DMHAS-EQMI

SPECIAL FOCUS QUALITY ALERT NEWSLETTER

January 2019

ICD-10 Diagnosis Codes for Supportive Housing Programs

Supportive housing programs are required to collect ICD-10 diagnostic information on the clients they serve. Supportive housing levels of care are considered to be Targeted Case Management (TCM) providers, which is why this diagnostic information is required. Depending on how a provider submits data to DMHAS (either through file upload or direct data entry), will dictate any process changes that may need to occur in order to now capture this valuable information.

DHMAS has partnered with Nutmeg (the vendor who manages the Homeless Management Information System, HMIS) regarding this new requirement. Nutmeg has already updated the HMIS software to include the ICD-10 diagnosis field(s) to be mandatory.

The following outline guides you through the four potential scenarios:

1) For providers who submit data to DMHAS via direct data entry into DDaP and diagnostic information is **not** available at time of admission
2) For providers who submit data to DMHAS via direct data entry into DDaP and diagnostic information **is** available at time of admission
3) For providers who submit data to DMHAS via file upload through respective EHR **or** a Nutmeg generated file and diagnostic information is **not** available at time to of admission
4) For providers who submit data to DMHAS via file upload through respective EHR **or** a Nutmeg generated file and diagnostic information **is** available at time of admission

Providers who submit data to DMHAS via direct data entry into DDaP:

DDaP Axis Default Field

When entering client data into DDaP directly, you will note under the "Axis I Diagnoses" section on the Diagnosis page, that the Axis I diagnosis automatically pre-populates to:

"799.9 Other unknown and unspecified cause"

This diagnosis serves to be a placeholder for situations when a client's diagnostic information is not readily available at admission. Please adhere to the following steps, depending on whether the diagnostic information is available at intake or not:

*If a client's diagnostic information is **NOT** available at admission:*

- In DDaP: You will be allowed to leave "799.9 Other unknown and unspecified cause" as the ***temporary*** diagnostic place holder in order to complete the admission in DDaP. However, you will be required to obtain the Axis I diagnosis information post-admission. Once this information is obtained, you will be required to re-visit the Diagnosis page in DDaP for the respective client, and remove "799.9 Other unknown and unspecified cause" as the primary diagnosis and then manually enter the correct diagnosis instead. Remember to check the green check box to indicate the Axis I diagnosis entered is the primary diagnosis.
- In HMIS: Similarly, you may populate the HMIS diagnostic field(s) with 799.9 in order to submit the initial admission data. However, you will be required to obtain the Axis I diagnosis information post-admission and re-visit the HMIS diagnostic field(s) to enter the correct diagnosis.

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Providers who submit data to DMHAS via direct data entry into DDaP (continued):

*If a client's diagnostic information **IS** available at admission:*

- In DDaP: You will remove the pre-populated "799.9 Other unknown and unspecified cause" as the primary diagnosis and then enter the correct diagnosis. Remember to check the green check box to indicate the Axis I diagnosis you entered is primary.
- In HMIS: You will enter the correct Axis I diagnosis information in the required diagnostic fields.

Providers who submit data to DMHAS via a file upload through EHR or a Nutmeg generated report:

Your Electronic Health Record (EHR) submits data directly DDaP via a file submission. However, it is still necessary for the provider to enter a valid ICD-10 diagnosis into the respective EHR software so that DDaP can be supplied with the information.

*If a client's diagnoses information is **NOT** available at admission:*

In this scenario, you will be allowed to leave "799.9 Other unknown and unspecified cause" as the ***temporary*** diagnostic place holder in order to complete the admission in the EHR. However, the provider will be required to obtain the Axis I diagnosis information post-admission. Once this information is obtained, the provider will be required to re-visit the Diagnosis fields in their respective EHR and remove "799.9 Other unknown and unspecified cause" as the primary diagnosis. The correct diagnosis must then be entered.

*If a client's diagnoses information **IS** available at admission:*

In this scenario, the provider will enter the correct ICD-10 diagnosis in the diagnostic fields of their respective EHR. This information will then be uploaded to DDaP via a file submission in accordance with already established process and timelines.

We certainly appreciate your time and attention to this matter. For any assistance with this new procedure, please contact EQMI Behavioral Health Program Manager Michael Girlamo, at michael.girlamo@ct.gov, or at (860)418-6919. Thank you.