Diagnosis Code Requirements for a Professional Claim (837P)

Information posted September 15, 2016

Per federal regulation, a valid diagnosis code has been required on all claims forms submitted for payment, including the 837P professional claims form. A contracted provider delivering medical or health-related services to an individual who has a qualifying medical condition should use a diagnosis code specific to the individual when submitting claims for those services. For dates of service up to and including September 30, 2015, an *International Classification of Diseases*, Ninth Revision (ICD-9) code is required. For dates of service on or after October 1, 2015, an *International Classification of Diseases*, Tenth Revision (ICD-10) code is required.

Claims submitted to the Texas Medicaid & Healthcare Partnership (TMHP) through TexMedConnect or Electronic Data Interchange (EDI) without a valid diagnosis code may reject after October 1, 2016, and may be subject to recoupment if discovered during federal payment reviews conducted in 2017.

Previous communications (Department of Aging and Disability Services *Information Letter 15-59*) allowed the use of ICD-10 Diagnosis Code Z76.89 (Persons encountering health services in other specified circumstances) when an individual's service is not directly linked to a specific diagnosis (e.g., Community Attendant Services, Day Activity Health Services, Primary Home Care, Home Delivered Meals, Emergency Response Services, Family Care, Adult Foster Care, and Special Services to Persons with Disabilities). This code remains valid and may be used where appropriate.

For more information, call the LTC Help Desk at 1-800-626-4117, Option 1.