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September 28, 2015

MEMORANDUM

MEMO NOs.
QI-1516
FFS-1511

TO: QUEST Integration (QI) Health Plans
All Fee-For-Service (FFS) providers

FROM: Judy Mohr Peterson, PhD
Med-QUEST Division Administrator

SUBJECT: ICD-10 CONVERSION GUIDELINES

This memorandum contains additional guidance on ICD-10 conversion items. The three items that will be discussed on the memorandum are:

1) Use of unspecified diagnosis codes;

2) Specificity level of diagnosis codes; and

3) Prior Authorizations (PA) for Long Term Services and Support (LTSS)/Home and Community Based Services (HCBS) services.

The additional ICD-10 guidelines communicated on ADM-1404A, ADMX-1403A & QI-1410 still apply.

Use of Unspecified Diagnosis Codes

Beginning on October 1, 2015, the use of the 'R69' ICD-10 unspecified diagnoses code will not be accepted. For Long Term Services and Support (LTSS) and Home and Community Based Services (HCBS) services, a suitable ICD-10 diagnosis codes will be beneficiary-specific, and will relate to the persistent clinical reasons the beneficiary qualified for LTSS/HCBS. Documentation on which these diagnoses can be found are the beneficiary's:

- Prior authorizations
- Inpatient discharge summaries
- Doctor's orders
- Doctor's visit form
- DHS 1147
- LTSS Tool
- Service plan

The only services for which the 'R69' ICD-10 unspecified diagnoses code will be accepted are for transportation and interpretation services. All other services must have a beneficiary-specific ICD-10 diagnosis code.

Specificity Level of Diagnosis Codes

CMS informed the State Medicaid Agencies on July 9, 2015 that they have come up with Medicare guidelines related to the specificity of the ICD-10 diagnosis required on Medicare claim submissions. At the same time, they communicated to us that Medicaid guidelines would be forthcoming. These Medicaid guidelines have not yet been issued. When CMS issues Medicaid specific guidance, MQD will evaluate and adjust our previous ICD-10 guidance accordingly.

MQD has made the decision to follow these Medicare guidelines related to specificity level of diagnosis coding, and apply these to the Medicaid population. These guidelines state that while ICD-10 diagnosis coding to the correct level of specificity is the goal, we will not pend or deny claims solely based on the specificity of the ICD-10 diagnosis code used as long as a valid code is used from the correct family.

These Medicare specific guidelines can be found in a FAQ (#2) here:
https://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD-10-guidance.pdf

Prior Authorizations

Health plans should NOT be telling their providers specific diagnosis codes to use when submitting a specific claim for a specific beneficiary. Beginning October 1, 2015, providers need to use a medically appropriate, beneficiary-specific ICD-10 diagnosis code on all claim bills. Appropriate prior authorizations issued by health plans to LTSS/HCBS providers can meet both these needs.

LTSS/HCBS prior authorizations issued by health plans for services October 1, 2015 and forward should have at least one appropriate ICD-10 diagnosis code. More than one ICD-10 code may be used. The ICD-10 diagnosis codes used will relate to the persistent clinical reasons the beneficiary qualified for LTSS/HCBS.

If you have questions or concerns, please contact the MQD provider hotline at 808-692-8099.