

PROVIDER BULLETIN No. 13-58

August 30, 2013

TO: All Providers Participating in the NE Medicaid Program
All Medicaid EDI Trading Partners

FROM: Vivianne M. Chaumont, Director 
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Medicaid IT Initiatives

RE: **Medicaid ICD-10 Implementation Project
August 2013 Update**

Please share this information with Clinical, Coding, Billing, and IT Staff

The United States Department of Health and Human Services requires that all HIPAA covered entities use the International Classification of Diseases, 10th Revision (ICD-10) codes beginning October 1, 2014. This bulletin provides information regarding the Nebraska Medicaid ICD-10 Implementation Project.

ICD-10 Impacts on Medicaid Claims beginning October 1, 2014

Beginning on October 1, 2014, Nebraska Medicaid will implement the following diagnosis code rules when processing claims:

1. Electronic and paper claims will be processed using the same rules for diagnosis coding.
 - Providers must work with their IT staff, billing software vendors, clinical staff, coders, billing staff, clearinghouses, etc., to ensure both paper and electronic claims can be correctly coded with either ICD-9 or ICD-10 based on the date of service claimed beginning October 1, 2014.
 - Claims not properly coded will be rejected/denied.

2. Providers must use either ICD-9 or ICD-10 based on the date(s) of services claimed, not on the date the claim is submitted. The following chart illustrates which code to use based on the date of service, regardless of the billing date.

Reminder: Claims must be submitted to Nebraska Medicaid within 180 days after the date of service. See [Provider Bulletin #13-50](#) for more details.

Date of Service	Diagnosis Code Allowed	Please Note
Prior to October 1, 2014	ICD-9 codes, regardless of billing date	If coded with ICD-10 codes, claims will be rejected/denied.
		Diagnosis codes will be processed as submitted by providers.
		Diagnosis codes will not be translated, mapped or cross-walked.
		Diagnosis codes should be the most specific codes available to accurately describe the patient's documented diagnoses.
On or After October 1, 2014	ICD-10 codes	If coded with ICD-9 codes, claims will be rejected/denied.
		The diagnosis should be coded to the level of certainty known for each healthcare encounter.
		Unspecified diagnosis codes should need to be selected less often due to greater number of code choices in ICD-10-CM.
		Unspecified codes should be reported when they most accurately reflect what is known about the patient's condition at the time of that particular encounter.

Specific ICD-10 Impacts by Claim Type

In addition to the diagnosis processing rules above, the following are rules that will be applied by claim type:

Institutional Claims (e.g., UB-04 and 837I)

Institutional claims will be handled as outlined below:

1. Inpatient Hospital Claims

Scenario: Inpatient hospital claims with discharge date and/or through date on or after October 1, 2014.

Solution: The entire claim must contain only ICD-10 codes.

Note: Inpatient stays with discharge date and/or through date before October 1, 2014, must be submitted with ICD-9 codes, even when billed after October 1, 2014.

2. Outpatient Hospital Claims and FQHC Claims

Scenario: Outpatient hospital and FQHC claims whose dates of service span the ICD-10 compliance date.

Solution: Providers must split claims so that ICD-9 codes remain on one claim for dates of service prior to October 1, 2014, and ICD-10 codes remain on a different claim for dates of service on or after October 1, 2014.

3. Skilled Nursing Facility (SNF) Claims

Scenario: SNF claims with a discharge date and/or through date on or after October 1, 2014.

Solution: The entire claim must contain only ICD-10 codes.

4. Home Health and Hospice Claims

Scenario: Home health and hospice claims whose dates of service span the ICD-10 compliance date.

Solution: Providers must split claims so that ICD-9 codes remain on one claim for dates of service prior to October 1, 2014, and ICD-10 codes remain on a different claim for dates of service on or after October 1, 2014.

5. Assisted Living Claims

Scenario: Assisted Living claims with a discharge date and/or through date on or after October 1, 2014.

Solution: The entire claim should contain only ICD-10 codes. The code to be used will be assigned by DHHS. An update to the billing instructions will be made when the code is determined.

Professional/Practitioner Claims (e.g., CMS 1500, 837P)

Scenario: Practitioner claims whose dates of service span the ICD-10 compliance date.

Solution: Providers must split claims so that ICD-9 codes remain on one claim for dates of service prior to October 1, 2014, and ICD-10 codes remain on a different claim for dates of service on or after October 1, 2014.

Dental Claims (e.g., ADA or 837D)

- Diagnosis codes are not currently required on dental paper and electronic claims (HIPAA 837D) and will not be required with the implementation of ICD-10 on October 1, 2014.
- If diagnosis codes are submitted:
 - Diagnosis codes submitted for dates of service prior to October 1, 2014, must be ICD-9, regardless of when the claim is submitted.
 - Diagnosis codes submitted for dates of service on or after October 1, 2014, must be ICD-10.
 - If a claim contains dates of services that span the ICD-10 compliance date, the claim must be split so that the ICD-9 codes remain on one claim for dates of service prior to October 1, 2014, and ICD-10 codes remain on another claim for dates of service on or prior to

Questions?

Please submit questions about this bulletin or about ICD-10 to DHHS.ICD-10Implementation@nebraska.gov.

The Nebraska Medicaid ICD-10 Project website also has a number of Frequently Asked Questions at <http://dhhs.ne.gov/medicaid/Pages/ICD-10.aspx>.

The Centers for Medicare & Medicaid Services (CMS) has resources to help prepare for a smooth transition. Visit www.cms.gov/ICD10 to find out more.