Connecticut Department of Social Services
Medical Assistance Program **Provider Bulletin PB 2015-47**
www.ctdssmap.com **July 2015**

TO: All Providers

RE: 1) ICD-10 Related Explanation of Benefit (EOB) Codes in Connecticut Medical Assistance Program (CMAP)
2) Fee Schedule Updates for ICD-10 Diagnosis Codes

The U.S. Department of Health and Human Services (HHS) has finalized October 1, 2015 as the new compliance date for health care providers, health plans, and health care clearinghouses to transition to International Classification of Diseases, 10th Revision (ICD-10) Code Sets. On October 1, 2015, the ICD-9 code sets used to report medical diagnoses and inpatient procedures will be replaced by ICD-10 code sets.

ICD-10 consists of two parts:

- ICD-10-CM for diagnosis codes
- ICD-10-PCS for inpatient procedure codes. This will impact only Inpatient Hospital claims.

1) ICD-Related Explanation of Benefit (EOB) Codes in Connecticut Medical Assistance Program (CMAP): The Department of Social Services (DSS) will be implementing certain new EOB codes in CMAP to comply with the ICD-10 mandate. Certain edits for ICD-10 will apply across all claim types, whereas others will be relevant for specific claim types.

One of the global edits to be implemented with ICD-10 will not allow both an ICD-9 and ICD-10 code to be billed on the same claim. If services provided span the ICD-10 implementation date, providers must split their claims to either submit with ICD-9 codes or ICD-10 codes based on the date of service. The date span logic will be explained in a future bulletin. Furthermore, ICD-10 implementation requires certain global billing changes. The ID code qualifier for ICD-10 codes is different than the ID code qualifier for ICD-9 codes. Providers need to be aware of the correct ID code qualifier to be submitted for the different ICD versions. These billing changes were communicated to providers in Provider Bulletin 2014-20. Providers are urged to refer to **PB 2014-20 for further information on this topic.** If your claims are submitted by a clearinghouse or a Value Added Network (VAN), it is your responsibility to ensure your billing agency is making changes to be compliant with the ICD-10 changes by October 1, 2015.

Following is a list of new EOB codes that will set on claims with the implementation of ICD-10 in CMAP:

EOB Codes Applicable to all Claim Types:

485 – Diagnosis codes must be all same code set

492 – ICD9 diagnosis code qualifiers after ICD10 implementation date

4027 – Diagnosis code not covered for date of service

4039* – The primary diagnosis code is not covered

**During ICD-10 testing being conducted by HP, it was discovered that several provider test claims hit edit 4039. Providers need to follow coding guidelines and not submit a diagnosis code that has been classified an unacceptable principal diagnosis code as the principal diagnosis on their claims. External causes of morbidity codes, manifestation codes, and nonspecific codes are just some examples of codes that cannot be used as principal diagnoses.*

EOB Codes Applicable to Professional Claim Types:

760 – Condition Code restriction for billed procedure

4042 – Third diagnosis code is not on file (New for Professional Claims)

4043 – Fourth diagnosis code is not on file (New for Professional Claims)

4047 – Fifth diagnosis code is not on file (New for Professional Claims)

4951 – Condition code restriction for billed ICD procedure code under provider contract

4991 – Condition code restriction for billed procedure under provider contract

EOB Codes Applicable to Institutional Claim Types:

486 – ICD surgical procedure code must be same code set (Inpatient Claims only)

487 – ICD DX and surgical procedure must be same code set (Inpatient Claims only)

488 – ICD surgical procedure not allowed on outpatient claim

491 – ICD9 surgical code qualifier submitted after effective date (Inpatient Claims only)

760 – Condition Code restriction for billed procedure

4048 – Claim sixth diagnosis code is not on file (Inpatient Claims only)

4049 – Claim seventh diagnosis code is not on file (Inpatient Claims only)

4050 – Claim eighth diagnosis code is not on file (Inpatient Claims only)

4051 – Claim ninth diagnosis code is not on file (Inpatient Claims only)

4067 – Non-covered ICD procedure code (Inpatient Claims only)

4252 – One or more of diagnosis codes 10 through 24 are not on file (Inpatient Claims only)

4951 – Condition code restriction for billed ICD procedure code under provider contract

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HP will maintain a list of the ICD-10 related EOB codes as an ICD-10 related Frequently Asked Question (FAQ) available from the ICD-10 Important Message posted on the Home page of our Web site www.ctdssmap.com. The list will be supplemented with additional EOB codes if necessary. Please make it a point to refer to the Important Message frequently to keep up to date with ICD-10 related news.

2) Fee Schedule Updates for ICD-10 Diagnosis Codes: DSS has updated references to specific diagnosis codes related to Policy in the Provider Fee Schedule Headers, Footers and Fee Schedule Instructions. These documents now list both ICD-9 and ICD-10 diagnosis codes. Fee Schedules can be accessed and downloaded from the Connecticut Medical Assistance Program Web site www.ctdssmap.com. From this Web page, go to "Provider", then to "Provider Fee Schedule Download" and Click on the "I accept" button. Fee Schedule Instructions are available at the top of the next page and the various provider Fee Schedules are listed alphabetically by provider type.

If you have any questions regarding this bulletin, please contact the HP Provider Assistance Center Monday through Friday from 8:00 a.m to 5:00 p.m. at 1-800-842-8440.