



# Bulletin

**NUMBER**

#15-25-11

**DATE**

July 29, 2015

**OF INTEREST TO**

County Directors

Social Services Supervisors  
and Staff

Lead Agencies (Counties  
and Tribes)

Managed Care  
Organization Care  
Coordinators

**ACTION/DUE DATE**

Please read information  
and prepare for  
implementation

**EXPIRATION DATE**

July 29, 2017

## ICD-10 Diagnosis Code Implementation

**TOPIC**

Explain ICD-10 codes effective October 1, 2015, the transition process for ICD-9 to ICD-10 codes for home and community based service (HCBS) agreement letters, and the action needed on screening documents and home care authorizations.

**PURPOSE**

This bulletin replaces bulletins 13-25-12 and 14-25-05.

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**TERMINOLOGY NOTICE**

The terminology used to describe people we serve has changed over time. The Minnesota Department of Human Services (DHS) supports the use of "People First" language.

## **I. BACKGROUND**

The ICD-9 CM code set, volumes 1 and 2 are used to report medical diagnoses which will be replaced by ICD-10 CM code set. The transition to ICD-10 is occurring because the ICD-9 system has limited data about medical conditions and hospital inpatient procedures. ICD-9 is 31 years old, has outdated terms, and is inconsistent with current medical practice. The structure of ICD-9 limits the number of new codes that can be created and many categories are full.

The Centers for Medicare and Medicaid Services (CMS) mandates all Health Insurance Portability and Accountability Act (HIPAA) entities (providers, payers, health plans, clearinghouses, and vendors) begin using ICD-10-CM and ICD-10 PCS on transactions for dates of service/inpatient discharge dates on and after October 1, 2015. More information may be obtained through CMS' ICD-10 [website](#).

The Minnesota Department of Human Services (the department) provides more information on their [ICD-10](#) webpage.

The ICD-10 diagnosis code may be up to seven digits in length. The format is xxx.xxxx, and the first digit is always an alpha character. The second digit is always a numeric character. The remaining digits are a combination of alpha and numeric characters.

## **II. THE LONG TERM CARE (LTC) SCREENING DOCUMENT**

There are five fields on the MMIS ALT1 screen of the LTC screening document to record diagnosis codes:

- PRIMARY DIAG
- SECONDARY DIAG
- DD DIAGNOSIS
- MI DIAGNOSIS
- BI DIAGNOSIS

## **Editing**

The primary diagnosis code is mandatory and transfers to the provider and billing agent service agreement letter.

Edit 205 *Primary Diagnosis Code is Missing* will post if left blank.

Other edits check all of the diagnosis fields for valid codes, as well as age and gender conflicting with diagnosis.

- When a "Y" is placed in the DD/MI/BI Diagnosis History fields, the corresponding diagnosis code must be entered.
- If the DD DIAGNOSIS field is populated, it must contain a developmental disability or related diagnosis code. Currently, these codes are 317, 318, 318.1, 318.2 and V79.8. See table in Section VIII for new DD ICD-10 diagnosis codes.

## **III. THE DEVELOPMENTAL DISABILITY (DD) SCREENING DOCUMENT**

There are four fields on the ADD1 screen of the DD screening document for diagnosis codes:

- DIAG 1
- DIAG 2
- DIAG 3
- DIAG 4

## **Editing**

The Diag 1 field is mandatory and transfers to the provider and billing agent service agreement letter.

Edits check all fields for valid codes, as well as age and gender conflicting with diagnosis.

Currently, the diagnosis 1 field must be an ICD-9 CM code such as: 317, 318.0, 318.1, 318.2 or V79.8. If the first diagnosis field is V79.8, then the 2<sup>nd</sup> diagnosis field must be a code that qualifies the individual for the related condition and vice versa.

Diagnosis code fields 3 and 4 must be a valid diagnosis code. See table in Section VIII for new DD ICD-10 diagnosis codes.

## IV. HOME CARE AUTHORIZATION

There are three fields on the AHC1 screen of the Home Care authorization for diagnosis codes:

- DIAGNOSIS 1
- DIAGNOSIS 2
- DIAGNOSIS 3

### Editing

The diagnosis 1 code is mandatory and transfers to the provider and billing agent service agreement letter.

Edit 205 *Primary Diagnosis Code is Missing* will post if left blank.

Other edits check all diagnosis fields for valid codes, as well as age and gender conflicting with diagnosis.

## V. SERVICE AGREEMENT LETTER

Letters are produced when a waiver, home care, Essential Community Supports (ECS), Moving Home Minnesota (MHM), or Alternative Care (AC) service agreement/authorization is entered into the MMIS and one or more line items are in a status of approved, pended, or denial. Letters are produced for the:

- recipient (if the SEND RECIP LTR field = y)
- case manager (for Waiver, Essential Community Supports, and Alternative Care)
- providers
- billing agent (if applicable)
- South Country Health Alliance managed care organization (for Elderly Waiver recipients enrolled with this health plan)
- all other health plans for Essential Community Supports program

The diagnosis code is shown on the provider and billing agent letters for billing purposes. The provider and billing agent are not obligated to use this diagnosis code and must use the most current diagnosis code for the person.

## VI. WAIVER, HOME CARE, AC, ECS, and MHM CLAIMS

All waiver, home care, Essential Community Supports, Moving Home Minnesota, and Alternative Care claims must contain a valid diagnosis code.

## VII. SOURCES OF DIAGNOSTIC CODES

While all providers must include a valid diagnosis code on a claim, not all providers are “diagnosing” providers. That is, they have no authority within their scope of practice to assign a medical diagnosis to an individual. Assessors completing assessment and support planning are not diagnosing providers. If a medical diagnosis is entered into the Screening Documents or Home Care Authorization by an assessor, it must be obtained from a medical record.

As described in this bulletin, many HCBS and home care providers obtain the diagnostic code for billing purposes from the service agreement Letters.

### Optional Codes for Assessor Use

CMS provided a list of available codes for billing for non-diagnosing providers. The table below contains a subset of those codes identified by Continuing Care for Older Adults and Community Supports policy staff. The codes can be used by assessors in completing screening documents and service authorizations when a diagnosis from a medical record is unavailable.

ICD -10 Codes	Code Description	Definition	Some Examples
Z74.1	Need for assistance with personal care	No data here	ADLS needs
Z73.6	Limitation of activities due to disability	Disability is the consequence of an impairment that may be physical, cognitive, mental, sensory, emotional and developmental, or some combination of these.	“Activities” include assistance to complete IADLs, go into the community, physician visits, pharmacy, transportation, etc.

ICD -10 Codes	Code Description	Definition	Some Examples
Z59.1	Inadequate housing	No data here	Unaffordable, inaccessible, ill repair, etc.
Z59.0	Homelessness	No data here	No data here
R69	Illness, unspecified	"Illness" is a health deficit.	Includes physical and mental health, active illness, chronic disease, self-reporting diagnoses, medications, etc.
T14.90	Injury, unspecified	"Injury" is an impairment as a result of an injury.	Injury as a result of a traumatic event, e.g. car accident, etc.
Z13.9	Encounter for screening, unspecified	No data here	I&R, informational screening, screening for asset assessment
Z59.9	Problem related to housing and economic circumstance, unspecified	No data here	Unaffordable housing, qualifying for housing assistance

### Use of Optional Codes and MMIS/SSIS

Selection of the optional codes by an assessor does not affect

- Where diagnostic codes are required in either MMIS or SSIS
- How codes are used in operations and transactions

- The hierarchy in MMIS or SSIS related to where the systems “looks” for codes and selects them for use.

## **VIII. MMIS CHANGES FOR ICD-10 DIAGNOSIS CODES**

Providers must use valid ICD-9 codes for services provided prior to October 1, 2015 and use valid ICD-10 codes on their claims for services provided on October 1, 2015 or later.

Service agreements and home care authorizations may be effective for a period of up to twelve months into the future, and service agreement letters will show valid diagnosis codes that can be used for billing. The service agreement letters for providers and billing agents will show:

1. The ICD-9 diagnosis code for service agreements ending **prior to** October 1, 2015;
2. Both the ICD-9 and ICD-10 diagnosis codes for service agreements ending on and after September 30, 2015; or
3. The ICD-10 diagnosis code for service agreements beginning on October 1, 2015 or greater.

MMIS will automatically add an ICD-10 CM code to letters until lead agency staff begins adding the ICD-10 CM code to screening documents for screenings with an activity type or action date of October 1, 2015. Providers must use the ICD-9 CM codes for services provided **prior to** October 1, 2015, and use the ICD-10 CM code for services provided beginning on or after October 1, 2015.

Lead agency staff enters the LTC screening document and DD screening document into the MMIS. All documents with an Activity Type Date (LTC) or Action Date (DD) October 1, 2015 or later must contain an ICD-10 diagnosis code. Home care authorizations with a begin date of October 1, 2015 or after, must contain an ICD-10 diagnosis code.

For the DD diagnosis field on both the LTC and DD screening document, use the new ICD-10 codes as follows:

ICD-9 code	ICD-9 Description	ICD-10 code	ICD-10 Description
317	Mild intellectual disabilities	F70	Mild intellectual disabilities
318.0	Moderate intellectual disabilities	F71	Moderate intellectual disabilities
318.1	Severe intellectual disabilities	F72	Severe intellectual disabilities
318.2	Profound intellectual disabilities	F73	Profound intellectual disabilities
319	Intellectual disabilities NOS	F79	Unspecified intellectual disabilities
V79.8	Other specified mental disorders and developmental handicaps	F78	Other intellectual disabilities

Note: For three character ICD-10 CM diagnosis codes, there is no decimal used after the third character.

## **IX. SOCIAL SERVICES INFORMATION SYSTEM (SSIS)**

The capability for SSIS users to enter an ICD-10 diagnosis code in a client's Disability/Diagnosis/Substance folder was implemented in Release 14.1.

## **X. AMERICANS WITH DISABILITIES ACT (ADA) ADVISORY**

This information is available in accessible formats for people with disabilities by calling (651) 431-2590 (voice) or toll free at (800) 882-6262 or by using your preferred relay service. For other information on disability rights and protections, contact the agency's ADA coordinator.