Frequently Asked Questions

1. Will both an SUD and MH diagnosis be required for a client who has co-occurring disorders?
   a. All relevant diagnoses for a recipient should appear in the clinical record.

2. Can a clinical record have more than one “principal diagnosis”?
   a. Yes, many recipients may have more than one principal diagnosis that is the basis for treatment. However, when billing Medicaid or other third party insurances only the diagnoses relevant to the services provided would be utilized on the billing claim.

3. Will there be changes to the regulations prior to Oct. 1 that govern clinical record requirements and grantee provider requirements?
   a. Yes, the Division in general intends to revise regulation to accomplish the following:
      i. Adopt both the DSM-5 and the ICD-10 as diagnostic standards of reference
      ii. Adjust service criteria where indicated to be compatible with the selected diagnostic standards of reference (e.g. assessments)
      iii. Modify various definitions (e.g. SED)

4. Will grantee providers be allowed a transition period to make changes to clinical records?
   a. Providers may begin immediately including DSM-5 / ICD-10 diagnostic codes in clinical records.
   b. However, any new clinical record opened prior to Sept. 30, 2015 is still required to have a DSM-IV diagnosis.
   c. Any service provided before Oct. 1, 2015 must be linked to a DSM-IV diagnosis
   d. The most important fact related to the conversion process is that all services provided after Oct. 1 must have an ICD-10 diagnosis for billing claims, and the clinical record must include documented evidence to support that diagnosis.
   e. Providers may include this documentation prior to October 1; or, at the first service after Oct. 1; or at the next scheduled client status review (if the review occurs after Oct. 1 providers should not have billed for any service provided between September 30 and the date of the client status review)
5. Will grantee providers be required to re-assess all current recipients in all levels of care before Oct. 1, 2015?
   a. No. However, any service provided after Oct. 1 will need to be supported by an ICD-10 diagnosis.
   b. To meet this requirement, agencies may update assessments; use cross-walks; or reassess a recipient as indicated to determine the appropriate ICD-10 diagnosis.
   c. Providers may request a Service Authorization for additional assessments that need to be conducted prior to the six-month service limit.

6. How are grantee providers expected to transition clinical records documentation related to assessments and treatment plans, etc.?
   a. The assessment and treatment plan used in support of a service provided after October 1 must include evidence to support the ICD 10 diagnosis included on a billing claim.
   b. Agencies should develop procedures to guide their staff for making changes to clinical records documentation. Options include: reviewing and/or updating the assessment, using a crosswalk, or begin to use both DSM-IV / ICD-9 and DSM-5 / ICD-10 code sets for new assessments and treatment plans.
   c. An ICD 10 diagnosis code will be required on all billing claims with dates of service that occur after October 1.
   d. All Service Authorizations and Service Authorization updates submitted after Oct. 1 (with all dates of service to occur after October 1) must be submitted with an ICD 10 diagnosis code.

7. Will the DSM-5 still be required for assessments, treatment plans, and progress notes after Oct. 1?
   a. Providers will still be required to identify a recipient diagnosis in assessments, treatment plans and progress notes. However, they will have the option to use codification from any one of the diagnostic standards referenced in regulation.
   b. After October 1, AKAIMS will transition to using only ICD-10 codes for all new client records.

8. Will grantee providers still be required to assess for functional impairment?
   a. Yes.
   b. [Provider discussion about Functional Assessment tools]
9. Should ICD-10 “Z” codes related to psychosocial issues be used in the clinical record?
   a. Providers should use the “Z” codes as applicable, like any other relevant diagnosis that is the focus of a recipient’s condition and treatment.

10. Where can Providers access information about the continuing updates to both the DSM-5 and the ICD-10, and which versions will the Division require on October 1, 2015?
   a. Providers may obtain information on current updates to the DSM-5 through the American Psychiatric Association.
      [www.psychiatry.org/practice/dsm]
   b. Providers may obtain information on current updates to the ICD-10 through the Centers for Medicare & Medicaid Services.
   c. The Division will utilize whatever versions are in effect on Oct. 1, 2015.
   d. All ICD-10 updates will automatically be reflected in AKAIMS.

11. Can ICD-10 codes be used in the clinical record prior to Oct. 1?
   a. Providers may utilize ICD-10 codes within clinical records prior to Oct. 1.
   b. However, any clinical record opened prior to Oct. 1 will still require a DSM-IV diagnosis.
   c. Keep in mind that ICD-10 coding will not be available within AKAIMS until after September 1, 2015.

12. How are grantee providers expected to code Medicaid billing after Oct. 1, 2015 for services provided before that date?
   a. As you know, Providers have up to one year from the date of service to bill Medicaid for any service provided to an eligible recipient.
   b. Billing must include the diagnosis relevant at the time the service was conducted.
   c. For services provided prior to October 1, 2015 but billed to Medicaid after that date Providers would use the proper ICD-9 code.

13. How should grantee providers manage current Service Authorizations for services that will extend past Oct. 1?
   a. Service Authorizations submitted prior to Oct. 1 should include the relevant diagnoses as they currently appear in the clinical record.
   b. Providers are encouraged to include both DSM-IV-TR and ICD-10 codes if both are known.
c. The Division will not require any Service Authorizations approved prior to Oct. 1 to be resubmitted with new ICD-10 diagnosis.

14. What will the new diagnosis format look like in AKAIMS?
   a. The new diagnostic screens in AKAIMS will utilize only ICD-10 codes
   b. There will be three drop-down boxes: Principal behavioral health diagnosis; Medical Diagnosis; Psychosocial Information (“Z” codes).
   c. To the right of each of the three drop-down diagnostic boxes there will be a free-form text box to record any other relevant diagnostic impressions, comments, or issues.

15. Will recipient diagnosis automatically change in AKAIMS for all clinical records on October 1?
   a. No. Providers will be responsible for updating new diagnosis information for each clinical record prior to conducting any service after Oct. 1.
   b. Providers will still have access for one calendar year to the DSM-IV / ICD-9 diagnoses for all records currently opened in AKAIMS before COB September 30, 2015. After Sept. 30, 2016 providers will no longer be able to make modifications to any DSM-IV / ICD-9 diagnosis in any clinical record.
   c. Because documentation may lag behind the actual date of service delivery Providers must choose the correct diagnosis for data entry based upon the delivery date of each service (e.g. A service delivered September 28, but documented October 2 would require the relevant DSM-IV / ICD-9 diagnosis that appeared in the clinical record on September 28).
   d. Only ICD-10 diagnoses should be used with any new record opened in AKAIMS after Oct. 1

16. Will Medical codes be available for use in AKAIMS?
   a. Medical codes will be available within AKAIMS, but their inclusion in the clinical record is optional and not required.
   b. However, Providers are encouraged to reflect any known medical conditions that may have an effect on behavioral health treatment and recovery.

17. Will the GAF Score still be used?
   a. The Global Assessment of Functioning scale will no longer be required as part of a recipient’s diagnosis.
   b. However, a free-form numerical box for a GAF score will still appear in AKAIMS as an option for Providers who still wish to use it.
18. Besides the changes to the ICD codes will there be any other changes to AKAIMS minimal data set requirements, or changes to any other data reporting requirements?
   a. At this time changes to data reporting requirements is an unknown factor.
   b. The Division will keep all Providers informed of any new developments as they occur.

19. What training will the Division offer to grantee providers related to DSM-5 and ICD-10?
   a. The Division intends to collaborate with the Alaska Behavioral Health Association to potentially provide training on the DSM-5.
   b. Zerox intends to provide training on the ICD-10 and billing claims information.
   c. The Division will provide training on regulation revisions and clinical records documentation requirements including data entry changes to AKAIMS.
   d. The Division will also share information as it becomes available on other sources of training that Providers and individual professionals might access on their own.

20. Will the Division or Health Care Services publish a current cross-reference of ICD-9 and ICD-10 and DSM-5 codes?
   a. No, these cross-walks are readily available through other sources.