AH – Elective Abortion
- A7 - Induced Abortion - Danger to Life
- A8 - Induced Abortion - Victim Rape/Incest

Effective for dates of service October 1, 2014 and forward, providers in CMAP will be required to submit claims for abortion services with one of the above condition codes.

**4) Pharmacy Claim Changes:** Pharmacy and compound claims require diagnosis codes for certain circumstances that are controlled by edits (such as Tuberculosis) or by rules on the NDC (Family Planning, specific other drugs, etcetera) or for certain audits (extended enteral nutrition).

The ICD qualifier will be used to identify the difference between ICD-9 or ICD-10 code sets for pharmacy claim submission. Updates will be made to the existing Companion Guides prior to the October 1,

2014 ICD-10 implementation date. The value submitted in NCPDP field 492-WE (diagnosis code qualifier) will transition from 01-ICD-9 to 02-ICD-10.

**5) ICD-10 Related Explanation of Benefits (EOB)**

**Codes:** Claims processing in CMAP will be enhanced to ensure that claims are meeting ICD-10 compliance requirements. Claims cannot be submitted with ICD-9 and ICD-10 codes on the same claim and the codes must be submitted with the appropriate ID Code qualifier. CMAP will implement new EOBs to set on claims with the implementation of ICD-10. We will publish a list of ICD-10 related EOB codes in the future.

**6) CMAP Policy References to Specific Diagnosis**

**Codes:** DSS will update all references to specific diagnosis codes related to Policy in the following documents. Providers will be notified via Important Messages and Banner Messages when specific documents are updated.

- Fee Schedule Headers and Footers
- Fee Schedule Instructions
- Chapter 5 Claim Submission Instructions
- Chapter 7 Policy/Regulation
- Chapter 8 Claims Submission Instructions
- Chapter 9 Prior Authorization

In addition, CHNCT and CTBHP will update their Web sites to reflect any changes to Prior Authorization requirements related to ICD-10.

**7) Automated Voice Response System (AVRS)**

**Changes:** As a result of the ICD-10 implementation, the AVRS no longer offers the option to look up diagnosis codes using the automated system. Chapter 10 of the Provider Manual has been updated accordingly.

**8) Resources:**

HP is maintaining an ICD-10 Important Message on the home page of the Web site [www.ctdssmap.com](http://www.ctdssmap.com). Providers may access the latest ICD-10 related news and training resources from this document. Interested providers may also subscribe to receive email updates for ICD-10 notifications and sign up to be a beta tester for ICD-10 claims submission. If your organization has any specific ICD-10 related questions, please contact HP via the following mailbox: [cmapid10questions@hp.com](mailto:cmapid10questions@hp.com).

