Frequently Asked Questions

Who is affected by the transition to ICD-10?
Everyone who is covered by Health Insurance Portability and Accountability Act (HIPAA) must transition to ICD-10 effective October 1, 2015. It is not just limited to Medicare.

Why is there a transition to ICD-10?

ICD-10 is a more advanced and robust system than ICD-9 that allows for complex and detailed reporting that better fulfills the needs of today's healthcare. The move to ICD-10 will increase the level of specificity available for research, public health and other purposes.

What should I do to prepare for the transition to ICD-10?

The Centers for Medicare & Medicaid Services (CMS) website, cms.gov, will help you prepare for this transition. The steps include assessing, budgeting, planning, communicating, training, implementing and monitoring.

What happens if I do not transition to ICD-10 Codes?

ICD-10 is federally mandated. If claims are not filed with ICD-10 codes, claims will be rejected and you will not be paid. The only exceptions are Worker's Compensation and Auto Liability claims, which may accept either ICD-9 or ICD-10; however they have said that they will be ICD-10 ready by October 1, 2015.

Is ICD-10 more difficult to use than ICD-9?

ICD-10 codes have a completely different structure than ICD-9 codes. ICD-9 codes are mostly numeric with three to five digits, and ICD-10 codes are alphanumeric with three to seven characters. The process of looking up codes will remain the same, but ICD-10 will require additional documentation that provides more information for the codes chosen, such as the external circumstances and the location of injury or accidents.

Can my billing coders manage ICD-10 codes?

Yes. However, coders can only code what is given to them. ICD-10 is more robust and may require additional patient-specific information. If the documentation you provide is not complete and does not provide the necessary information, you will be required to provide the coder with more details.

Can mapping systems, such as general equivalence mappings (GEMs), be used?

Many mapping tools do not drill deep enough for the fourth through seventh digits. Also, because there is not always a one-to-one mapping between ICD-9 and ICD-10, mapping tools cannot always provide the definitive code for a given situation.

What types of information will clients need to include in their documentation?
In general, you will need to include details such as laterality and ordinality. For specific conditions, requirements will vary; some examples for common conditions in family medicine include:

- Asthma: intermittent, mild persistent, moderate persistent, severe persistent?
- Fractures: Gustilo classification, type of fracture?
- Seizures: General or focal, what type, intractability?
- Pregnancy: Which trimester?
- Poisoning or toxic effect: Which substance?
- Ulcers: Which stage?

Can you submit ICD-9 and ICD-10 on a single claim?
Only one code set will be accepted on a single claim. For outpatient claims with a date of service September 30, 2015 and before, use code set ICD-9. For outpatient claims with a date of service of October 1, 2015 and forward use ICD-10. Systems or clients will be required to split claims by date to avoid mixing code versions.

Where can ICD-10 codes be found?
You can download a text file of all ICD-10 codes and descriptions from the CMS website:
http://www.cms.gov/Medicare/Coding/ICD10/2014-ICD-10-CM-and-GEMs-.html

Will there be a grace period for submitting ICD-9 claims after the deadline?
The Centers for Medicare & Medicaid Services (CMS) has stated that it will not accept claims using ICD-9 for discharges on or after October 1, 2015. From that date forward, only claims encoded using the ICD-10 code set will be accepted. Commercial payers and state Medicaid plans are also requiring providers to begin using the ICD-10 code set on October 1, 2015.