healthfirst
Health Insurance for New Yorkers

Frequently Asked Questions (FAQs)

ICD-10 CODING

On **October 1, 2015**, the International Classification of Diseases, 10th Edition, or ICD-10, replaced ICD-9, the previous set of diagnosis and procedures codes. As a provider, vendor, biller, or administrator, Providers need to ensure that they bill with the appropriate codes to avoid denials.

1. What has changed with ICD-10?

ICD-10 uses 3–7 digits, up from the 3–5 digits used with ICD-9. As a result, ICD-10 allows for more detail and specificity in diagnosis and classification. These codes are used to identify symptoms and conditions, shorten patient chart information, note complaints and social circumstances, and more.

2. How are claims affected?

All claims submitted with dates of service (DOS) after **October 1, 2015**, must use ICD-10 codes. Combinations of ICD code versions must not be submitted together on a claim. Providers are expected to utilize the appropriate ICD qualifier (Diagnosis Type Code within the ASC X12 v5010 standard), which Healthfirst uses to distinguish between ICD-9 and ICD-10 code submissions. This means that if the qualifier indicates ICD-9, then the code must be a valid ICD-9 code; if the qualifier indicate ICD-10, then the code must be a valid ICD-10 code. Mixing the qualifiers and diagnosis codes will result in your claim being denied.

These guidelines are very important, as any claims submitted without the appropriate code versions will be denied.

3. What qualifier should be used for ICD-10 diagnosis codes on electronic claims?

For X12 837P 5010A1 claims, the HI01-1 field for the Code List Qualifier Code must contain the code “ABK” to indicate the principal ICD-10 diagnosis code being sent. When sending more than one diagnosis code, use the qualifier code “ABF” for the Code List Qualifier Code to indicate up to 11 additional ICD-10 diagnosis codes that are sent.

For X12 837I 5010A1 claims, the HI01-1 field for the Principal Diagnosis Code List Qualifier Code must contain the code “ABK” to indicate the principal ICD-10 diagnosis code being sent. When sending more than one diagnosis code, use the qualifier code “ABF” for each Other Diagnosis Code to indicate up to 24 additional ICD-10 diagnosis codes that are sent.

For NCPDP D.0 claims, in the 492.WE field for the Diagnosis Code Qualifier, use the code “02” to indicate an ICD-10 diagnosis code is being sent.

4. How can denials be avoided?

Code Correctly - All claims submitted with dates of service (DOS) after October 1, 2015 must only include ICD-10 codes.

Don't Combine Code Versions - Combinations of ICD code versions (ICD-9 and ICD-10) must not be submitted together on a claim.

Use the correct ICD-10 Qualifier Code - Claims with ICD-10 diagnosis codes must use ICD-10 qualifiers. More information on qualifier codes for ICD-10 can be found here.

5. How should claims that span the ICD-10 implementation date be billed?

CMS has guidance for providers:

- MLN Matters Special Edition Article SE1408 - Medicare FFS Claims Processing Guidance for Implementing ICD-10. A Re-Issue of MM7492• .
- MLN Matters Special Edition Article SE1325 - Institutional Services Split Claims Billing Instructions for Medicare FFS Claims that span the ICD-10 Implementation Date.•
- MLN Matters Special Edition Article SE1410 - Special Instructions for ICD-10 Coding on Home Health Episodes that span October 1, 2015.•

6. Is Healthfirst using a crosswalk for claims processing?

No, we will not use a crosswalk for claims processing. Standard transactions with dates of service as of **October 1, 2015**, must be submitted with ICD-10 codes. After that date, Healthfirst will process claims submitted with ICD-9 codes **only for dates of service (outpatient) or dates of discharge (inpatient) prior to October 1, 2015.**

7. What happens if a claim does not have an ICD-10 code?

If a claim does not include a compliant ICD-10 diagnosis for dates of service beginning **October 1, 2015**, the claim will be denied, with an explanation code stating "CLAIM DENIED: ICD- 9 AFTER TRANSITION – ICD-10 REQUIRED." **It is critical that all provider types include compliant and appropriate diagnosis codes on all claims forms (paper and electronic) as of October 1, 2015**.

8. What happens if a claim is billed with an ICD-10 code for a date of service before October 1, 2015?

The claim will be denied, with an explanation code stating "CLAIM DENIED: ICD-10 BEFORE TRANSITION – ICD-9 REQUIRED." A "corrected" claim will need to be submitted for reprocessing. Claims for dates of services provided before **October 1, 2015**, must be billed with a compliant ICD-9 diagnosis.

9. How is ICD-10 related to DSM tools for coding that Mental Health Providers use?

Version 5 of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) was released in May 2013 and took effect on January 1, 2014. As was the case with DSM-4, the codes within DSM-5 contain valid ICD-9 Clinical Modification (CM) codes that can be used to bill dates of service prior to **September 30, 2015**. Effective **October 1, 2015**, the ICD-10-CM codes are the official system that must be used. ICD-10-CM codes are already included in the DSM-5 and are listed in parentheses next to each disorder title. Simply use the codes listed in parentheses to code your diagnoses on health insurance claims for services rendered on and after the implementation date of **October 1, 2015**.

10. Does the ICD-10 conversion have an effect on provider reimbursement and contracting?

The ICD-10 conversion is not intended to transform payment or reimbursement. However, it may result in reimbursement methodologies that more accurately reflect patient status and care.

11. What can providers do to ensure compliance with ICD-10?

The ICD-10 conversion affects nearly all provider systems and many processes. The largest impacts will likely be on clinical and financial documentation, billing, and coding. It is important that providers ensure that their billing or software vendors are billing appropriately.

12. What is Healthfirst's approach to mapping ICD-9 codes to the ICD-10 codes?

CMS has provided General Equivalency Mappings (GEMs) as an approach to define reasonable alternatives for mappings between ICD-9 and ICD-10 codes in both directions. While the GEMs provide guidance and a starting point for crosswalk development, there is currently no industry standard for mapping. As such, we have contracted with an industry-reputed vendor with ICD-10 expertise to assist us with fine-tuning the crosswalk between ICD-9 and ICD-10 for benefit design.

13. Where can I find more information?

Visit www.healthfirst.org/ICD10 for tools and resources to help your practice during this transition, including a special edition of *The Source*, and links to educational videos and webinars.
You may also visit the ICD10 page from the Centers for Medicare & Medicaid Services (CMS) at www.cms.gov/ICD10, where you'll find implementation guides, references, job aids, and General Equivalence Mappings (GEMS, also referred to as crosswalks), which provide information linking code versions.

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Review listings of CMS ICD-10 Resources and Coding and Clinical Documentation Resources.