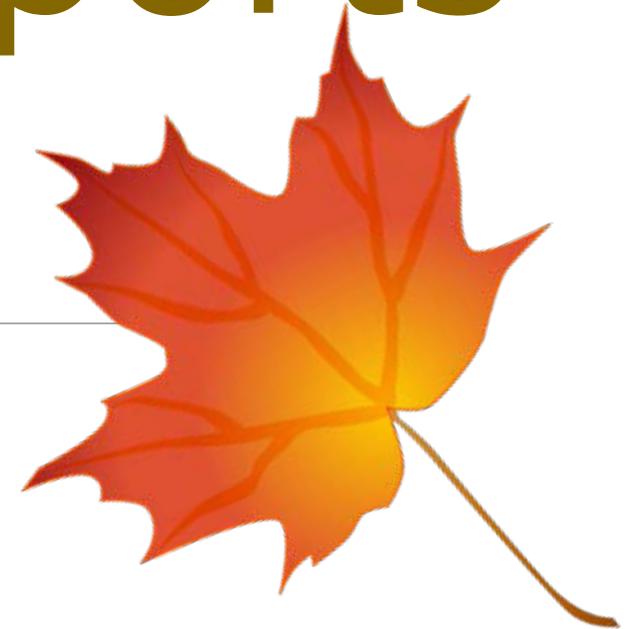


ICD-10 and Essential Community Supports Guidance



PRESENTER – STACEY ALSDURF



Overview

- Review diagnosis code source by Claim Category
- Diagnosis Code Entry
- Diagnosis Mental Health (MH) Billable Indicator
- ICD-10 Testing
- ECS Client Eligibility
- Identify ECS Clients
- ECS and Staff Provided Rates
- ECS Subprogram



CW-TCM Diagnosis

- The CW-TCM Claim Category always uses a default diagnosis code
- The ICD-9 default diagnosis is V68.9 until Service Date 09/30/2015
- The ICD-10 default diagnosis Z60.9 on or after Service Date 10/01/2015

RSC-TCM and VA/DD-TCM Diagnosis

- DD Screening
- LTC Screening
- Disability/Diagnosis/Substance folder/Diagnosis screen
- If no billable diagnosis found:
 - Default ICD-9 code V68.9 until Service Date 09/30/2015
 - Default ICD-10 code Z60.9 on and after Service Date 10/01/2015

MH-TCM and Rule 5 Diagnosis

- Only diagnosis codes entered on Diagnosis screen in client's Disability/Diagnosis/Substance folder used
- Diagnosis codes must have Mental Health (MH) Billable Indicator "Y"
- MH Billable Indicator applies to both ICD-9 and ICD-10 diagnosis codes
- No default diagnosis codes!
- If no billable mental health diagnosis found, proofing message #2020 (MH diagnosis required) displays

Waiver and AC Diagnosis

- DD Screening
- LTC Screening
- Disability/Diagnosis/Substance folder/Diagnosis screen
- No default diagnosis codes!

Waiver and AC Diagnosis

- Screening documents support one type of diagnosis code (ICD-9 *or* ICD-10)
- Client screening documents continue to have only ICD-9 codes after the 10/01/15 implementation date until clients receive new screenings
- Enter clients ICD-10 diagnosis codes from MMIS Service Agreement letters in their Disability/Diagnosis/Substance/Diagnosis folder for client's with screening documents that contain ICD-9 codes that span beyond 10/01/2015

Waiver and AC Diagnosis

- Time Records and/or Payments might display in Healthcare Claim Proofing with message #2019 – Diagnosis Required after 10/01/2015 if:
 - Active DD Screening has ICD-9 diagnosis
 - Active LTC Screening has ICD-9 diagnosis
 - No diagnosis code from MMIS Service Agreement letter or other source entered on client's Diagnosis screen in their Disability/Diagnosis/Substance folder

Diagnosis Code Entry

- Entry of ICD-10 diagnosis codes has been available in SSIS since V14.1
- Enter only professionally determined diagnosis codes or diagnosis codes from MMIS Service Agreement letters
- The diagnosis start and end dates should reflect the date that the diagnosis for that client actually started and ended
 - Entry of a future start date is not allowed
 - The start and end dates can be left blank

Diagnosis Code Entry

- The effective dates from MMIS are used to determine whether or not the diagnosis code can be used for claiming
 - ICD-9 diagnosis codes have an effective end date of 09/30/2015 or earlier
 - ICD-10 diagnosis codes have an effective start date of 10/01/2015 unless they are non-specific.
 - Non-specific ICD-10 codes have an effective start date of 09/30/2015 and are not valid for claiming

Diagnosis Code Entry

The screenshot shows a software interface for entering diagnosis codes. It includes three dropdown menus at the top: 'Type' (set to ICD-9-CM), 'Code' (set to 789.00), and 'Diagnosis' (set to ABDOMINAL PAIN, UNSPECIFIED SITE). Below these is a text field showing 'Diagnosis code effective dates: 10/01/1994 to 09/30/2015.' A callout box points to this text, stating: 'These dates are used to determine diagnosis code effective dates for Healthcare Claiming.' Below this is a section titled 'Client's Diagnosis Information' containing two date dropdowns: 'Diagnosis Start Date:' and 'Diagnosis End Date:'. A callout box points to these two fields, stating: 'Use actual dates the client's diagnosis started and ended.' At the bottom of this section is a radio button group for 'Primary Diagnosis:' with 'Yes' and 'No' options, where 'No' is selected.

Type: ICD-9-CM Code: 789.00 Diagnosis: ABDOMINAL PAIN, UNSPECIFIED SITE

Diagnosis code effective dates: 10/01/1994 to 09/30/2015.

Client's Diagnosis Information

Diagnosis Start Date: [] Diagnosis End Date: []

Primary Diagnosis: Yes No

These dates are used to determine diagnosis code effective dates for Healthcare Claiming.

Use actual dates the client's diagnosis started and ended.

MH Billable Indicator

- A “Y” and “N” indicator stored in SSIS that indicates whether the diagnosis code (ICD-9 or ICD-10) meets the definition of a mental health diagnosis
 - Determined by policy staff
- If a Healthcare Claim requires a mental health diagnosis, the diagnosis code entered must have a “Y” MH Billable Indicator
- If the MH Billable Indicator is an “N” and a mental health diagnosis is required and not found, proofing message #2020 displays

MH Billable Indicator

- The MH Billable Indicator does not display on the diagnosis screen
 - We will be putting a copy of ICD-9 and ICD-10 codes with a MH Billable Indicator value of "Y" on the SSIS website and in the mentor manual
- Minnesota Healthcare Programs (MHCP) policy changed the designation of some diagnosis codes that were previously considered mental health diagnosis codes
- The MH Billable Indicator of several ICD-10 codes and ICD-9 codes 315.9 and 316 will be changed from "Y" to "N" in V15.3
 - Potential healthcare claims with these diagnosis codes will now display in proofing with proofing message #2020
 - Some claims might have been denied prior to V15.3 because policy made this change a couple of months ago

Non-specific Diagnosis

Reminder: A diagnosis code must be specific. If the diagnosis screen displays the message “The diagnosis code is not specific enough for claiming.”, the diagnosis code cannot be used on a Healthcare Claim

- Proofing message #2019 or #2020 displays if a diagnosis code is not specific enough for claiming

Note: Social workers may enter non-specific diagnosis codes for case management purposes and not healthcare claiming purposes

The screenshot shows a software interface with three tabs: 'Diagnosis', 'Professionally Determined Disabilities', and 'Substance Involvement'. The 'Diagnosis' tab is active. It contains the following fields and information:

- Type:** ICD-10-CM (dropdown menu)
- Code:** F01 (text field with a magnifying glass icon)
- Diagnosis:** Vascular dementia (text field)
- Diagnosis code effective dates:** 09/30/2015 to 10/01/2015.
- Message:** The diagnosis code is not specific enough for claiming. (An arrow points from the right to this message.)
- Client's Diagnosis Information:**
 - Diagnosis Start Date:** (dropdown menu)
 - Diagnosis End Date:** (dropdown menu)
 - Primary Diagnosis:** Yes No

ICD-10 Testing

- SSIS implemented Healthcare Claiming changes for ICD-10 in V15.3
- Testing was limited because the ICD-10 implementation date was after the statewide release of V15.3

ICD-10 Testing

- Internal ICD-10 testing must be done in October
- Counties cannot submit Healthcare Claims through SSIS with ICD-10 codes until November or later
- Submit Healthcare Claims in October for September service dates and ICD-9 diagnosis codes

Essential Community Supports

- Provides community based supports for clients who do not meet the revised Nursing Facility Level of Care criteria but meet the eligibility requirements for Essential Community Supports (ECS)
- ECS is not a waiver program but is processed in MMIS like other waiver programs

ECS Client Eligibility

- Major Program “UN – Screened – not Placed on Waiver/AC”
- Eligibility Type “EC – Essential Community Supports”
- Waiver Type “Y – LTC – Essential Comm Support”
- LTC Waiver Type:
 - “29 – Essential Community Supports”
 - “30 – ECS Transitions”
- MMIS Service Agreement Type “Y – Agreement – Essential Comm Support”

Identify ECS Clients

- MMIS Service Agreement Report located under Healthcare Claiming/Healthcare Eligibility Reporting
- Group MMIS Service Agreement Report results by Service Agreement Type to identify ECS clients

Setup MMIS Service Agreement Use Group by function to identify MMIS Service Agreement Types.

Type Name/SSIS Person #

Prior Authorization Number	Start Date	End Date	Status
Type : Agreement - Essential Comm Support			
Name/SSIS Person # : Doe, Jane #111111111			
1111111111	12/12/2015	1/31/2016	Approved
Line Item Number	Status	Provider Name	NPI/UMPI
1	Approved	Bjorn County 1	A000000000
2	Approved	Bjorn County 2	M000000000

Healthcare Claiming Report including ECS

Claim Detail Report

Setup **Claim Detail**

Searches: Max results: Search on open

Claim #: **F** Claim category: **F** Claim detail: **F** Claiming county: **F**

Claim status: **F** Disposition: **F**

Date filters
Date type: Date To:

Client filters
Client first name: Client last name: County person #: SSIS person #: PMI #: **F**

HCPCS/modifiers filters
 F

Additional filters
Filter by: TCN: **F**

Amount filters
Amount type: Operation: Minimum: Maximum:

AC
BI
CAC
CADI
DD
ECS
EW

Healthcare Eligibility Reports including ECS

Waiver Eligibility Detail

Waiver Type

Check All Uncheck All

- AC
- BI
- CAC
- CADI
- DD
- ECS
- EW



Waiver Eligibility Summary

Setup Waiver Eligibility Summary

Date Range

Period: Custom

From: To:

WaiverType

Check All Uncheck All

- BI
- CAC
- CADI
- DD
- ECS
- EW



ECS and Staff Provided Rates

If rates in your agency are determined by Waiver Type, remember to enter Staff Provided Rates for ECS in Admin by specifying Claim Detail value "ECS" to prevent Proofing Message # 2004 – No Staff-provided Rate for the "HCPCS/Modifiers on the activity date" from displaying

The screenshot shows the 'T1016 UC- Waiver case management' interface. At the top, there are input fields for 'HCPCS:' (T1016), 'Mod 1:' (UC), 'Mod 2:', 'Mod 3:', and 'Mod 4:'. Below this is the 'HCPCS/Modifier description:' field containing 'Waiver case management'. A callout box with an arrow pointing to the 'Claim Detail' column of the table below contains the text: 'If rates are specified by Claim Detail code in your county, add Staff-provided Rate for ECS.'

	Rate	HCPCS Unit Type	Rate Start Date	Rate End Date	Claim Detail
\$	\$23.7000	15 Minutes	10/01/2008		BI
\$	\$23.7000	15 Minutes	10/01/2008		CADI
\$	\$24.6500	15 Minutes	10/01/2008		AC

New Subprogram for ECS

- New subprogram for Essential Community Supports scheduled to be added in V15.4
 - Display in Admin/Programs and Services Administration/Programs
 - Abbreviation code "AECS"
 - Used in Workgroup name

Program:	675 - Adult - Essential Community Supports	
Service:	601 - Information and Referral	
Association Start Date:	01/01/2015	Association End Date:

Questions?

