DSM 5 and ICD-10

Community Care is sending this Provider Alert to answer some of the questions that contracted providers may have about implementation of the new code sets, ICD-10 and DSM 5. This Alert will provide a high level overview of the way that Community Care will be implementing these changes. It is important to note that the Department of Public Welfare has not published its guidance on ICD-10 and so the information in this Alert may be amended at that point.

ICD-10

ICD-10 will be required as of October 1, 2014 for all covered entities. The Federal government has stated that all state Medicaid agencies must be using these new codes as of that time frame. Therefore Community Care will be asking providers to bill using the new codes for all services with a service date of October 1, 2014 or later. If you have a claim for a service that occurred prior to October 1, 2014, you may bill after that date with the ICD-9 code set.

If an entity is billing with the ICD-9 code set for claims as described above, the electronic claims will have an indicator “9” or “0” which will alert the claims system which code set to use. Community Care will accept claims with the “9” indicator until October 1, 2016.

After October 1, 2014, all entities that are billing Community Care will need to be able to submit the ICD-10 codes on the claims regardless of whether they are a covered entity or not.

DSM 5

DSM 5 was published in May, 2013 and effectively does away with the concept of a multi-axial diagnosis for behavioral health disorders. However, given the requirement for changes in a variety of systems to ones that do not require the multiple axis values, Community Care is not going to accept the DSM 5 codes for the purposes of clinical review until October 1, 2014. This means that when staff are completing information for Community Care review, submitting authorization requests or any type of BHRS packet, the full diagnosis will be defined as the DSM IV code set, including all 5 axes. In addition, as described above, claims submissions for services prior to October 1, 2014 must use DSM IV (ICD-9) diagnoses.
General Information and FAQ

- ICD-10 and DSM 5 are complimentary since DSM 5 uses the ICD-10 coding standards. ICD-9 and DSM IV are similarly complementary.
- While the mapping between the two set is not quite 100%, it is very close. The APA has stated that mapping will continue to move closer with ICD-11 and DSM 5.
- Once ICD-10 and DSM 5 code sets are in place, Axis 2 and Axis 3 will no longer be required. Therefore providers should ensure that their billing systems can assure that the primary diagnosis on the claim forms are behavioral in nature. Claims billed to Community Care with a primary medical diagnosis will be rejected.
- Both ICD-10 and DSM 5 provide an opportunity for the code to express much more specificity about a person’s clinical presentation. It is Community Care’s expectation that providers will use the full specificity in their clinical coding.

Below are some guidance points that were created by the Federal government to help providers get ready for ICD and DSM coding changes:

1. Establish a transition team or DSM 5/ICD-10 project coordinator, depending on the size of your organization, to lead the transition to DSM 5/ICD-10 for your organization.
2. Develop a plan for making the transition to DSM 5/ICD-10 that includes:
   - timeline that identifies tasks to be completed;
   - crucial milestones/relationships;
   - task owners;
   - resources needed;
   - estimated start and end dates.
3. Determine how DSM 5/ICD-10 will affect your organization. Start by reviewing how and where you currently use DSM IV/ICD-9 codes. Make sure you have accounted for the use of DSM IV/ICD-9 in authorizations/pre-certifications, physician orders, medical records, interim billing, encounter forms, practice management and billing systems, and coding manuals.
4. Review how DSM 5/ICD-10 will affect clinical documentation requirements and electronic health record (EHR) templates. Make sure that your EHR documents will still work without the 5 axis paradigm.
5. Communicate the plan, timeline, and new system changes and processes to your organization, and ensure that leadership and staff understand the extent of the effort the DSM 5/ICD-10 transition requires.
6. Develop a plan to train all clinical staff responsible for developing diagnoses.
7. Secure a budget that accounts for software upgrades/software license costs, hardware procurement, staff training costs, revision of forms, work flow changes during and after.