State Medicaid Manual
Part 11 - Management Information System

Department of Health and Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

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HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
11375	11-3-17 - 11-3-20 (4 pp.)	11-3-17 - 11-3-20 (4 pp.)

EFFECTIVE DATE: Upon Implementation of ICD-10

This transmittal contains language-only changes for updating to ICD-10 language in the State Medicaid Manual. There are no new policies in his transmittal. Specific related policy changes have been announced previously in various communications.

Section 11375 Data Requirements is updated to include ICD-10-CM diagnosis codes and ICD-10-PCS procedure codes.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

57. Laboratory Service Authorized Code:
A code indicating the services/procedures that a laboratory which meets the requirements for participation in Medicare is authorized to perform.

*58. Physician Identification:
a. Attending Physician Number
The provider number of the physician attending an inpatient in a hospital, nursing home, or other institution.

This is the physician primarily responsible for the care of the patient from the beginning of this institutional episode.

**b. Operating Physician
This is the physician who performed the principal procedure. See Data Element No. 87 below, for definition of principal procedure.

59. Referring Physician Number:
The provider number of the physician referring a recipient to another practitioner or provider.

60. Prescribing Physician Number:
The provider number of the physician issuing a prescription.

*61. Principal Diagnosis Code:
a. The diagnosis code for the principal condition requiring medical attention.

**b. The condition established after study to be chiefly responsible for causing the patient's admission to the hospital for care for the current hospital stay. (*The CMS* requires the acceptance of ICD-CM cod*es*)

62. Other Diagnosis Code:
a. The diagnosis code of any condition other than the principal condition which requires supplementary medical treatment.

**b. Conditions (up to four) other than the principal condition that coexisted at the time of admission, or developed subsequently, which affected the treatment received and/or the length of stay. Exclude diagnoses that relate to an earlier episode which have no bearing on this hospital stay. (*The CMS* requires the acceptance of ICD-CM cod*es*)

*63. Admission Date:
The date a recipient was admitted to a medical institution.

64. Beginning Date of Service:
The date upon which the first service covered by a claim was rendered. If a claim is for one service only (e.g., a prescription), this is the only service date.

65. Ending Date of Service:
The date upon which the last service covered by a claim was rendered.

*66. Discharge Date:
The formal release of an inpatient from a hospital.

67. Place of Service:
A code indicating where a service was rendered by a provider.

*68. Patient Number:
Any number assigned by a provider to a recipient or claim for reference purposes, such as a medical record number.

69. Patient Status:
A code indicating the patient's status on the last date of service covered by an institutional claim.

70. Total Claim Charge:
The sum of all charges associated with an individual claim.

71. Units of Service:
A quantitative measure of the services rendered to, or for, a recipient (e.g., days, visits, miles, injections).

72. Third Party Payment Amount:
The amount of payment applied toward a claim by third party sources.

73. Medicare Cash Deductible Amount:
The unmet Medicare deductible subject to payment by Medicaid.

74. Medicare Blood Deductible Amount:
The unmet Medicare deductible for blood subject to payment by Medicaid.

75. Medicare Coinsurance Charge:
The Medicare coinsurance amount subject to payment by Medicaid.

76. Medicare Reasonable Charge:
Payment amount recognized as the reasonable charge for Medicare.

77. Medicaid Co-Payment Amount:
The portion of the claim charge which the recipient must pay, called coinsurance when expressed as a percentage of the payment amount.

78. Prior Authorization Control Number:
A number that uniquely identifies a particular instance of prior authorization.

79. Payment Amount:
The computed amount of payment due a provider for a claim transaction.

80. Date of Adjudication:
The date a claim is approved (or partially approved) or disallowed.

81. Error Code:
A code indicating the nature of an error condition associated with that claim transaction.

82. Date Entered Suspense:
The date a claim transaction was initially suspended.

83. Payment Date:
The date a payment instrument was generated for a claim transaction.

84. Allowable Procedure Payment:
The maximum allowed amount payable for a particular medical procedure, treatment, or service item.

85. Professional Fee:
The amount allowed to a dispenser of drugs as compensation for his professional services.

86. Prescription Number:
The number assigned by a pharmacist to a prescription at the time it is filled.

87. Procedure Codes:
Codes identifying medical procedures (i.e. accept and use exclusively the HCPCS in a physician or outpatient setting). (For an inpatient setting, ICD-9-CM Volume 3 is recommended *for discharges before implementation of ICD-10, and ICD-10-PCS coding is recommended for discharges upon implementation of ICD-10.*)

**a. Principal Significant Procedures:
When more than one procedure is reported, designate the principal procedure. In determining which of several procedures is the principal, apply the following criteria:

(1) The principal procedure is the one which was performed for definitive treatment rather than performed for diagnostic or exploratory purposes, or was necessary to take care of a complication.

(2) The principal procedure is that procedure most closely related to the principal diagnosis.

**b. Other Significant Procedures:

(1) One which carries an operative or anesthetic risk, requires highly trained personnel, or requires special facilities or equipment.

(2) Up to four significant procedures can be reported.

(HCFA requires the acceptance of ICD-9-CM coding *for discharges before implementation of ICD-10, and requires ICD-10-PCS coding for discharges upon implementation of ICD-10.*)

88. Drug Code:
Codes identifying particular drugs; e.g., National Drug Code, drug tables.

89. Diagnosis Code:
A table of codes identifying medical conditions; i.e., ICD-9-CM *or ICD-10-CM*.

90. Drug Name:
The generally accepted nomenclature for a particular drug.

91. Drug Classification:
The therapeutic group in to which a drug is categorized.

92. Minimum Days Supply of Drugs:
The minimum units of a drug prescription eligible for payment.

93. Maximum Days Supply of Drug:
The maximum units of a drug prescription eligible for a particular drug.

94. Procedures Names:
The generally accepted nomenclature for medical, surgical, dental, etc., procedure.

95. Diagnosis Name:
The generally accepted nomenclature for a diagnosis. Name is required only if not encoded by provider. (See Data Element No. 6l.)

96. Unit of Measure:
The unit in which a drug is dispensed (e.g., cc, capsule, tablet).

97. Drug Cancellation Date:
The date after which a particular drug is no longer covered under the State Medicaid program.

98. Medicaid Reasonable Charge:
Payment amount recognized as the reasonable charge for Medicaid.

*99. Discharged Patient's Destination:
A code indicating a recipient's destination upon discharge from a medical institution.

a. Discharged to home (routine discharge).
b. Left against medical advice.
c. Discharged to another short term hospital.
d. Discharged to a long term care institution.
e. Died.
f. Other.

100. Billing Date:
The date a provider indicates a claim was prepared.