

DDPA ICD-10 Provider Education Session Questions 8/28/13

Question: Will the new ICD-10 system still accept the code without the decimal point?

Answer: Yes, there is no change to that level of functionality with the change from ICD-9 to ICD-10

Question: If the diagnosis is unspecified, how would you code a situation where a patient has Down's syndrome and mental retardation?

Answer: ICD codes should be assigned based on the clinical documentation provided by the physician and contained in the medical record. Codes should be assigned to the highest level of specificity based on the clinical documentation contained within the medical record.

Question: If unspecified codes are going away in Medicaid, what will happen?

Answer: Unspecified codes are not going away but should only be used if there is a lack of clinical documentation that would allow for coding to the highest level of specificity. The use of unspecified codes may result in claims being pended for additional documentation or claims being denied. It should be noted that when the ICD-9 codes were translated to ICD-10 there was very minimal acceptance of unspecified codes; providers are encouraged to take advantage of the specificity offered in ICD -10. This is a trend across the healthcare industry, not just with State Medicaid Agencies.

Question: How will providers know which coding subsets to apply to a particular case?

Answer: ICD codes are assigned based on the clinical documentation contained within the medical record. One way to assess current documentation and potential gaps is to conduct a documentation audit. By reviewing the medical record and assigning codes in both ICD-9 and ICD-10 you will have a better understanding of any documentation improvements that may need to be addressed. Reviewing the results with the providers will also give them insight regarding the complexity of the new ICD-10 codes.

Question: Will there be an assessment to help with the documentation assessment?

Answer: There are several assessment tools available on the internet. The Centers for Medicare & Medicaid Services has several resources available at www.CMS.gov/ICD10. These resources are available free of charge and are updated frequently.

Question: Will the codes come from the physician?

Answer: Claims submitted for payment must be supported by clinical documentation contained within the medical record. The provider; i.e., the physician or the referring facility may provide the ICD codes to you or it may be the responsibility of the receiving

facility or agency to determine the ICD code based on the clinical documentation. The process you are utilizing today would remain the same; the only change will be the transition from ICD-9 to ICD-10 codes.

Question: What happens if providers are ready to submit ICD-10 codes before the go live date; when can ICD-10 codes be submitted to AR Medicaid?

Answer: Claims containing ICD-10 codes cannot be submitted for payment for dates of service or dates of discharge prior to October 1, 2014. DMS will begin ICD-10 testing with providers in the coming months. Information regarding this effort will be provided via the AR ICD-10 Website, the HP Provider Wire and other channels including the DDPA website.

Question: When is the earliest date that providers can test?

Answer: DMS will begin ICD-10 testing with providers in the coming months. Information regarding this effort will be provided via the AR ICD-10 Website, the HP Provider Wire and other channels including the DDPA website.

Question: Is the testing similar to a testing pilot?

Answer: There are several levels of testing that can be done including internal testing and end-to-end testing. The initial testing that DMS will be conducting is internal testing. There are several national testing pilots that are available as well. Additional information regarding testing can be found at www.cms.gov/ICD10.

Question: How do you know if diagnosis 315.9 (unspecified delay in development) should be coded as scholastic or psychological in ICD-10?

Answer: ICD codes are assigned based on clinical documentation contained within the medical record. If the provider does not indicate the level of specificity needed; i.e.; scholastic or psychological then a query should be initiated to ensure that the most accurate and correct code is assigned. All codes assigned must be supported by the clinical documentation contained within the medical record.

Question: If you are submitting a claim to Medicaid for diagnosis 318.1 (severe intellectual disabilities) in ICD-9, can you use F72 in ICD-10? Will Medicaid require a re-evaluation of the client?

Answer: Based on the 2013 ICD-10CM DRAFT code translations you would use F72 to bill for services rendered on or after October 1, 2014 for the diagnosis of severe intellectual disabilities. If the client is due for an annual evaluation on or after October 1, 2014 the ICD 10 diagnosis of F72 would be submitted for reimbursement of services rendered. There should be history in the claims system that includes the ICD-9 diagnosis of 318.1. It is not anticipated that a re-evaluation of the client will be required based on the coding change from ICD-9 to ICD-10.

Question: If you bill for services rendered, could they take money away from you later if it is billed/coded incorrectly?

Answer: Anytime there is an audit by a payer (commercial, Medicare or Medicaid) there is a risk of money being taken back if the documentation contained in the medical record does not support the diagnosis or service being billed. ICD codes; both ICD-9 and ICD-10 are assigned based on the clinical documentation contained within the medical record.