Frequently Asked Questions

OHIO DEPARTMENT OF MEDICAID August 30, 2019

Diagnosis Code Requirement for Claims

(Effective 1/1/2020)

On 10/1/2018, the Ohio Department of Medicaid (ODM) announced diagnosis codes will be required on claims. ODM had previously allowed for a small subset of Medicaid covered services - for example, some transportation services and many home and community-based waiver services — for which a claim can be submitted without a diagnosis code. Because this exemption does not comply with current Health Insurance Portability and Accountability Act (HIPAA) standards, it is being discontinued. (Note, dental claims (837D) are exempt from this requirement and do not require a diagnosis code.)

As of 1/1/2020, all new Ohio Medicaid claims and all adjustments submitted for previous paid claims, regardless of date of service, must include a valid diagnosis code to be accepted for processing. This document has been created to help address any questions providers may have regarding the new diagnosis requirement.

For more information, please see MAL 626-A (revised September 2, 2019) posted at:
https://www.medicaid.ohio.gov/RESOURCES/Publications/ODM-Guidance#161542-medicaid-policy

What is a diagnosis code and why is it required?

- Diagnosis codes are used in healthcare as a tool to group and identify diseases, disorders, symptoms, poisonings, adverse effects of drugs & chemicals, injuries and other reasons for patient encounters.
- Diagnosis codes are published by the International Classification of Diseases, currently using version 10 (ICD10).
- HIPAA requires a diagnosis code to be included on the claim forms for healthcare services rendered.

What is considered a valid diagnosis code?

- When a claim is processed for payment, using the date the service was rendered, the diagnosis code is checked to see if it is active and included in the ICD10 code set for that date.
- The ICD10 diagnosis codes are updated effective October 1 every year.

Does the new diagnosis code requirement impact the current Medicaid rates?

- No. The Medicaid reimbursement is not changing with this requirement.

What if my claim is not compliant with the 1/1/2020 effective date?

- Your claim will not be processed for payment and will be rejected or denied.

When submitting claims on or after 1/1/2020, will diagnosis codes be required on claims with dates of service on or prior to 12/31/2019?

- Yes. Diagnosis codes will be required for all claims (and adjustments) submitted to ODM on or after 01/01/2020, regardless of date of service. There will not be a transition period.
- Examples:
  - A claim submitted on 1/15/2020 with a date of service of 9/10/19 will require a diagnosis code
  - A claim submitted on 9/1/2019 with a date of service of 7/1/19 will not require a diagnosis code
  - A claim that was previously paid in 8/2019 for dates of service in 5/2019 that is being adjusted on or after 1/1/2020 will now require a diagnosis code although it previously paid without a diagnosis code.

What happens if I start including a diagnosis code on my claim prior to 1/1/2020?

- Providers are encouraged to start using diagnosis codes prior to 1/1/2020. Their claims will be processed for payment. However, the diagnosis code used on the claim will need to be valid.

My claims are submitted through the Medicaid MITS web portal. Will they require a diagnosis code?

- Yes. The same requirements will be applied to both electronic and web portal claims.

What if I submit my claims using a Clearinghouse/Billing service, what do I need to do?

- The diagnosis code will need to be included in the claim information you provide the clearinghouse/ billing service vendor.
- You should also ensure your vendors will be ready to accommodate a diagnosis code from you.
- You may want to consider sending test claims to ensure their readiness.
- You should contact your clearinghouse/billing Service directly to determine their readiness and potential for testing with them, if it's needed.

When reporting a diagnosis code on a claim, do I have to use the diagnosis pointer field?

- Yes. Diagnosis code validation edits on professional claims are based on diagnosis pointers and the 5010 X12 837P standard also allows for the pointer to be used with diagnoses codes.
- Examples of the detail-level diagnosis pointers are shown in the appendix to this document.

What diagnosis code should I use?

- Diagnosis codes should be based on documentation included in the medical record.
- If you are a service provider, you must research the codes that will apply to your business.
- You may want to seek the advice of a professional coder.
- Providers are permitted to bill with a miscellaneous diagnosis code.

Where do I get an ICD10 diagnosis code for my claim?

- Unfortunately, Ohio Medicaid cannot answer coding questions. Providers that know the appropriate diagnosis code must enter it on their claim.
- Questions about which diagnosis to report should be directed to the ordering/referring/prescribing provider associated with a claim.
- You may want to seek the advice of a professional coder or participate in ICD-10 coding training.
- For some providers, a diagnosis is not related to the service provided (e.g., transportation by wheelchair van), so there is no need to know a diagnosis code. In these rare cases, ODM recommends that the provider choose an appropriate diagnosis code for the service. For example, diagnosis code Z41.8 (entered without the period as Z418) indicates an "encounter for other procedures for purposes other than remedying health state."

What do I need to do to prepare for the 1/1/2020 effective date?

- Providers can begin preparing by taking the following steps:
  - If you use a billing service or clearinghouse, start talking with them about their ability to accept diagnosis codes from you, and ensure updates will be installed for the effective date.
  - If you work with a case management agency, start talking with them about identifying the diagnosis code to be used on a claim.
  - If you are providing services from an ordering physician, start talking with them about getting the diagnosis code to be used on a claim.
  - Determine if billing forms, billing software, or any documents used when receiving orders need to be updated for compliance to include diagnosis codes.

What do I do if I am a provider of Medicaid home and community-based waiver services?

- **For Ohio Home Care Waiver providers**, however, diagnosis is not related to the waiver service provided, so there is no need to know a diagnosis code. In these cases, ODM recommends the provider choose an appropriate diagnosis code for the Ohio Home Care Waiver service:
- Examples:
  - Diagnosis code Z41.8 indicates an “encounter for other procedures for purposes other than remedying health state, unspecified” and
  - Diagnosis code R69 indicates “illness, unspecified.”
- Ohio Home Care Waiver providers should direct any questions related to claims submission to the Medicaid Provider Hotline at 1-800-686-1516.

Do dental claims require a diagnosis code?

- Dental providers that bill on a dental claim do not require a diagnosis code.
- FQHC dental services billed on a professional claim format (837P) are required to include a diagnosis code.
- Dental services rendered by non-dentists and reported on a professional claim format (837P) are required to include a diagnosis code.

Do pharmacy claims require a diagnosis code?

- Pharmacy claims submitted to the Ohio Medicaid point of sale vendor are excluded from this requirement.
- Claims which include drugs submitted on the 837 Institutional or 837 Professional claim format will require a diagnosis.
- Pharmacy billing procedures are posted at: https://pharmacy.medicaid.ohio.gov/pharmacy-billing-information.

What if you submit your claims to the Ohio Department of Developmental Disabilities (DODD) for waiver services (Level One, Individual Options, and SELF.)?

- This correspondence does not apply to providers who only submit claims through DODD's Medicaid Billing System (MBS).
- If you have further questions about MBS billing, it's recommended to contact the DODD Claims Services Unit by either:
  - Telephone: 800-617-6733, option 2; or
  - Email: dodd.support@dodd.ohio.gov

What if you submit your claims to the Ohio Department of Aging (ODA) for waiver services (PASSPORT and Assisted Living)?

- This correspondence does not apply to providers who only submit claims through ODA's Medicaid Billing System.
- If you have further questions about billing, please contact ODA at Provider_Inquiry@age.ohio.gov.

Will the Managed Care Plans require diagnosis codes on their claims?

- Managed Care Plans (MCPs) are required to comply with the diagnosis code changes.
- Each MCP may have specific requirements for billing; therefore, providers are encouraged to contact the MCP with whom they contract for specific billing information.

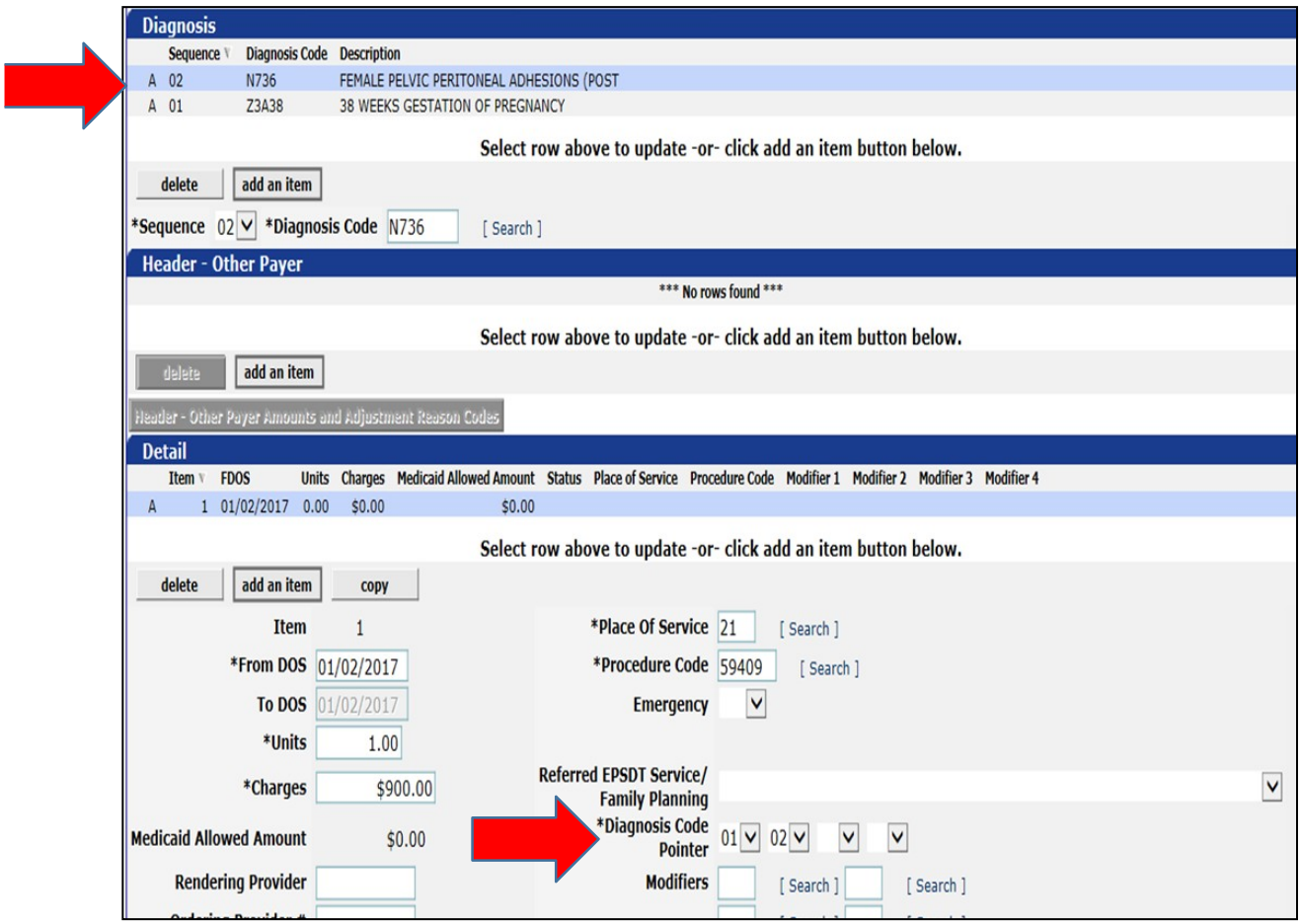
Additional Information?

- Questions pertaining to this FAQ should be addressed to:
  - Telephone: (800) 686-1516; or
  - Email: HomeHealthPolicy@medicaid.ohio.gov or NONINSTITUTIONAL_POLICY@medicaid.ohio.gov

APPENDIX

Professional Claim Pointer Examples

Example 1 - Ohio Department of Medicaid Web Portal



Example 2 - X12 837P Transaction
(For trading partners and providers who submit EDI claims)

SEGMENT DETAIL

HI - HEALTH CARE DIAGNOSIS CODE

X12 Segment Name: Health Care Information Codes

X12 Purpose: To supply information related to the delivery of health care

Loop: 2300 — CLAIM INFORMATION

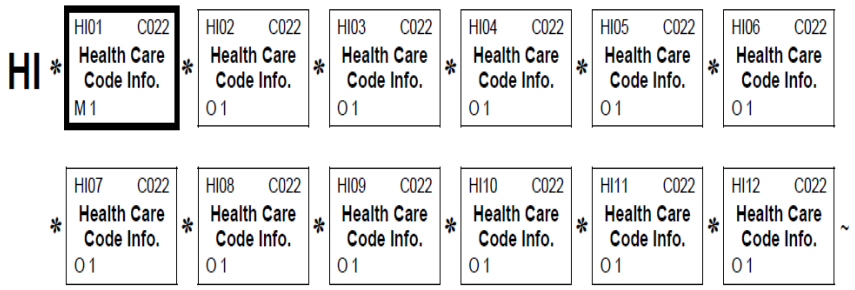
Segment Repeat: 1

Usage: REQUIRED

TR3 Notes: 1. Do not transmit the decimal point for ICD codes. The decimal point is implied.

TR3 Example: HI*BK:8901*BF:87200*BF:5559~

DIAGRAM



SEGMENT DETAIL

SV1 - PROFESSIONAL SERVICE

X12 Segment Name: Professional Service

X12 Purpose: To specify the service line item detail for a health care professional

X12 Syntax: 1. P0304
If either SV103 or SV104 is present, then the other is required.

Loop: 2400 — SERVICE LINE NUMBER

Segment Repeat: 1

Usage: REQUIRED

TR3 Example: SV1*HC:99211:25*12.25*UN*1*11**1:2:3**Y~

DIAGRAM