

CBAS – ICD-10 Transition Frequently Asked Questions September 2015

1. Q: Which diagnoses should be included for billing purposes, primary or all?
Which codes are reimbursements based on?

A: Once you convert existing ICD-9 codes to ICD-10, you should be able to use the same diagnostic codes you have in the past for billing purposes. In addition, the inclusion of number of codes depends on your billing software and which codes they use in billing files. If you bill manually on your clearing house website (i.e., create claims directly on their website) they should specify the number of codes needed and which ones should be used. There are various claims forms available through managed care plans, clearinghouses, etc., so be sure to check on their specific requirements when submitting your claims.

You should keep both code sets, ICD-9 and ICD-10, in order to be able to bill for service dates prior to October 1, 2015 (ICD-9) and beginning October 1, 2015 (ICD-10).

2. Q: In case of coding errors, what is the procedure for getting them corrected?
Will the managed care plan provide us a correct code? Will there be some latitude for coding errors during the transition period?

A: When there is an unbillable ICD code, generally the managed care plans will reject the claim altogether. You will need to either resubmit the claim with the corrected code, or call the managed care plan and request to reprocess the claim with a different code. The procedure will vary depending on the plan. Whether or not there will be any 'latitude' is up to each plan.

In order to identify correct billable codes, you can use ICD-10 coding resources (Such as websites/books) or consult with a billing/coding professional.

3. Q: I have found an incorrect conversion from ICD-9 to 10. I brought this to the attention of the programming company. They pointed to a governmental conversion that was incorrect. What can we do?

A: Most companies that provided ICD-10 mapping and/or ICD-10 crossroad materials used the GEMs mapping tool provided by CMS. This is a suggested mapping tool provided by CMS. Ultimately, the translation

of ICD-9 to ICD-10 codes should be verified by diagnosing medical professionals for the best accuracy.

4. Q: If the center is unable to obtain the ICD-10 codes from the participant physician,
(a) Can the center make its own selection? (b) Can the center address this at each reassessment, rather than all at once?

A: (a) If you are unable to obtain the ICD-10 codes from the participant physician, you can take different steps to obtain the necessary codes:

- Based on previous physician notes, your professional staff may be able to map to the new ICD-10 codes*
- Consult with your center's staff physician*
- Contact your managed care plan(s) to see if the physician is in their system and if they can assist you*
- Discuss with your software vendor how you can use your software to update the participant codes*

(b) Regardless of the participant reassessment timing, all claims for services provided beginning October 1, 2015, must be submitted with ICD-10 codes. Contact each of your contracting managed care plans for more direction regarding updating participant Individual Plans of Care (IPCs).

5. Q: What is the time frame for conversion of all IPCs to the new codes? Since they are not sent along with the bills, would it matter if they were converted as the 6 month authorization cycles occur rather than all at the same time on October 1st?

A: Check with your contracting managed care plan(s) to obtain further direction and ensure that you are following their procedures for IPC updates.

6. Q: How would you code for the participant that received the three day approval assessment at the end of September and is admitted on October 1, 2015?

A: For all services prior to October 1st, including the three assessment days, ICD-9 codes are required. For all services provided beginning October 1st, including assessment days, ICD-10 codes are required.

7. Q: Do we need to manually change the codes every time we bill them weekly? Can the clearing houses or health plans help us during this conversion period by having an automated conversion system?

A: Please consult your software company for information regarding the automation of the ICD-9/10 code conversion and its proper usage for claims and what your responsibility will be.

If billing manually, you must consult with you clearinghouse regarding any tools or support it may or may not provide to you for ICD coding.

8. Q: Is there a website/link where we can obtain ICD-10 codes?

A: Yes. Visit www.roadto10.org for more information.

9. Q: Where do we obtain the "cheat" sheet or the software or a hard copy of the most common CBAS ICD-10 conversions discussed during the webinar?

*A: You may access it by clicking on the following link:
<http://turbotar.com/icd10downloads.html>*

10. Q: There are a few different types of ICD-10 codebooks. Which one do you recommend for CBAS?

A: There are some codebooks available for providers with various specialties (e.g., Podiatry, Cardiology). However, CBAS participants have a variety of conditions not limited to a singular medical specialty.

We would recommend researching and reading reviews on ICD-10 coding materials and services. You want to focus on a codebook that is most user-friendly for your staff and will provide information regarding which codes are billable.