ICD-10 Frequently Asked Questions
Version 4 February 2, 2016

ICD-10 Compliance

Q1: What is ICD-10 Compliance?

In January 2009, HHS announced the implementation of ICD-10-CM and ICD-10-PCS. This ruling (CMS-0013-F, Health Insurance Portability and Accountability Act of 1996 (HIPAA) Administrative Simplification: Modifications to Medical Data Code Set Standards) mandates the replacement of the current ICD-9 coding structure to adopt the International Classification of Diseases, 10th Revision. This revision requires modifications to Clinical Modification codes (ICD–10–CM) for diagnosis related coding and the Procedure Coding System (ICD–10–PCS) used in inpatient hospital procedure coding.

On September 5, 2012, the United States Department of Health and Human Services (HHS) announced a one-year delay for the implementation of ICD-10.

On April 2, 2014, the Protecting Access to Medicare Act of 2014 (H.R. 4302) was passed. This legislation contained specific language that addressed ICD-10. This language prohibited the Department of Health and Human Services (HHS) from adopting the ICD-10 code set before October 1, 2015.

In July 2014, the Centers for Medicare & Medicaid Services (CMS) announced the new implementation date for ICD-10 compliance as October 1, 2015.

Q2: Will there be a grace period for accepting claims with ICD-9 codes for dates of service/dates of discharge on or after October 1, 2015?

No. DMAHS will comply with the HIPAA Modifications to Medical Data Code Set Standards as required by all covered entities. Please take the necessary steps to comply by submitting appropriate code sets based on documented dates.

Q3: What billing codes are affected by this transition?

The only codes impacted by the transition are codes previously known as ICD-9 Diagnosis Codes and ICD-9 Procedure Codes. ICD-9 Diagnosis codes are commonly used in all health care settings. ICD-9 Procedure Codes are only used in the Inpatient Setting. Beginning on October 1, 2015, claims with a date of service of 10/1/2015 and beyond or date of discharge of 10/1/2015 and beyond will need to use the appropriate ICD-10-CM (diagnosis) and ICD-10-PCS (Procedure Code).

The change to ICD-10 does **NOT** affect Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) coding for outpatient procedures.

Q4: Will DMAHS be ready for ICD-10?

DMAHS and DXC Technology have completed all technical and operational requirements to implement the new ICD-10 Code set. Claim submission and adjudication procedures have been tested internally and externally for ICD-10. In addition, DMAHS will continue to support ICD-10 external testing for providers who may not have completed their ICD-10 testing. Providers who need to test claim submissions in the ICD-10 format may utilize the DXC Technology (DXC) EDI Proof System. Instructions for testing can be found on the NJMMIS website: ICD10 Testing Newsletter Volume 24 No. 12. www.njmmis.com

Q5: How will the State determine the 'ICD compliance deadline' for inpatient hospital claims?

The 'ICD compliance date' for inpatient hospital claims shall be based upon 'date of discharge.'

Q6: When are providers required to report specific ICD-10-CM diagnosis codes to the NJFC/Medicaid Program?

The NJFC/Medicaid requirement to report specific diagnosis codes on claims for certain services shall not change. Providers must report a 'valid' ICD-10-CM diagnosis code that is HIPAA-compliant for claims with dates of service on or after October 1, 2015. ICD-9-CM diagnosis codes will be reported for claims with dates of service prior to October 1, 2015

Q7: Will DMAHS provide advanced payments?

DMAHS will not be issuing advance payments due to lack of provider readiness. It is the provider's responsibility to follow HIPAA guidelines surrounding the use of ICD-10 code sets. Failure to submit claims correctly will lead to denials and delay in payment.

Coding and Crosswalking

Q1: Where can I find a list of ICD-10 codes?

CMS maintains a complete list of ICD-10 codes by release year on their website. https://www.cms.gov/Medicare/Coding/ICD10

Q2: Is the State of New Jersey responsible for providing an ICD-10-CM diagnosis code that replaces or 'maps' to an ICD-9-CM diagnosis code that would have been reported prior to October 1, 2015?

No. The selection of appropriate ICD-10-CM diagnosis codes by providers is based on clinical information that is unavailable to the State of New Jersey. ***DXC Technology shall decline a provider's request for information concerning the mapping of an ICD-9-CM diagnosis code to an ICD-10-CM diagnosis code.***

Q3: What are the ICD-10 rules regarding the definition of a 'valid' ICD-10-CM code?

All claims with service dates on or after October 1, 2015 must report a **valid** ICD-10-CM diagnosis code. ICD-9-CM diagnosis codes shall be processed but denied for service dates on or after October 1, 2015. ICD-10-CM is composed of codes with 3, 4, 5, 6 or 7 characters. Codes with 3 characters are included in ICD-10-CM as the 'heading' of a category of codes that may be further subdivided by the use of 4th, 5th, 6th or 7th characters to provide greater specificity to the reported diagnosis.

A 3-character 'heading or header code' may be reported as a 'valid' ICD-10-CM diagnosis code only if the category is not further subdivided. However, in the majority of reporting situations, a 'valid' ICD-10-CM code will consist of code values with a greater number of characters to identify a diagnosis with the highest level of 'specificity.'

See the following example:

M87.0 Idiopathic aseptic necrosis of bone
M87.00 Idiopathic aseptic necrosis of unspecified bone
M87.01 Idiopathic aseptic necrosis of shoulder
M87.011 Idiopathic aseptic necrosis of right shoulder
M87.012 Idiopathic aseptic necrosis of left shoulder
M87.019 Idiopathic aseptic necrosis of unspecified shoulder

- ICD-10 code M87.00 is a **valid** ICD-10 code **because the category is not further subdivided.**

- ICD-10 code M87.01 is a subcategory, but an **invalid** ICD-10 code **because there are more detailed codes beneath it,** including M87.01**1**, M87.01**2** and M87.01**9**, in this example.

Q4: What on-line information is available for providers to select a valid ICD-10-CM diagnosis code?

Many providers interchange the terms 'billable codes' and 'valid codes.' A complete list of the 2016 ICD-10-CM valid codes and code titles is posted at the CMS website at http://www.cms.gov/Medicare/Coding/ICD10/2016-ICD-10-CM-and-GEMs.html. The codes are listed in tabular order, in the same order as in the ICD-10-CM code book. This list is important to those providers unsure as to whether an additional 4th, 5th, 6th or 7th character is required to provide the code 'specificity' required by New Jersey Medicaid policy and procedures.

CMS also launched a new ICD-10 Clinical Concepts Series for provider specialties. The Series includes common ICD-10 codes and corresponding ICD-9 codes; clinical documentation tips; as well as other helpful information. The Series may be accessed at https://www.roadto10.org/

Information is also available on-line that could assist providers with the mapping process. For example, the American Academy of Professional Coders (AAPC) has a website which may serve as a good reference. The website has an online tool for

mapping diagnosis codes (not PCS codes) in both directions (ICD-9 > ICD-10; or ICD-10 > ICD-9). The mapping tool may be found at https://www.aapc.com/icd-10/codes/.

Q5: Will psychiatric and other mental health professionals need to submit ICD-10-CM diagnosis codes? Currently, diagnosis information is obtained from the Diagnostic and Statistical Manual (DSM) of Mental Disorders.

Yes. All providers must report ICD-10-CM diagnosis codes on claims with dates of service/date of discharge on/after October 1, 2015.

The ICD-10 classification system is designed to meet the needs of all types of health care professionals. Mental health providers will not need to use most of the codes in the classification system; in fact, they generally will only need to use a subset of ICD-10-CM codes that largely come from Chapter 5: Mental and Behavioral Disorders. Other chapters of relevance may include:

- Chapter 6: Diseases of the Nervous System.
- Chapter 18: Symptoms, Signs and Abnormal Clinical and Laboratory Findings.
- Chapter 21: Factors Influencing Health Status and Contact with Health Services.

For quick reference, ICD-10-CM codes can be found in parentheses within the diagnostic criteria box for each disorder. There is a listing of ICD-10 codes found in the "DSM-5 Classification" in the front of the DSM-5 Manual, as well as alphabetical and numerical listings in the DSM appendices. For further information, please visit http://www.apapracticecentral.org/business/legal/icd-10-questions.aspx for frequently asked questions regarding the ICD-10 implementation prepared by the American Psychiatric Association.

Q6: What is GEMS and how can accessing GEMS assist a provider with the ICD-10-CM implementation?

Mappings between ICD-9-CM and ICD-10-CM play a critical role in the successful transition to ICD-10-CM. CMS and the Centers for Disease Control and Prevention created the General Equivalence Mappings (GEMs) to ensure consistency within national data. GEMs act as a translation dictionary to bridge the language gap between the ICD code sets. GEMs can be accessed at: http://www.cms.gov/Medicare/Coding/ICD10/2016-ICD-10-CM-and-GEMs.html.

Q7: What is the difference between 'mapping' and 'coding?'

Mappings simply provide a linkage between a code in one code set and its closest equivalent in another code set, without consideration of context or specific patient encounter information. Coding involves assigning the most appropriate code based on health record documentation; knowledge of other codes on the medical record; and applicable guidelines.

Common ICD-10-CM Terminology:

Unspecified – means a valid ICD-10 code that is reported when clinical information does not provide a definitive documented diagnosis. The term 'unspecified' is not intended to be reported when a surgical procedure has been performed or a diagnostic determination has been made involving a specific body part (i.e. left arm, right arm, etc.).

Valid ICD-10-CM Code - means an ICD-10-CM code composed of 3, 4, 5, 6 or 7 characters. Codes with three characters (1st character alpha,/2nd character numeric/3rd character numeric) are included in ICD-10-CM as the heading of a category of codes that may be further subdivided by the use of a 4th character (etiology); a 5th character (anatomical site); a 6th character (severity); and a 7th character (extension). A three-character code is used ONLY if it is not further subdivided.

Valid ICD-10-PCS Code – See https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2016-Official-ICD-10-PCS-Coding-Guidelines-.pdf

Family of Codes – Codes within a category are clinically related. For example, the category or family H25 (Age-Related Cataract) contains a number of more specific codes composed of 4, 5, 6 or 7 characters that capture information on the type of cataract as well as information on the eye involved, such as H25.031 (Anterior subcapsular polar age-related cataract, right eye).

Prior Authorization

Q1: When will DMAHS be able to accept prior authorizations/referral requests with ICD-10 diagnosis codes for services expected to be delivered on or after 10/1/2015?

NJ Medicaid is ready to receive authorizations/Referral requests as soon as providers are able to submit for services on or after 10/1/2015. The prior Authorization/Referral submission process remains the same for ICD-10 as it is under ICD-9.

Q2: How will your system handle claims with DOS after October 1, 2015 but associated with an authorization/referral approved using ICD-9 diagnosis codes?

The current Prior Authorization (PA) process for DMAHS evaluates whether a PA is on file. The system does not maintain logic that evaluates diagnosis codes relative to PA and claims submission. The evaluation is whether a PA exists based on the manual review of medical necessity.

Claims Processing/Reimbursement

Q1: Can a provider submit ICD-9 and ICD-10 codes on a single claim?

No. Individual claims submitted with both ICD-9 and ICD-10 codes will be accepted but denied.

Q2: Can a provider submit claim batches with both ICD-9 and ICD-10 claims?

Batch claim files can be submitted with claims that include both ICD-9 and ICD-10 codes as long as each claim in the batch contains only one code set- ICD-9 or ICD-10. An individual claim displaying both ICD-9 and ICD-10 codes will be accepted but denied.

Q3: What ICD Grouper Version will DMAHS be using at the time of the ICD-10 implementation?

The Department will use 3M AP-DRG version 27 and Mapper Version 32 on October 1, 2015.

Q4. If there is an issue with submitting ICD-10 claims, who can I contact?

For any questions regarding the processing of claims please follow our current procedures by contacting DXC Technology Provider Relations at 1.800-776- 6334.

Q5: How will NJFC/Medicaid price inpatient FFS claims?

NJFC/Medicaid will continue to price inpatient claims using the AP version 27 grouper upon implementation of ICD-10 code reporting. The grouper, used in conjunction with the most current 3M mapper, allows ICD-9 or ICD-10 codes from one year to be used with a grouper from another year, in determining the correct DRG for inpatient pricing

Q6: Please explain the Division's payment policy regarding hospital re-admissions.

For New Jersey hospitals, if a patient is re-admitted to the same hospital for the same or similar diagnosis within seven calendar days, payment for the second claim shall be denied by DMAHS.

For dates of service before October 1, 2015, the same or similar diagnosis shall be defined as principal diagnoses with the same first three digits, in accordance with ICD-9-CM.

For dates of service on or after October 1, 2015, the same or similar principal diagnosis shall be defined as principal diagnoses in the same diagnosis category, as defined by the first three characters, in accordance with the ICD-10-CM.

In the event that one claim has a date of service prior to October 1, 2015, and another claim has a date of service on or after October 1, 2015, the principal diagnosis reported on the first claim as an ICD-9-CM diagnosis code shall be compared to the principal diagnosis reported on the other claim reporting an ICD-10-CM diagnosis code utilizing the Centers for Medicare and Medicaid Services (CMS) General Equivalency Mapping (GEM).

Q7: How should inpatient hospital claims be billed that span the ICD-10 implementation date?

If an inpatient hospital claim has a date of discharge on or after October 1, 2015, the entire claim shall be billed reporting the ICD-10 code set.

Q8: How should a hospital bill claims in which the Principal and/or Other Procedure Code has a service date prior to October 1, 2015 and the inpatient stay spans the ICD-10 implementation date?

If a hospital claim has a date of discharge on or after October 1, 2015, the entire claim shall be billed reporting the ICD-10 code set.

Q9: When is it appropriate for a hospital to 'split' an inpatient claim?

Using the 'date of discharge' for determining the appropriate code set to report on an inpatient hospital claim minimizes the need to bill a 'split' claim to Medicaid. In the situation where Medicare requires a 'split' claim because an inpatient claim was submitted to a Part B carrier for payment of professional services, the hospital would bill Medicaid a single claim (not 'split') reporting the value '12X' in the 'Bill Type' field. The 'date of discharge' would continue to be used to determine the appropriate code set to be reported on the '12X' claim.

Q10: When is it appropriate for a hospital to 'split' an outpatient claim?

Hospitals must ensure that the appropriate ICD code set is reported on outpatient claims based on the date of service. When a mix of ICD-9-CM and ICD-10-CM diagnosis codes are required to properly report diagnosis codes for billed services, hospitals are required to 'split' the claim so that all ICD-9-CM diagnosis codes remain on one claim with dates of service through September 30, 2015; and all ICD-10-CM diagnosis codes are reported on the other claim with dates of service on or after October 1, 2015.

Q11: When is it appropriate for a provider to 'split' a professional claim?

Providers must ensure that the appropriate ICD code set is reported on claims based on the date of service. When a mix of ICD-9-CM and ICD-10-CM diagnosis codes are required to properly report diagnosis codes for billed services, providers are required to 'split' the claim so that all ICD-9-CM diagnosis codes remain on one claim with dates of service through September 30, 2015; and all ICD-10-CM diagnosis codes are reported on the other claim with dates of service on or after October 1, 2015.

Q12: How should a supplier of durable medical equipment (DME) bill a capped rental claim or a claim for monthly supplies that span the ICD-10 compliance date?

Generally, the 'Through' date reported on a claim is used to determine the appropriate ICD code set for reporting a diagnosis. For DME claims that span the ICD-10 compliance date, the 'From' date reported on the claim shall be used to determine the appropriate ICD code set to be reported. For example, if a DME claim has a 'From' date of September 15, 2015 and a 'Through' date of October 15, 2015, the 'From' date of September 15, 2015 shall be used to determine that the ICD code set to be reported on this claim must be ICD-9-CM since the 'From' date is prior to October 1, 2015.

Q13: What changes are required to report the ICD-10-CM code set on HIPAA 837P transactions?

Providers should visit the New Jersey Medicaid HIPAA Companion Guide Version 5010 on the DXC Technology Website at www.njmmis.com for information regarding ICD-10 qualifiers that must be reported on HIPAA claims on or after October 1, 2015. To access the Guide: select 'Forms and Documents'; key: 'Provider'; and then key: 'HIPAA'; select the 837/835/277P HIPAA Companion Guide (Version 5010).

Q14: What changes to UB-04 and 1500 paper claims are required to report ICD-10-CM diagnosis codes?

Effective for UB-04 and 1500 paper claims submitted on or after October 1, 2015, providers are required to report the ICD version indicator value of '0' for ICD-10 code sets. For claims with service dates prior to October 1, 2015, providers must report the ICD version indicator value of '9' for ICD-9 code sets. The ICD Version Indicator on the 1500 paper claim form is identified as Form Locator 21 and as Form Locator 66 on the UB-04 paper claim.

Q15: Are there FFS Error Codes that address ICD-10-CM reporting issues?

The NJ Medicaid Management Information System (NJMMIS) required the reporting of certain ICD-9-CM diagnosis codes on claims for certain NJFC/Medicaid-covered services. These requirements have not changed. As part of the transition to ICD-10-CM, the NJMMIS has been updated with ICD-10-CM diagnosis codes that replace ICD-9-CM codes required for reporting purposes. NJMMIS Error Codes that previously denied claims when the incorrect diagnosis code was reported will continue to post, now requiring the appropriate ICD-10-CM code.

FFS Error Codes related to the ICD-10 transition include the following:

Error Codes	Description	Disposition	Denial Explanation
0166	Invalid/Missing Diagnosis Code	D/CCF	• The format for the ICD code set submitted is incorrect for the version • External Causes of Injury Invalid as primary diagnosis
0296	Diagnosis Code Not On File	D/CCF	• Invalid heading code (additional subcategories exist for this header code) • Reported qualifier/version indicator code value does not match code set reported • Inappropriate code set reported for service date • Invalid diagnosis code (does not exist)
1416	ICD Version Mismatch	D	• No ICD version reported in version indicator field • Mixture of ICD-9 and ICD-10 qualifiers reported
2227	POS Diagnosis qualifiers not equal	D	• POS Diagnosis Qualifiers are not equal

An explanation for Error Code 0166 External Cause of Injury Invalid as primary diagnosis edit is as follows:

For inpatient, inpatient crossover, outpatient, outpatient crossover or home health claims, the FIRST diagnosis code is in range V00-Y98.

OR

For all other claim types, if the first diagnosis code is in the range V00-Y98. AND the only other valid diagnosis codes on the claim also is in the range V00-Y98.

THEN Edit 0166 is posted.

ICD-10 Testing

Q1: Has the Division conducted an analysis of dual-coded ICD-9-CM/ICD-10-CM inpatient claims to determine the impact that changes in DRG assignment would have on hospital payments?

An analysis conducted by the Division indicated that DRG shifts were the result of (1) diagnosis code inconsistencies reported by providers; and/or (2) inconsistencies in reported surgical procedure codes. Providers who perform dual-coding exercises during the ICD-10 test window and experience a DRG shift may contact the DMAHS Office of Reimbursement at 609-588-2668 to request a review of their claim-specific test results.

Q2: Are providers able to continue submitting ICD-10-CM test claims to DXC Technology?

Yes, testing is always available for providers to test their ICD-10-CM claims utilizing the DXC Technology EDI Proof System. The DXC EDI Proof System is a self- serve testing environment that enables all providers and submitters to test their ICD-10 claims on their own schedule and enable them to consult the DXC EDI Department (609-588-6051) to rectify any problems encountered. The following is an excerpt from the Medicaid Newsletter, Volume 24, No. 12, dated September 2014, that provides testing instructions.

- Create a test file reporting the appropriate ICD-10-CM diagnosis codes or the appropriate ICD-10-PCS procedure codes for the healthcare services provided.
  - In the header specification, change the ISA 15 field value to a “T” to represent your file as a “test” file.
  - Limit the number of claims submitted in the test file to **no more than** 100 FFS claims or **less than 1000** HMO encounter claims.
  - Use Version 5010 HIPAA standards, which have been required since January 1, 2012 and accommodate ICD-10-CM diagnosis codes and ICD-10-PCS procedure codes.
  - **DO NOT** report both ICD-9 and ICD-10 codes **within the same claim**. The same test file may contain a combination of claims reporting only ICD-9 codes or only ICD-10 codes.
  - ICD-10 coding must be at the most granular level possible and will be edited accordingly by the “Proof” system.
- Login to the NJFC/Medicaid website @ www.njmmis.com; select HIPAA claims; sign in using your Use Name and Password; submit your created test file.
- Submitted test files will be processed the following morning. At approximately 9:00 AM on the day after your submission, proceed to the download page to retrieve detail and summary reports, as well as a HIPAA 835 Remittance File for all submitted test claims.