ICD-10 Frequently Asked Questions

Below are some frequently asked questions (FAQs). Please refer to this FAQ often as updates will be made regularly. Last updated 11/30/2015.

The US Department of Health and Human Services (HHS) has mandated the replacement of the ICD-9-CM code sets used by medical coders and billers to report healthcare diagnoses and procedures with ICD-10 codes, effective Oct. 1, 2015.

Q. What is the difference between ICD-10, ICD-10-CM, and ICD-10-PCS?
A. ICD-10 is frequently used as a catch-all term for ICD-10-CM (clinical modification) and ICD-10-PCS (procedural coding system), but most often refers to ICD-10-CM. ICD-10-CM is the medical diagnosis codes used for outpatient and inpatient services. There are approximately 69,000 ICD-10-CM codes, compared to approximately 13,600 ICD-9-CM codes.

ICD-10-PCS codes are used for inpatient services. There are approximately 71,000 ICD-10-PCS codes.

Q. Where can I find the ICD-10 codes?

Providers can purchase ICD-10 Codebooks through various vendors.

Q. Can you give an example of how ICD-10 is more specific than ICD-9?
A. Consider that there are four ICD-10 codes described on the following table that match the ICD-9 code for "hematuria," as derived from the General Equivalency Mappings (GEMs). Notice that the ICD-10 codes are more specific than the general 599.70 code used in ICD-9.

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>599.70 - Hematuria (blood in urine)</td>
<td>R31.0 - Gross hematuria</td>
</tr>
<tr>
<td></td>
<td>R31.1 - Benign essential microscopic</td>
</tr>
</tbody>
</table>
ICD-10 Frequently Asked Questions

<table>
<thead>
<tr>
<th>hematuria</th>
</tr>
</thead>
<tbody>
<tr>
<td>R31.2 - Other microscopic hematuria</td>
</tr>
<tr>
<td>R31.9 - Hematuria, unspecified</td>
</tr>
</tbody>
</table>

This example is from the "Hematuria" ICD-10 index listing. There are many more matches to "hematuria" in the official ICD-10 coding manuals (more than 20 total); however, these matches are not included in the GEMs. It is important to refer to both the coding manuals and the GEMs to identify the proper code assignment.

Q. Who will be responsible for making sure providers use the correct codes?
A. Providers must be responsible for their own quality by becoming familiar with the code sets and guidelines to be sure the correct codes are assigned. For more supporting information, please see the CMS Web site: http://www.cms.gov/Medicare/Coding/ICD10/Index.html

Q. Does ICD-10 apply to all providers in Connecticut Medical Assistance Program (CMAP)?
A. All providers who currently use ICD-9 codes in their transactions will be affected by the transition to ICD-10. The transactions include claims as well as Prior Authorization requests. Burden of the transition to ICD-10 rests primarily on providers classified as “Primary providers.” These healthcare providers are responsible for diagnosing, prescribing and/or ordering medical services. The primary providers are responsible for conveying the diagnosis codes to “Ancillary providers” when they order, prescribe or refer clients to these providers. Affected ancillary providers include but are not limited to:
- Home health agencies
- Case managers
- Durable medical equipment (DME) providers
- Transportation providers
- Laboratories
- Radiology providers
- Waiver providers
- Therapists

Q: Are my claims impacted by ICD-10 changes in CMAP?
ICD-10 Frequently Asked Questions

A: ICD-10-PCS impacts only Inpatient Hospital claims. ICD-10-CM, on the other hand, has a much wider impact. Noted below are the select few claims and/or provider types in CMAP that do not require diagnosis codes.

Currently, CMAP does not require a diagnosis code on dental claims unless procedure code is D9920 (Behavior Management)

The following provider types or provider types/specialties that bill on the professional claim format do not require a diagnosis code to be submitted on the claim:

- DME/Medical Supply Dealer (Provider Type 25)
- Transportation (Provider Type 26)
- Radiology (Provider Type 29)
- CHC/Access Agency/CHC Billing Provider (Provider Type/Specialty 57/541)
- CHC/CHC Service Provider (Provider Type/Specialty 57/544)

*Please note: If any of the above providers submit their claims with diagnosis codes, they will be subject to ICD-10 editing.

Q. Is CMAP planning to allow a grace period after October 1, 2015, for submitting claims that contain ICD-9 codes and have dates of service (DOS) on or after the implementation date?

A. No. There are no exceptions. Claim submissions with dates of service (DOS) on or after October 1, 2015, must use ICD-10 codes. By the same token, a claim submission with a DOS before October 1, 2015, must use ICD-9 codes. This includes adjustments and resubmissions. Claims may not be submitted with a combination of ICD-9 and ICD-10 codes. Each claim must have only one ICD code set as dictated by the DOS.

Q. Will CMAP accept claims with both ICD-10 and ICD-9 codes?

A. CMAP will accept claims only if ICD-9 and ICD-10 are submitted on separate claims. A claim submitted with both ICD-9 and ICD-10 codes will reject. This will be effective October 1, 2015.

Q. What has changed on the CMS-1500 claim form as a result of ICD-10? When will the form be published and available for use?

A. The 1500 Health Insurance Claim Form (version 02/12) draft form is available from the National Uniform Claim Committee (NUCC) Web site. The 1500 Health Insurance Claim Form Change Log (2/17/2012) details all the changes proposed to the form. The
ICD-10 Frequently Asked Questions

Form will require a qualifier entry to differentiate between ICD-9 and ICD-10 claims. Hewlett Packard Enterprise has published provider bulletin PB13-83 that outlines the changes to the revised CMS-1500 form as well as the implementation timeline. To access the bulletin, click on the following link: Provider Bulletin PB13-83.

Q. Does ICD10 claim testing require a special setup?
A. Test claims are submitted just as though they were production claims, but are marked as “test” in the ISA15 segment of the 837 electronic claim formats.

Q. What type of response will I get from testing using ICD10?
A. An ICD10 testing coordinator will notify you by email or telephone the compliance results of the test file/claims. No 999 is created; however, upon request, paper remittances containing the accepted test claims will be emailed to the submitter.

Q: Will the Provider Manual be updated to reflect ICD-10 changes and available for review prior to the ICD-10 implementation date?
A: The Provider Manual is currently under review and will be published in advance of the ICD-10 implementation date. Prior to this publication please review the CMS General Equivalency Mapping (GEM) for further guidance on billing with ICD-10.

CMS GEM

Q: May I continue to use my vendor software after the ICD-10 federal mandate date?
A: If your software vendor has made the necessary changes for ICD-10 you may continue to use your vendor software. Please contact them to verify the changes have been made.
ICD-10 Frequently Asked Questions

Q: Will other payers be ready to implement at the same time as Connecticut Medicaid?
A: The ICD-10 implementation date is a CMS federal mandate and all health plans must comply with the October 1, 2015 implementation date.

Q: Will CMAP be implementing new Explanation of Benefit (EOB) Codes with the implementation of ICD-10?
Yes, following is a list of new EOB codes that will set on claims with the implementation of ICD-10 in CMAP:

**EOB Codes Applicable to all Claim Types:**

485 – Diagnosis codes must be all same code set
492 – ICD9 diagnosis code qualifiers after ICD10 implementation date
4027 – Diagnosis code not covered for date of service
4039* – The primary diagnosis code is not covered

* This EOB will initially be set to “Post and Pay” in CMAP instead of denying the claims in order to offer providers additional time to evaluate their code usage and select a more appropriate diagnosis on future claims. Providers need to follow coding guidelines and not submit a diagnosis code that has been classified an unacceptable principal diagnosis code as the principal diagnosis on their claims. External causes of morbidity codes, manifestation codes, and nonspecific codes are just some examples of codes that cannot be used as principal diagnoses.

**EOB Codes Applicable to Professional Claim Types:**

760 – Condition Code restriction for billed procedure
4042 – Third diagnosis code is not on file (New for Professional Claims)
4043 – Fourth diagnosis code is not on file (New for Professional Claims)
4047 – Fifth diagnosis code is not on file (New for Professional Claims)
4951 – Condition code restriction for billed ICD procedure code under provider contract
4991 – Condition code restriction for billed procedure under provider contract

**EOB Codes Applicable to Institutional Claim Types:**

486 – ICD surgical procedure code must be same code set (Inpatient Claims only)
487 – ICD DX and surgical procedure must be same code set (Inpatient Claims only)
488 – ICD surgical procedure not allowed on outpatient claim
491 – ICD9 surgical code qualifier submitted after effective date (Inpatient Claims only)
ICD-10 Frequently Asked Questions

760 – Condition Code restriction for billed procedure
4048 – Claim sixth diagnosis code is not on file (Inpatient Claims only)
4049 – Claim seventh diagnosis code is not on file (Inpatient Claims only)
4050 – Claim eighth diagnosis code is not on file (Inpatient Claims only)
4051 – Claim ninth diagnosis code is not on file (Inpatient Claims only)
4067 – Non-covered ICD procedure code (Inpatient Claims only)
4252 – One or more of diagnosis codes 10 through 24 are not on file (Inpatient Claims only)
4951 – Condition code restriction for billed ICD procedure code under provider contract
4991 – Condition Code restriction for billed procedure under provider contract

The list will be supplemented with additional EOB codes if necessary.