Overview:

1. Goals
   a. Accuracy – it's more complicated than just a one-to-one translation from ICD-9 to ICD-10
   b. Completeness
      - Only one valid code for each child is needed for billing/reimbursement, BUT…
      - Coding **all** pertinent conditions (developmental, medical, social/behavioral) is important to fully justify the services we provide and to provide data for future EI Branch planning
   c. Consistency
      - Limited guidance from Branch in past has caused each CDSA to develop its own coding procedures; this was not necessarily wrong, just often incomplete
      - Movement away from a "medical model" has left few medical staff in CDSAs, leaving many without medical expertise to be able to code thoroughly
      - Uniformity in coding will allow us to obtain clear data for use in future programmatic planning, monitoring, funding, staffing, etc.

2. All CDSAs – state & contract - must begin coding per these guidelines **by October 1, 2015**.
   a. *Individualization/modifications at the local level are not permitted.*
   b. HIS will accept EITHER an ICD-9 or ICD-10 code between September 8th and 30th. It will automatically bill with the ICD-9 code until October 1st.
   c. Services underline occurring before October 1st must be billed using old ICD-9 codes and procedures – even if the bill is submitted after October 1st. HIS will maintain ICD-9 capability for at least 6 months.
   d. Services occurring on and after October 1st require ICD-10 codes.

3. All **currently-enrolled** children will need to have their ICD-9 codes converted to ID-10 codes.
   a. HIS cannot do a code conversion automatically – a person needs to open each child's chart in HIS and manually assign a new code in place of each old code.
   b. "Catch-up" assignment and entry of ICD-10 codes for children already enrolled also needs to be done between September 8 and October 31st.
   c. Due to the large burden of date entry, it is acceptable to enter only 1-2 applicable codes for children already enrolled in EI. (Completeness should be the goal for those entering on/after October 1).
   d. Because some knowledge of clinical information is needed, this task should be assigned to medical staff and other clinicians, NOT clerical or billing staff.

4. Going forward from October 1st, each CDSA should decide which staff members are responsible for reviewing records and assigning codes from the "Cheat Sheet" provided.
   a. This task should primarily be done by clinicians/evaluators; some CDSAs may assign this to selected supervisors or intake EISCs as well.
   b. Due to the complexity of code conversion and the multiple descriptors used in HIS, it is NOT recommended that billing staff do code entry in HIS. This introduces another point of error.

5. Medical staff should be consulted for any code that is NOT listed on the "Cheat Sheet" or any time there are questions.
   a. See list of "Coding Consultants" – primary and back-ups – for each CDSA.
   b. See list of contact information for each: most prefer to be contacted by email first.
   c. Send email with "Code?" in subject line and as many details as possible in the message.

6. **Code medical diagnoses ONLY if they are documented in records**.
   a. Each CDSA may choose to accept a *very limited number* of diagnoses based *only* on a referral form (for instance, birth weights and gestational ages reported by NICUs).
   b. Gold standard: Medical records to document every Established Condition, and at least some records obtained on every child so that potential Established Conditions are not missed. CDSAs are encouraged to educate their referral sources on the importance of sending pertinent records.
   c. *Example*: IUGR must be *documented in records*, not calculated from birth weight/gestational age.

7. Licensed clinicians may prefer to follow coding guidance from their professional associations.
   a. This practice is *not encouraged*, but it is acceptable.
   b. **If** clinicians use alternate coding practices, enter those codes only on your *individual* progress note- NOT the **Diagnosis** screen.

8. Future Plans for Ongoing Updates of Codes in HIS- Implementation Date TBA (2016-2017)
   a. Entering of codes resulting from discipline-specific evaluations by private providers in the community, especially when they are providing ongoing treatment.
   b. Entering of relevant medical codes when children receive new diagnoses during their enrollment (for instance, an infant with increased muscle tone upon entry later gets diagnosed with cerebral palsy, or a child who enters with language delays and later is diagnosed with autism).

General Tips for Using the Diagnosis Input function in HIS:

1. Evaluators/clinicians should input diagnoses as soon as possible after initial/entry evaluations are completed – preferably the same day. Billing staff should *not* do these entries.
   - Suggested order: Log into HIS, input the diagnoses using the Diagnosis module, write your Ambulatory Progress Note (including diagnoses from the drop-down boxes) and finally, complete initial COS form.
   - Codes need to be inputted even if the assessment is non-billable (i.e. child with Established Condition who receives assessment only).
2. Non-medical CDSA staff should only use codes on the "Cheat Sheet". Consult medical staff if other codes are needed, including coding more specifically for general codes when medical info is available.
   - Up to 12 codes may be inputted for each child, so use ALL codes that apply
   - In billing subsequent services or TCM, up to four codes can be used for each billing note
3. *Diagnosing Practitioner:*
   - If one person of a 2-person evaluation team is submitting all the codes, he/she can enter his/her own name for all *general* codes.
   - If *discipline-specific* codes are being submitted, make sure those diagnoses are linked to the appropriated licensed clinician on the evaluation team.
   - If a medical record review is done by a physician or extender to assign medical codes, then tag those codes with the *medical staff* person's name.
4. Do not use "P" (perinatal) codes as "Primary" on children >12 months of age. The claim will be denied.
   - Choose either a developmental delay code or an applicable medical diagnosis as *Primary.*
   - If no other codes are applicable – use **Z00.70** (per Medicaid)
   - P-codes should still be entered into HIS at *any* age to provide data on the child's risk factors, however. (P codes are in red on the Cheat Sheet to highlight this.)
5. Make sure to hit SUBMIT after entering diagnoses (before leaving the page) or they will not "stick"