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ICD-10 Frequently Asked Questions (FAQs)

Compliance Date: October 1, 2015

Q: What is ICD-10?

A: The International Classification of Disease tenth revision (ICD-10) is a system of codes that provide detail on various medical records including diseases, symptoms, abnormal findings and external causes of injury.

The ICD-9 code sets used to report medical diagnoses and inpatient procedures will be replaced by the ICD-10 codes for services provided on or after October 1, 2015. ICD-9 diagnosis and inpatient procedure codes cannot be used for services provided on or after this date.

Q: Why is the ICD-10 transition important?

A: ICD-10 codes will provide more data about a patient's medical condition(s) and hospital inpatient procedure(s). ICD-9 is 30 years old and many of the terms are outdated and obsolete. ICD-10 will allow for more specificity when describing a patient's diagnoses and in classifying the inpatient procedures.

Everyone covered by the Health Insurance Portability and Accountability Act (HIPAA) must be ICD-10 compliant starting on October 1, 2015.

Q: What is the difference between ICD-9 and ICD-10?

A: The ICD-10 codes are vastly different form the ICD-9 codes. ICD-9 codes are mostly numeric and have 3-5 characters compared to ICD-10 codes which are alphanumeric and contain 3-7 characters. ICD-10 is more robust and descriptive. One ICD-9 code may have many ICD-10 matches.

Q: What happens if I am unable to switch to ICD-10?

A: Claims for all health care services and hospital inpatient procedures performed on or after October 1, 2015, must be billed using ICD-10 codes. Claims that do not include ICD-10 codes will be denied.

Q: What should providers do to prepare for the ICD-10 transition?

A: Providers should test ICD-10 several months prior to the transition date to help ensure they will be ready by the compliance date. Plan to test claims, eligibility verification, quality reporting, and other transactions and processes that involve ICD-10 codes from beginning to end. It is important to test both within your organization and with your payers.

Beginning steps in the testing phase include:

- Establish an ICD-10 team and assign a project coordinator
- Develop a plan for making the transition
- Determine how ICD-10 will impact your organization
- Review how ICD-10 will impact clinical documentation requirements and health record templates
- Communicate the plan with your organization
- Talk with your payers, billing and IT staff about their preparations and readiness

Q: Where can I obtain more information?

A: http://www.cms.gov/ICD10
http://www.ahima.org/ICD10/default.aspx
http://www.dhcs.ca.gov/formsandpubs/laws/hipaa/Pages/1.08%20ICD-10.aspx

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Q: How will this change impact me?

A: If you do not submit the appropriate ICD code based on the service date for authorizations (receipt date), claims and encounters in relation to the 10/1/15 compliance date, it can affect the timeliness of claim submissions, increase rejections, and impact your revenue potential. Also, this change will impact Quality of Care measures, HEDIS, consumerism reporting, patient mix statistics, care management and data capture for other statistical reporting and disease management.

Q: I have an authorization already approved by GCHP that expires after 10/1/15. Do I need to submit a new authorization request for the time period after 10/1/15?

A: No, if you have an approved authorization that expires after 10/1/15 already in place, you do not have to do anything. If you need to submit a new request once the authorization expires, it will need to be submitted with the appropriate ICD-10 code.

Q: What ICD code do I use to submit a prior authorization request for a service that is scheduled on or after 10/1/15?

A: If the request is submitted prior to 10/1/15 for services prior to 10/1/15, an ICD-9 code needs to be used. If the request is submitted on or after 10/1/15 for services incurred on or after 10/1/15, an ICD-10 code needs to be used. Regardless if this is an outpatient, inpatient or concurrent stay, the same rules still apply. The provider is ultimately responsible for translating the ICD-9 codes previously used to the correct ICD-10 code.

Q: The claim(s) I submitted were denied. Why?

A: Please make sure that you submit your claims with the appropriate ICD code set for the date of service in question as this may be the primary reason for the denial. However, the claim(s) could have been denied for several different reasons. Please be sure to review all denial reason If your claim was denied for invalid coding, please correct and re-submit using the GCHP corrected claim form. The form is accessible via this link: http://goldcoasthealthplan.org/providers/resources.aspx#forms

Q: I resubmitted the corrected claim(s) with the appropriate ICD code and it was still denied. What can I do?

A: Follow the current Provider Dispute Resolution process.

The Provider Dispute Resolution Form can be found on the GCHP website under Provider Resources at the following link: http://goldcoasthealthplan.org/providers/resources.aspx#forms

Please complete and mail it to the address located on the form.

Q: Can I submit claims prior to 10/1/15 with ICD-10 codes?

A: No. You cannot submit ICD-10 codes for services rendered prior to 10/1/15.

Q: What steps have been/will be taken to prevent claims from being inappropriately denied due to ICD-10 coding or mapping problems, causing cash flow interruptions.

A: GCHP is requiring providers to submit claims with the appropriate diagnosis code set based on date of service. Claims with dates of service prior to 10/1/15 must be submitted with ICD-9 coding. Claims with dates of service on or after 10/1/15 must be submitted with ICD-10 coding. Claims that span the compliance date of 10/1/15 must be split into separate claims (see question #15).

Q: When claims are adjudicated under ICD-10, do you expect to maintain ICD-9 levels of timeliness in adjudication, i.e. for a similar clinical encounter, will the ICD-10 claim be adjudicated in the same timeframe as was the ICD-9 claim? if not, what differences do you expect? Will timeliness of adjudication be part of your testing?

A:
- Crossover claims - Crossover claims received from DHCS are for dually eligible Medicare/Medi-Cal members. Claims will be received and processed by Medicare with ICD-10 codes. It is our expectation that ICD-10 codes will be passed to GCHP in that format.
- Secondary claims - The expectation is that the provider is submitting claims to GCHP with the appropriate code set based on the date of service, regardless of what code set the primary carrier accepted.

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Q: How do I bill if the dates of service span the 10/1/15 Compliance Date?

A: For claims that span the compliance date of 10/1/15, claims must be split. Providers must submit one claim using ICD-9 codes for services dated prior to 10/1/15 and submit a separate claim using ICD-10 codes for service dates on or after 10/1/15. The exception to this split billing requirement is for hospitals whose reimbursement is based on APR-DRG. GCHP is currently identifying a process for billing APR-DRG claims that span the compliance date and will provide updated information in the future.

Q: Will you be updating your on-line or fax forms? If so, when? Will your updated forms replace the current forms (combined ICD-9 & ICD-10) or will it be an additional form? If you have two forms, are there timeline restrictions for the use of either form?

A: GCHP will be updating all on-line pre-authorization request forms by 10/1/15 to reflect ICD- 10.

Q: Is there a website for ICD-10 codes that help providers/billers determine which codes are billable and which are not?

A: Once DHCS has updated their provider manual with non-billable ICD-10 codes, GCHP can update the list of non-billable codes previously communicated to providers.

Q: If my physician works in an inpatient setting, will professional codes change?

A: Procedure codes used to bill for professional services are not changing. ICD-9 PCS and ICD-10 PCS codes are used by hospitals when billing inpatient services on a UB 04 claim form to designate what procedure(s) were performed during the hospital stay. If you currently bill for professional services using CPT or HCPCS codes, you will continue to do so after 10/1/15.

Q: How will this impact any coverage and billing related to behavioral health?

A: For questions related to behavioral health coverage and/or billing, please refer to the Beacon Health Strategies (BHS) website site: http://www.beaconhealthstrategies.com/DSM5ICD10/Default.aspx or call BHS at 855-765-9702 for information.