

CLASS and DBMD ICD-9 to ICD-10 Conversion Webinar

Q: After October 1, do the current individuals with the ICD-9 codes have to ask the PMD to sign off on page 2 of Form 8578 with the new codes?

A: If the ICD-10 code is a direct conversion, meaning there is no diagnostic decision made, then a provider can populate a new ID/RC and it does not require a physician's signature. If the individual has a new diagnosis with an ICD-10 code that does not have a direct conversion from their ICD-9 code, the provider has to have a physician provide an ICD-10 code and sign a new ID/RC. To identify if a DADS-approved related condition code has a direct conversion, you can access ICD Conversion Code Lookup for Related Conditions on the DADS ICD-10 webpage (<http://www.dads.state.tx.us/providers/icd10/index.cfm>).

Q: Am I correct: you must obtain new documentation (doc signature and ICD-10 code) for every authorization that is tied to an ICD-9 code in order to bill after Oct 1?

A: No. All ID/RC submissions for forms effective on or after Oct. 1, 2015, must contain valid ICD-10 codes only. However, you do not have to make changes until the time of the renewal, or if there is a significant change in the person's status that would warrant a new ID/RC. Beginning on October 1, 2015, you may use Z76.89 as a transitional code on claims.

Q: For acute care authorizations that start before and end after October 1, do we need to have both ICD-9 and ICD-10 codes on it?

A: For inpatient claims, the date of service will determine the correct ICD code to place on the claim; for outpatient claims, the patient discharge date will determine the correct ICD code to place on the claim. If you are not a DADS contracted provider and are not a medical professional, this will not affect you. For more information about acute care claims, visit: <http://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html> , or <http://www.tmhp.com/Pages/CodeUpdates/ICD-10.aspx>.

Q: How can we find the conversion for IDD codes if that is considered a secondary diagnosis for certain individuals? We've been told these aren't converted using the widget.

A: These codes can be found on DADS ICD-10 Q/A page <http://www.dads.state.tx.us/providers/icd10/faq.html>, under the question "How do I know if there is a one to one match for an existing ICD-9 code?"

Q: How does the physician know which code is a related condition?

A: The federal definition of a related condition can be found at 42 CFR 435.1010, or Texas Department of Aging and Disability Services Approved Diagnostic Codes for Persons with Related Conditions (http://www.dads.state.tx.us/providers/guidelines/icd-9-cm_diagnostic_codes.pdf) DADS has provided a Physician letter attached to [Information Letter No. 15-36](#), which can be used as a tool to help a physician to understand what DADS is requiring of providers to ensure uninterrupted eligibility of individuals in the CLASS and DBMD programs. You may also find the list of conditions, recognized by DADS which qualify an individual as having a related condition and the corresponding ICD-10 codes at, <http://www.dads.state.tx.us/providers/guidelines/icd10-codes.pdf>.

Q: How will DADS work with DSAs who have trouble getting the physician to sign and fax the IDRC back with new ICD code in a timely manner?

A: ICD-10 is required of all HIPPA-covered entities. That means all physicians that are billing for services are required to transition to ICD-10 on October 1, 2015. This transition is something they should already be prepared for. DADS has also developed a [sample letter that a DADS contracted provider or LIDDA may give a physician to explain the effect of the ICD-10 transition on an individual's eligibility in the HCS and TxHmL programs](#).

Q: Can you describe what diagnosis to use when submitting claims, if the individual receiving services does not yet have a valid ICD-10 code?

A: You will be required to submit ICD-10 diagnosis codes on all claims for services delivered on or after Oct. 1, 2015. For services which are not directly related to a diagnosis, such as ICF/IID services, waiver services, and community care services, beginning Oct. 1, 2015, up to the date of a person's IPC, DADS contracted service providers may use the following diagnosis code for claims submissions: Z76.89 (persons encountering health services in other specified circumstances).

Q: Just for clarification, do we need all new IDRCs for CLASS and ICF regardless of when their current IDRC expires to be able to bill starting October1?

A: No. All ID/RC submissions for forms effective on or after Oct. 1, 2015, must contain valid ICD-10 codes only. However, you do not have to make changes until the time of the renewal, or if there is a significant change in the person's status that would warrant a new ID/RC. Beginning on October 1, 2015, you may use Z76.89 as a transitional code on claims.

Q: Please explain why two IDRCs for new enrollments for the months of Jun-Aug are required. Why are the two different coding systems necessary for these months only?

A: Two ID/RCs are required for new enrollments during these months because it is unknown when the effective date of an ID/RC will be. Once an ID/RC is submitted, DADS Utilization Management and Review must review the form. Then they may approve the form, deny it, or request more information prior to approving it. Because the effective date is unknown, in order to assist providers from having to go back and obtain a new ID/RC if they have submitted the wrong version, DADS is directing them to fill out two ID/RCs at the time of submission, one with an ICD-9 code and one with an ICD-10 code, each one attested to by a physician.

Q: Since DSA's will submit 2 ID/RC's for approval between June and October, will the CMA submit both copies of the ID/RC to DADS with IPC renewals or revisions?

A: A CLASS CMA or DBMD provider should include an ID/RC reflecting ICD-9 coding when the enrollment effective date is prior to October 1, 2015. If the effective date of the enrollment IPC is October 1, 2015, or later, the submitter of the enrollment packet must include an ID/RC reflecting ICD-10 coding. The submission of both ID/RC versions will not result in remands from DADS PE/UR. Renewal ID/RCs do not require 2 forms. For renewals, the ICD version will be driven by the effective date.

Q: Are the ICD-10 codes currently available?

A: Yes. CMS has a list of all of the ICD-10 codes. You may also be able to find the codes at various sites online.

Q: What are you doing for authorizations that are already in place but expire after October 1 with the ICD-9 code. Are new authorizations going to be issued?

A: Authorizations are not automatically going to be issued in the new code version. CLASS and DBMD providers must submit ID/RCs with effective dates on or after Oct. 1, 2015, with valid ICD-10 codes only. However, CLASS and DBMD providers do not have to make changes until the time of the renewal, or if there is a significant change in the person's status that would warrant a new ID/RC.

Q: What is the time frame for how long code Z76.89 can be used, and will this be accepted by all carriers?

A: You may use Z76.89 on claims from October 1, 2015 through October, 1, 2016. DADS advises providers to use an individual's valid ICD-10 code once it has been established for claims.

Q: Will there be a related condition diagnosis list?

A: You may find the list of conditions, recognized by DADS which qualify an individual as having a related condition and the corresponding ICD-10 codes at, <http://www.dads.state.tx.us/providers/guidelines/icd10-codes.pdf>.

Q: Does the DSA RN fill out the IDRC and take it to the PMD? Or does the family take the completed IDRC to the PMD?

A: The DSA or DBMD provider is responsible for ensuring that the ID/RC is filled out correctly, and that it has the correct ICD code version. If the ICD-10 code is a direct conversion from the original ICD-9 code, there is no need to get a physician to sign the ID/RC. If there is not a direct conversion (meaning the individual will have diagnosis and associated code) DSAs and DBMD providers must have a physician provide a new ICD-10 code and attest to the diagnosis by signing the ID/RC.

Q: Are we required to submit an IDRC with ICD-10 coding for enrollments already made this month - June?

A: If you submitted the ID/RC with an ICD-9 code prior to [Information Letter No.15-36](#) being published on June 11, 2015, then you do not need to submit a new ID/RC. However, you will need to submit a new ID/RC next year with a valid ICD-10 code. If you submitted an ID/RC after June 11, 2015, with an ICD-9 code, you will need to submit an ID/RC with an ICD-10 code.

Q: Is there a testing schedule, and if so, what is it? Do you have an open testing?

A: Testing is an important part of the ICD-10 transition. DADS and Accenture have remediated all of the systems used by DADS providers and have been conducting internal testing. If you use a third party billing system or have any specific questions about testing, please contact ICD10@dads.state.tx.us.

Q: Are there ICD-10 webinars that are just for LTC nursing home facilities, and what they need to do for the transitioning of ICD-10?

A: DADS is not holding any webinars specific to NFs; however, there are many resources available on the internet. The DADS ICD-10 Training Resources webpage provides helpful information that may be of interest to you. (<https://www.dads.state.tx.us/providers/icd10/training.html>) DADS updates this website as resources and information becomes available. CMS.gov is a good source for information and resources for providers of nursing facilities.

Q: Do we have to convert all ICD-9 to ICD-10 codes on the system as of 9/31?

A: No. All ID/RC submissions made on or after Oct. 1, 2015, must contain valid ICD-10 codes only. However, you do not have to make changes until the time of the renewal, or if there is a significant change in the person's status that would warrant a new ID/RC. You may use Z76.89 as a transitional code on claims.