1. **With regard to targeted case management, do any of these new codes relate to TCM?**

No, targeted case management would actually be a procedure code, a CPT code it identifies the actual procedure/service, and those CPT codes are not affected by ICD-10. However, when you submit any kind of claim for targeted case management or anything else to Medicaid or private payer, the claim form also requires a diagnosis code. It describes the condition(s) of the client or for whom you are providing the service. That diagnosis code must be an ICD 10 starting October 1, 2014.

1. **With regard to children with developmental delay, how does that play into the ICD-10 code?**

If a child is eligible with an established condition, states usually have a list of conditions, sometimes with corresponding codes. For children who are eligible by virtue of developmental delay, and you are submitting any kind of claim for speech therapy, occupational therapy, TCM, etc. there has to be a diagnosis code. Some states use different approaches. There are different codes that are applicable for children even without an established condition. We’ll look at those in a bit as “billing codes.”

1. **Is there going to be a period when both codes will be present because of the time periodfor everyone to get their systems updated?**

Yes, but for claiming/billing, remember, there is no grace period. There will be such periods, however, because you can submit claims for services beyond the actual date of service.

1. **We send Medicaid claim file on the weekly basis. In each file, it will contain hundreds or thousands of claims. Assume that we need to submit a claim filed on 10/2/14. This file may contain claims with service date of 9/28/14 and claims with service date of 10/2/14. Should we use ICD-9 for services dated 9/28/14 and ICD-10 for services dated 10/2/14 in this single claim file?**

Yes, you should use ICD-9 for services dated before 10/1/14, and ICD-10 for those with dates of services on or after 10/1/14. However, you may not be able to submit those on a single claim. Medicaid and other payers, like BCBS, talk about “splitting the bill/claim” – so you should definitely talk with your State Medicaid office and other payers.

1. **These changes apply to the form (claim)? Not the 837 electronic file? The 837 would have to be able to support comingling of service dates.**

Not sure. Again, I suggest you check with your State Medicaid office.

1. **Is anyone preparing their general assembly for reduced revenue? (from CT)**

Maureen – as Robin and Kim both said, even if not at the state level, if providers aren’t prepared and have a cash flow problem, then that will likely become a problem for you at the State level. That’s why it’s important for you to make sure your local programs are prepared for this.

You need to be talking with your budget agency, your budget analyst about potential for reduced revenue. Be proactive on this issue and its potential impact on service provision. CMS says to expect increased pends or denials. There’s just no way around it. Any time there is a major systems change, such as with the implementation of the ACA, it brings a degree of chaos and confusion.