ICD-10 Frequently Asked Questions: Providers

I. General ICD-10

a. What codes will be required on October 1, 2015?

ICD-10 CM diagnosis and ICD-10 PCS procedure codes will be required on all inpatient claims with discharge dates on or after October 1, 2015. ICD-10 CM diagnosis codes will replace ICD-9 CM diagnosis codes, and will be required on all professional and outpatient claims with dates of service on or after October 1, 2015. Service dates or discharge dates prior to October 1, 2015 will require ICD-9 codes. Other codes (CPTs, HCPCS, revenue codes, etc.) will not be impacted by this change.

b. Does the State Medicaid Agency have to make changes for its programs or is it exempt?

ICD-10 compliance is an industry wide requirement and is applicable to services paid by Medicare, Medicaid, and Marketplace.

c. Will there be changes to the paper claims form guide?

FOR PAPER CLAIM SUBMITTERS

In accordance with CMS, the health plan requires ICD-10 codes on paper claims for dates of service (for professional claims) and discharge dates (for institutional claims) as of October 1, 2015. The CMS-1500 professional claim form has been revised with changes including those to more adequately support the use of the ICD-10 diagnosis code set. Changes related to ICD-10 include the addition of an ICD-9/10 indicator as well as an expansion of diagnosis codes available for submission. In accordance with CMS, the health plan began accepting the revised form on January 6, 2014. The CMS-1450 institutional claim form has not been revised recently, but does contain the necessary ICD-9/10 indicator.

Changes that have been made to the CMS-1500 claim form are communicated through the National Uniform Claim Committee and changes that have made to the CMS-1450 (UB-04) claim form are communicated through the National Uniform Billing Committee, as these groups are responsible for updating paper claim forms on behalf of CMS.

More information on the CMS-1500 (professional) claim form can be found here.

More information on the CMS-1450 (institutional) claim form can be found here.

Providers will not be required to enter a “9” or a “0” in the ICD Indicator field until 10/1/2015, however the health plan will accept claims with the ICD indicator field populated prior to that date.

II. Readiness

a. Will Centene health plans be ICD-10 compliant by October 1, 2015?

Yes. Centene health plans will be able to use ICD-10 codes in all areas of operations in compliance with the CMS mandate.

b. What is the health plan doing to prepare for the ICD-10 conversion?

A detailed implementation plan is in place. Centene and its health plans completed an ICD-10 assessment in Q4 2011. Centene and its health plans are actively remediating impacted systems and processes to meet business requirements and will be testing through 2015 *(see VI. Testing section for details).*

III. Claims Operations

a. Will date of service or date of discharge determine which code to use to achieve compliance on October 1, 2015?

In general, inpatient claims with discharge dates on or after October 1, 2015 must be coded in ICD-10. Outpatient and professional claims with dates of service on or after October 1, 2015 must contain ICD-10 diagnosis codes.

For specific guidance on claims acceptance, please reference these CMS publications (SE1325 and MM7492).

Claims may not contain a combination of ICD-9 and ICD-10 codes. Claims may only contain one code set. Outpatient claims with service dates straddling the compliance date should be split. Interim bills for long hospital stays (TOB: 112, 113, 114) are expected to follow the same rules as other claims (e.g., claims with discharge / through dates that span compliance must be split, claims with discharge / through dates pre-compliance must bill in ICD-9, claims with discharge / through dates post-compliance must bill in ICD-10). If a provider submits a replacement claim (TOB: 117) to cover all interim stays, it is expected that the provider must re-code all diagnoses / procedures to ICD-10 since the replacement claim will have a discharge / through date post-compliance.

b. Will the health plan accept claims with ICD-9 and ICD-10 codes?

No. Providers must submit claims with codes that align with CMS and state coding guidelines. The health plan's systems are prepared to accept ICD-9 codes for dates of service prior to October 1, 2015 and ICD-10 codes on or after October 1, 2015.

c. Will the health plan accept ICD-10 codes prior to the compliance date?

No. The health plan will not process claims submitted with ICD-10 codes prior to the compliance date.

d. Will the health plan accept ICD-9 codes after the compliance date?

No. Claims must be submitted with ICD-10 codes if dates of service are post-compliance date.

e. How long post compliance date will ICD-9 codes be accepted?

Claims containing ICD-9 codes with a date of service on or after October 1, 2015 will be rejected. All first-time claims and adjustments for pre-10/1/2015 service dates must include ICD-9 codes, even if claims are submitted post-10/1/2015. Claims with pre-10/1/2015 service dates can be submitted with ICD-9 codes for as long as CMS, provider contracts and manuals specify to properly adjudicate 9 coded claims with dates of service pre-10/1/2015.

IV. Medical Policy

a. Will the health plan update coverage positions or medical necessity criteria for ICD-10?

Medical policies and benefit configurations will be impacted by the ICD-10 transition. The health plan is assessing the impact of such changes as it continues testing with each state and will communicate any changes with state agencies and providers as needed.

Example: Medical policy will cover bariatric surgery if claim is billed with ICD-9 diagnosis code V45.86 pre-compliance date. Medical policy will cover bariatric surgery if claim is billed with ICD-10 diagnosis code Z98.84 post-compliance date.

V. Contracts & Reimbursement

a. How will the ICD-10 transition impact provider reimbursement? Will you renegotiate the contract to replace ICD-9 codes with ICD-10 codes?

The ICD-10 conversion was not intended to transform payment or reimbursement; however, it may result in reimbursement methodologies that more accurately reflect patient status and care across the industry. The health plan is evaluating risk mitigation from impact to reimbursement through changes to contracting and clinical operations. Contract remediation will occur on an as-needed basis and is currently being reviewed on a contract by contract basis. Any changes will be communicated via existing channels.

b. Will the health plan use the CMS-provided GEMS/Reimbursement Mapping to crosswalk ICD codes during claim adjudication / reimbursement? During your transition?

The health plan plans to adjudicate claims natively in ICD-9 for dates of service prior to October 1, 2015 and natively in ICD-10 for dates of service on and after October 1, 2015, consistent with CMS requirements.

During the transition, we are using an enhanced GEMS crosswalk tool to identify the potential range of financial impact and isolate the sets of codes with the greatest risk,

volume and variability. Adjustments to the crosswalk, where used for policy or reimbursement, or to provider contracts, may be required. Post implementation, we plan to continue assessment efforts and make adjustments as required.

VI. Testing

a. Have you developed your external testing strategy and timeframes? How do we get involved with testing with you?

Transactional-level testing is available today to any provider interesting in participating and will continue to be available through the ICD-10 compliance date. As part of this testing effort, providers who register in Ramp Manager (application used for all testing efforts) and submit 837 X12 test claims will receive TA1, 999, 277CA, and 271 eligibility responses.

Providers or clearinghouses who are interested in transactional-level testing can contact the EDI service desk at 1-800-225-2573, ext. 25525 or EDIBA@centene.com for further instructions. Providers or clearinghouses who are interested in testing must be direct electronic claim submitters (837 X12 claims).

End-to-end testing will broaden the focus of transactional-level testing and will encompass the return of remittance advices (RAs) / explanation of payments (EOPs). Providers who conduct end-to-end testing will receive the outputs from transactional-level testing in addition to an 835 X12 Remittance Advice file.

End-to-end testing is currently being conducted with a limited number of providers and will end in Q2 2015. Providers and clearinghouses who are confirmed as test partners are submitting up to 50 ICD-10 coded test claims in an electronic 837 X12 format. The Ramp Manager application (application used for all testing efforts) is being used as a mechanism for receiving electronic test claims and distributing electronic remittance advices. Providers who normally submit claims via clearinghouses are being asked to work with their clearinghouse on test claim submissions.

VII. Other

a. Do you expect eligibility/authorization/referral processing to be impacted? If yes, please describe expected impact.

There should be no impact on eligibility.

ICD-10 diagnosis codes will be accepted on prior authorization requests submitted 7/1/15 or later for services with a start date on or after the ICD-10 compliance date. ICD-9 codes will no longer be accepted on prior authorization requests submitted on the ICD-10 compliance date or later except in the case of retro authorizations for services with a start date on or before 9/30/15. ICD-9 procedure codes are not used on authorizations and ICD-10 procedure codes will not be used on authorizations.

b. Will paper EOB layouts change? If so, how?

No, diagnosis codes are not included on EOBs and the changes should be seamless to the member.

c. Will paper EOP layouts change?

Diagnosis codes will not be used on paper EOPs at the time of the transition date.