MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 13-33

Distribution: All Providers

Issued: August 29, 2013

Subject: Claims Processing Guidance for Implementing the International Classification of Diseases, 10th Edition (ICD-10)

Effective: As Indicated

Programs Affected: Medicaid, Adult Benefits Waiver (ABW), Children's Special Health Care Services (CSHCS), Children's Waiver Program (CWP), Children's Serious Emotional Disturbance Waiver (SEDW), Maternity Outpatient Medical Services (MOMS), *Plan First!,* and other Health Care Programs administered by the Michigan Department of Community Health (MDCH)

This policy bulletin provides information about the Michigan Department of Community Health's (MDCH) implementation of the International Classification of Disease, 10th Edition, Clinical Modification and Procedure Coding System (ICD-10-CM/ICD-10-PCS) code sets. This information is intended to assist providers in preparing their business and systems' changes and applies to both Fee-for-Service (FFS) claims and encounters. Future policy bulletins will address ICD-10 diagnosis coding for Medicaid service coverage, limitations, and prior authorization requirements. The use of other code sets, such as Current Procedural Terminology (CPT)®, Healthcare Common Procedure Coding System (HCPCS) Level II, and revenue codes, will not be impacted by this change.

I. Reporting of ICD-10-CM Diagnosis Codes

For dates of services **prior to** October 1, 2014, ICD-9 diagnosis codes must be used. ICD-9 codes will not be accepted on claims (including electronic and paper) with FROM dates of service (on professional and supplier claims) or DATES OF DISCHARGE/THROUGH dates (on institutional claims) on or after October 1, 2014.

A. For dates of submission beginning October 1, 2014, MDCH will adhere to the following:

1. On professional and dental claims, ICD-10 diagnosis codes must be used with FROM dates of service on or after October 1, 2014.

2. On institutional claims, ICD-10 diagnosis codes must be used with DATES OF DISCHARGE/THROUGH dates that occur on or after October 1, 2014.

3. A claim cannot contain both ICD-9 codes and ICD-10 codes: The claim will be denied if a combination of codes is submitted on and after the October 1, 2014, implementation date. Services should be split into two claims so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2014, and all ICD-10 codes are placed on the other claim with DOS beginning 10/1/2014, and later.

B. For Dates of Service spanning the ICD-10 implementation date:

1. On professional, dental, and most institutional claims, the FROM date of service is used to determine the split for claim submission.

2. The following bill types for institutional claims cannot be split for claims submission and the entire claim must be billed with ICD-10 for DATES OF DISCHARGE/THROUGH dates that occur on or after October 1, 2014:

BILL TYPE(S)	FACILITY TYPE/SERVICES
11X	Inpatient Hospitals
18X	Swing Beds
21X	Skilled Nursing (Inpatient Part A)
32X	Home Health (Inpatient Part B)

3. There are certain exceptions where billing policy does not allow splitting the claim. The following table provides additional guidance to providers for these exceptions:

SERVICE	BILLING REQUIREMENT
Anesthesia	Anesthesia procedures that begin on 9/30/2014 but end on 10/1/2014 are to be billed with ICD-9 diagnosis codes using 9/30/2014 as both the FROM and THROUGH date.
Hospital Outpatient 3-day/1-day Payment Window	All outpatient services (with a few exceptions) are required to be bundled on the inpatient bill if rendered within three (3) days of an inpatient stay; therefore, if the inpatient hospital discharge is on or after 10/1/2014, the claim must be billed with ICD-10 for those bundled outpatient services.
DMEPOS	Billing for certain items or supplies (such as capped rentals or monthly supplies) may span the ICD-10 compliance date of 10/1/2014 (e.g., the FROM date of service occurs prior to 10/1/2014 and the TO date of service occurs after 10/1/2014). If the FROM date of service is before 10/1/2014, ICD-9 diagnosis codes should be reported.

ICD-10 diagnosis codes must be valid, contain the required number of characters, and be reported at the highest level of specificity based on the information available. Unspecified ICD-10 diagnosis codes may not be acceptable. In addition, when laterality of anatomical sites (e.g., left, right, bilateral) is defined by ICD-10, codes with unspecified laterality may not be accepted.

For CPT ® and HCPCS Level II procedure codes that bypass prior authorization requirements for specific conditions, ICD-10 related diagnosis codes must be submitted beginning October 1, 2014.

II. Reporting of ICD-10-PCS Procedure Codes

For dates of services **prior to** October 1, 2014, ICD-9 procedure codes must be used. ICD-9 codes will not be accepted on claims (including electronic and paper) with DATES OF DISCHARGE/THROUGH dates on or after October 1, 2014.

For dates of submission beginning October 1, 2014, MDCH will adhere to the following:

A. ICD-10 procedure codes will be accepted only on claims for hospital inpatient settings or services and must be used on claims with DATES OF DISCHARGE/THROUGH dates on or after October 1, 2014.

B. A claim cannot contain both ICD-9 and ICD-10 procedure codes.

C. ICD-10 procedure codes must be valid and contain the required number of characters.

D. For inpatient procedure codes, new bypass prior authorization requirements for specific conditions (e.g., breast cancer) will be implemented using ICD-10 codes beginning October 1, 2014.

Manual Maintenance

Retain this bulletin until the information has been incorporated into the Michigan Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

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