ICD-10 Help Kit

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1. Checklist for Batch (Electronic) Submissions

- ✓ Use the NCTracks ICD-10 Crosswalk to determine the appropriate ICD-10 codes.
- ✓ A claim may use ICD-9 or ICD-10 codes, but not both. A batch may include both ICD-9 and ICD-10 claims.
- ✓ Claims with **dates of service** prior to October 1, 2015, use ICD-9 codes. Claims with dates of service on or after October 1 use ICD-10 codes.
- ✓ When the dates of service on a claim begin before October 1 and end afterwards, you must **split** the claim into two separate claims. For services rendered before October 1, submit one claim using ICD-9 codes. For services rendered on or after October 1, submit a second claim using ICD-10 codes. The **exception is inpatient claims**, which are based on date of discharge, so they are not split.
- ✓ ICD-10 diagnosis codes are used in all U.S. health care settings. ICD-10 procedure codes are used in inpatient hospital settings only. The transition to ICD-10 **does not affect CPT/HCPCS** coding for outpatient procedures and physician services.
- ✓ As of October 1, claims submitted to NCTracks in an X12 837 electronic transaction **must include an ICD version code qualifier** that indicates whether the claim is using ICD-9 or ICD-10 codes. Refer to the X12 list of ICD qualifiers below for more details.

Note: If you use practice management software and/or a billing clearinghouse to submit your claims and you have any difficulties with the transition to ICD-10 on October 1, consider submitting your high impact claims via the NCTracks provider portal. (See section 3.)

2. List of EDI X12 Qualifiers

Field Name	Transaction	Loop	Segment	ICD-9	ICD-10	Occurrence
Principal Diagnosis	837I	2300	HI01-1	BK	ABK	1 occur
Admitting Diagnosis	837I	2300	HI01-1	BJ	ABJ	1 occur
Patient's Reason For Visit	837I	2300	HI01-1 HI02-1 HI03-1	PR	APR	up to 3 occurs
External Cause of Injury	837I	2300	HI01-1 HI02-1 HI03-1 HI04-1 HI05-1 HI06-1 HI07-1 HI08-1 HI09-1 HI10-1 HI11-1 HI12-1	BN	ABN	up to 12 occurs
Other Diagnosis Information	837I	2300	HI01-1 HI02-1 HI03-1 HI04-1 HI05-1 HI06-1 HI07-1 HI08-1 HI09-1 HI10-1 HI11-1 HI12-1	BF	ABF	up to 12 occurs
Principal Procedure Information	837I	2300	HI01-1	BR	BBR	1 occur

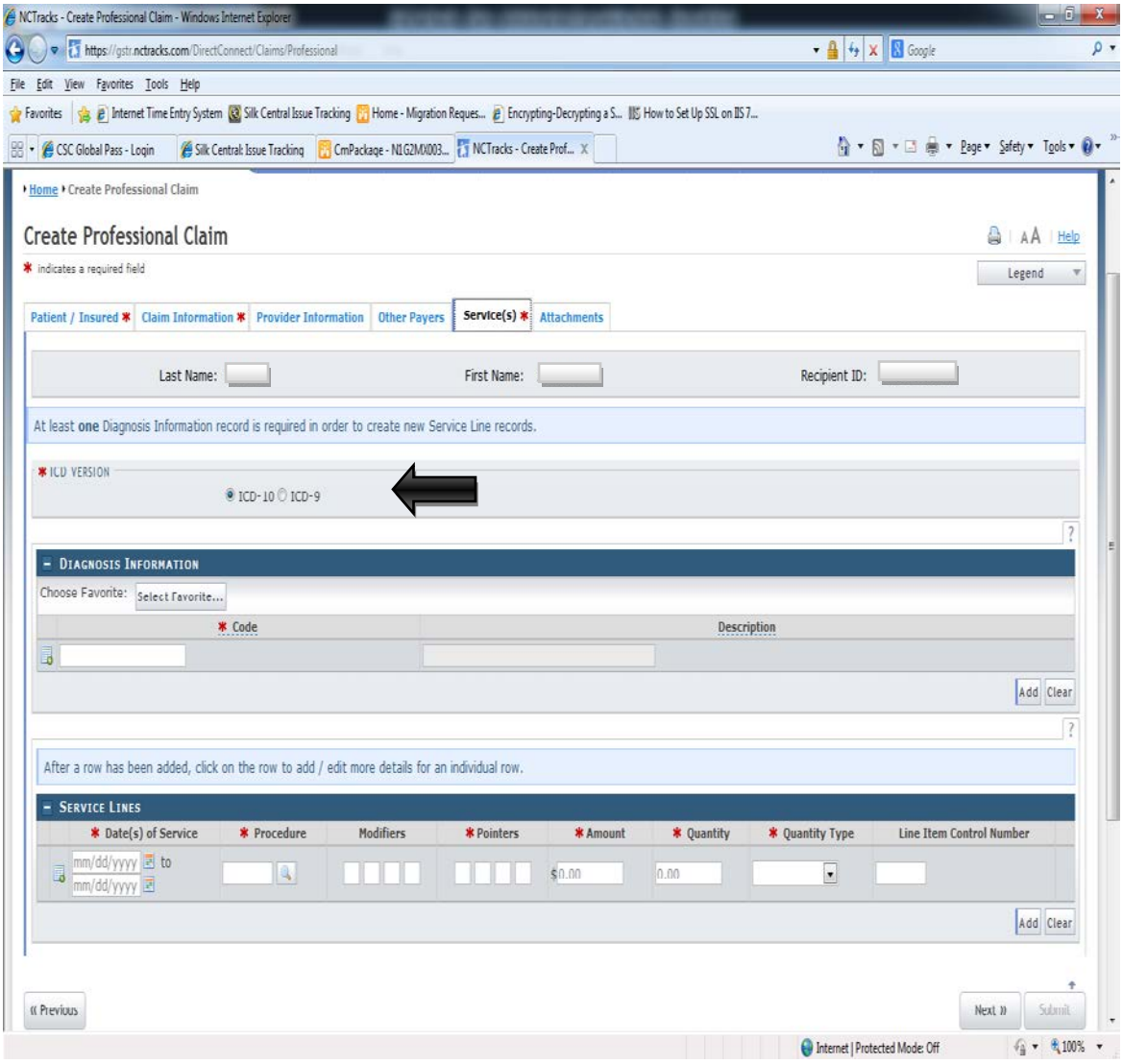
Other Procedure Information	837I	2300	HI01-1 HI02-1 HI03-1 HI04-1 HI05-1 HI06-1 HI07-1 HI08-1 HI09-1 HI10-1 HI11-1 HI12-1	BQ	BBQ	up to 12 occurs
Dental Primary Diagnosis	837D	2300	HI01-1	BK	ABK	1st occur
Dental Secondary Diagnosis	837D	2300	HI02-1 HI03-1 HI04-1	BF	ABF	2nd - 4th occur
Professional Primary Diagnosis	837P	2300	HI01-1	BK	ABK	1st occur
Professional Secondary Diagnosis	837P	2300	HI02-1 HI03-1 HI04-1 HI05-1 HI06-1 HI07-1 HI08-1 HI09-1 HI10-1 HI11-1 HI12-1	BF	ABF	2nd - 12th occur

3. Checklist for NCTracks Portal Claims Submissions

- ✓ Use the NCTracks ICD-10 Crosswalk to determine the appropriate ICD-10 codes
- ✓ A claim may use ICD-9 or ICD-10 codes, but not both.
- ✓ Claims with **dates of service** prior to October 1, 2015, use ICD-9 codes. Claims with dates of service on or after October 1 use ICD-10 codes.
- ✓ When the dates of service on a claim begin before October 1 and end afterwards, you must **split** the claim into two separate claims. For services rendered before October 1, submit one claim using ICD-9 codes. For services rendered on or after October 1, submit a second claim using ICD-10 codes. The **exception is inpatient claims**, which are based on date of discharge, so they are not split.
- ✓ ICD-10 diagnosis codes are used in all U.S. health care settings. ICD-10 procedure codes are used in inpatient hospital settings only. The transition to ICD-10 **does not affect CPT/HCPCS** coding for outpatient procedures and physician services.
- ✓ Specify which ICD code version is used on each claim as it is keyed into the portal (see below.)

4. Location of ICD indicator for portal submission

The ICD indicator is in essentially the same position for every type of claim keyed into the NCTracks portal, either on the Services tab or the Diagnosis/Procedure tab. The example shown is for a **Professional Claim.**



5. Prior Approval

Medicaid Prior Approvals (PAs) that span October 1, 2015, do not need to be split. If you have an approved PA request with a begin date before October 1 and an end date on or after October 1, no action is required. It is possible for a claim to be submitted after October 1 with an ICD-10 code and the PA to be approved with an ICD-9 code.

The ICD-10 transition won't affect Medicaid PAs because the diagnosis codes on PAs aren't used to adjudicate claims. Instead, PAs are used by clinicians to see if the service to be provided is appropriate for the diagnosis.

Therefore, most PAs that span October 1 do not need to be split. However, as noted in the previous sections, the claim submitted for services rendered on or after October 1 must use ICD-10 codes.

All PA requests submitted to NCTracks on or after October 1 should use ICD-10 codes. Retroactive requests for PA for dates of service before October 1 should use ICD-9 codes.

PA Exceptions: The exceptions to the rule regarding PA and ICD-10 are the Sickle Cell and EHDI (Early Hearing Detection and Intervention) programs under the N.C. Division of Public Health. PA requests for Sickle Cell and EDHI services cannot span the October 1 implementation date. **Providers must obtain a new PA for Sickle Cell and EDHI services rendered on or after October 1.** (NCTracks will automatically end date existing PAs for Sickle Cell and EDHI that extend beyond September 30.)

6. Assistance

Provider assistance is available through a variety of channels. Providers are encouraged to consult the NCTracks Provider Portal ICD-10 Page and the NCTracks Automated Voice Response System (AVRS) first for important announcements and updates regarding ICD-10.

- NCTracks Provider Portal ICD-10 Page: https://www.nctracks.nc.gov/content/public/providers/ICD10.html
- NCTracks AVRS: 1-800-723-4337
- NCTracks Contact Center: 1-800-688-6696
- Prior Approval Unit (Medical and Dental): 1-800-688-6696
- Prior Approval Unit (Pharmacy): 1-866-246-8505
- Trading Partner Team: 1-800-688-6696

For any policy related questions, email NCTracks-Questioner@dhhs.nc.gov

7. EOBs Effective with ICD-10 on October 1, 2015

To help facilitate successful claim submission to NCTracks following the implementation of ICD-10, it is important for providers to know and understand the most common claim edits and associated Explanation of Benefits (EOBs) that will appear on the paper Remittance Advice (RA).

New Edits and EOBs for ICD-10

The following new edits will be in place when the use of ICD-10 begins on October 1, 2015:

a) Claims containing ICD-10 diagnosis codes in the following range as the primary or only diagnosis will deny. **V00 – Y99** are codes indicating "External Causes of Morbidity". These codes are to be used secondary to another diagnosis code, indicating the event or circumstances causing the injury or other adverse condition.

EOB 01748 - PRIMARY OR PRINCIPAL DIAGNOSIS NOT ALLOWED. PLEASE VERIFY AND ENTER THE CORRECT DIAGNOSIS CODE AND SUBMIT AS A NEW CLAIM

b) ICD-10 codes must be submitted with the required number of digits; codes that are not will deny for "insufficient digits."

EOB 01757 - DIAGNOSIS NON-SPECIFIC. PLEASE VERIFY AND ENTER THE CORRECT DIAGNOSIS CODE AND SUBMIT AS A NEW CLAIM

c) Claims will deny if they contain a diagnosis code that is not covered.

EOB 01754 - DIAGNOSIS NOT COVERED. PLEASE VERIFY AND ENTER THE CORRECT DIAGNOSIS CODE AND SUBMIT AS A NEW CLAIM

Providers with claims that fail these edits can correct the diagnosis and resubmit the claim. To see what ICD-10 diagnosis codes correspond to ICD-9 codes, refer to the NCTracks ICD-10 Crosswalk.

New Edits for ICD Qualifier

There are also two new edits and associated EOBs related to the ICD Qualifier that is required on all X12 837 claim transactions beginning October 1. A claim can contain either ICD-9 or ICD-10 codes, but not both. The ICD Qualifier is used to designate which version of ICD codes is used on the claim. The new edits are triggered when the version of ICD code (9 vs 10) submitted on the claim does not match the version designated in the ICD Qualifier:

Edit 02670 - ICD VERSION INVALID (Drug Claims)
Edit/EOB 02671 - ICD VERSION INVALID FOR DATE OF SERVICE (All other claim types)

Correct the ICD Qualifier or the ICD code(s) on the claim, whichever is in error, and resubmit the claim. For more information about the ICD Qualifier, refer to the July 2 announcement on the NCTracks Provider Portal.

Existing Edits Affected by ICD-10

In addition, there are many existing edits and associated EOBs that will be triggered by errors related to ICD-10. These edits can be posted for various reasons, so it may not be immediately apparent that the cause of the failed edit is ICD-10 related. Following are details about some of the most common existing edits affected by ICD-10.

Diagnosis Not Valid

For example, Edit 00190 for Diagnosis Not Valid with EOB 00027: DIAGNOSIS CODE MISSING OR INVALID. VERIFY AND ENTER THE CORRECT DIAGNOSIS CODE AND SUBMIT AS A NEW CLAIM will post under several circumstances related to ICD-10:

- A claim with an ICD-9 diagnosis for a date of service on or after October 1
- A claim with an ICD-10 diagnosis for a date of service before October 1
- An invalid code, either ICD-9 or ICD-10, regardless of date of service
- Any end-dated diagnosis code

Other diagnosis code related edits and EOBs that may post with an ICD-10 error include:

Edit 00191 & Edit 00192	EOB 00019 - PRIMARY AND/OR SECONDARY DIAGNOSIS CODE INVALID. VERIFY, CORRECT, AND SUBMIT AS A NEW DAY CLAIM
Edit 00194	EOB 00012 - DIAGNOSIS OR SERVICE INVALID FOR RECIPIENT SEX

Providers with claims that fail one of these edits should ensure the claim reflects a valid diagnosis code based on the date of service and resubmit the claim.

Procedure Invalid for Diagnosis

Also, there are several EOBs that may post to claims that fail edits for Procedure Invalid for Diagnosis. These edits are triggered when the diagnosis code billed is not appropriate for the service rendered. Possible edits and EOBs in this category include:

Edit 00153	EOB 00082 - SERVICE IS NOT CONSISTENT WITH/OR NOT COVERED FOR THIS DIAGNOSIS/OR DESCRIPTION DOES NOT MATCH DIAGNOSIS
Edit 00441	EOB 00049 - MEDICAL NECESSITY IS NOT APPARENT

Edit 00442	EOB 02099 - EFFECTIVE 10/01/2011 THE MEDICAL EYE EXAM CODE BILLED IS NOT ALLOWED WHEN THE ONLY DIAGNOSIS CODE(S) ON THE CLAIM INDICATE THE SERVICE WAS PERFORMED FOR REFRACTION
Edit 04506	EOB 00082 - SERVICE IS NOT CONSISTENT WITH/OR NOT COVERED FOR THIS DIAGNOSIS/OR DESCRIPTION DOES NOT MATCH DIAGNOSIS
Edit 04507	EOB 07729 - DIAGNOSIS BILLED DOES NOT MEET MEDICAID GUIDELINES FOR PARING AND CUTTING OF LESIONS OR TRIMMING OF NONDYSTROPHIC NAILS
Edit 04508	EOB 07724 - DIAGNOSIS DOES NOT SUPPORT BILLING OF DEBRIDEMENT OF NAILS PER MEDICAID GUIDELINES
Edit 04509	EOB 07718 - CORONARY INTERVENTION SERVICE IS NOT CONSISTENT WITH/OR NOT COVERED FOR THIS DIAGNOSIS.
Edit 04510	EOB 07753 - MONITORED ANESTHESIA NOT SUPPORTED BY DIAGNOSIS
Edit 04511	EOB 01553 - REFER TO 1998 CPT FOR HIV VIRAL LOAD CODES AND REFILE

If a claim fails one of these edits, the provider should review the clinical coverage policies to ensure they are using the appropriate diagnosis code for the procedure that was rendered. The updated policies will be posted on the N.C. Division of Medical Assistance website by October 1. Also, bear in mind this list is not comprehensive. Other edits may be triggered by ICD-10 related errors.

8. Frequently Asked Questions

Listed below are some of the frequently asked questions (FAQs) regarding ICD-10 and NCTracks. For more information, please refer to the FAQs on the **NCTracks ICD-10 web site**.

Q: When will I be required to use ICD-10 codes?

ICD-10 codes must be used on all HIPAA transactions, including outpatient claims with dates of service, and inpatient claims with dates of discharge, on and after October 1, 2015.

Q: What are the requirements for use of ICD-10 codes?

You can view the CMS requirements online at http://www.cms.gov/ICD10.

Q: Why do we have to switch to ICD-10?

The federal Centers for Medicare and Medicaid Services (CMS) posted a final rule that requires all HIPAA covered entities to adopt the ICD-10 code sets, which replaces the ICD-9 code sets, with a compliance date of October 1, 2015.

Q: Will ICD-10 replace CPT coding?

No. The change to ICD-10 does not affect CPT/HCPCS coding for outpatient procedures and physician services. ICD-10-PCS codes are for hospital inpatient procedures only.

Q: Is the use of ICD-10 based on date of service or date of billing?

Date of service. Claims for all health care services and hospital inpatient procedures performed on or after October 1 must use ICD-10 diagnosis and inpatient procedure codes. Claims for services provided before October 1 must use ICD-9 diagnosis and inpatient procedure codes.

Q: After October 1, can providers submit an X12 batch file of 837s containing claims with ICD-9 codes and claims with ICD-10 codes in the same file?

Yes. Claims for dates of service prior to October 1 (using ICD-9 codes) and claims for dates of service on or after October 1 (using ICD-10 codes) can be submitted in the same batch. However, ICD-9 codes and ICD-10 codes cannot be used on the same claim.

Q: Is there a transition period when we can use either ICD-9 or ICD-10 codes?

No. If the date of service on a claim is before October 1, 2015, and contains ICD-9 codes, then the claim will be accepted for payment. If the date of service is on or after October 1, 2015, and uses ICD-9 codes, then this claim will be rejected. All claims that contain a date of service on or after the federally mandated compliance date of October 1, 2015, MUST use ICD-10 codes to be accepted for payment.

Q: At the point of transition to ICD-10, what will happen to claims in process with ICD-9 codes?

Claims with service dates prior to October 1, 2015, will continue to be processed with the ICD-9 codes.

Q: Will split billing be required? For example, if a patient is admitted on September 20, 2015, and discharged on October 5, 2015, will we have to do split billing?

If an inpatient claim has a discharge and/or through date of service on or after October 1, 2015, then the entire claim must be billed using ICD-10 codes. If an outpatient claim spans the compliance date, then the provider should split the claim so that all applicable ICD-9 codes remain on one claim with dates of service through September 30, 2015, and all ICD-10 codes are placed on a separate claim with date of service starting on or after October 1, 2015.

Q: How long after the October 1, 2015, ICD-10 compliance date must I continue to report and/or process ICD-9 codes?

Claims for dates of service prior to October 1, 2015, must be submitted with ICD-9 codes, regardless of the date submitted. Given the timeframes allowed for timely filing of claims and subsequent adjustments, this could be an extended period of time.

Q: How will the voided claims work after October 1 if the original date of service is before implementation?

No matter when the claim is submitted, which code to use is based on date of service. Services provided before October 1 require ICD-9 codes even if the claim is submitted after October 1.

Q: Will the codes automatically convert from ICD-9 to ICD-10 when I submit the professional claims?

No, it won't automatically convert. You must pick the most accurate code. See what your most used ICD-9 codes correspond to in ICD-10 using the NCTracks ICD-10 Crosswalk.

Q: Do we have to key all the fields in brand new for the ICD-10 claims or can we just change certain fields in the batch files?

For most providers, the only claim fields that are changing with the implementation of ICD-10 are diagnosis codes. Claims for inpatient hospital charges will also use ICD-10 procedure codes.

Q: How will the crossover claims work?

Crossover claims will work the same way they do today. All health care claims are affected by the implementation of ICD-10, based on the date of service (or date of discharge for inpatient hospital claims.)

Q: When is the first date of service that NCTracks will allow ICD-10 codes?

October 1, 2015

Q: As outpatient specialized therapies, we use V-codes. Are there ICD-10 codes for the V Codes: V571 for Speech Therapy, V572 for Occupational Therapy, V573 for Physical Therapy?

All the ICD-9 therapy V codes (PT, OT, and ST) map to a single ICD-10 code: **Z51.89 Encounter for other specified aftercare,** which will not be required on claim submissions**.**

Q: We are a therapy office specializing in Physical, Occupational and Speech therapy. Currently, we have to use a V code with each claim (V57.1, V57.21, V57.3) for each therapy. Are these still required once the transition happens and if so, what would be the corresponding ICD-10 code?

For services rendered on October 1 and forward, a secondary diagnosis code will no longer be required to differentiate between OT, PT & ST. The **rendering provider** taxonomy will determine the use of the revenue codes and the CPT codes on claims submitted. The single ICD-10 diagnosis code for outpatient specialized therapies will be **Z51.89 Encounter for other specified aftercare**, which will not be required on claim submissions**.**

Q: I have noticed on the Crosswalk the codes that differentiate Physical, Occupational, and Speech therapies are the same in the ICD-10 coding. What will happen when I am billing the same codes for PT, OT, and speech therapy on the same day of service for the same patient?

You are correct. The ICD-10 diagnosis code does not differentiate between the different types of therapy being provided. The taxonomy of the **rendering provider** should be the differentiating factor when the same CPT code is billed on the same date of service for the same beneficiary.

For example: Beneficiary sees the OT (rendering provider taxonomy 225X00000X) on May 5 and the OT bills for CPT Code 97530, **and** the beneficiary sees the PT (rendering provider taxonomy 225100000X) on the same day and the PT bills for CPT Code 97530. When the claims are adjudicated, the NCTracks system should pay both claims even though the CPT Code and the date of service match because the rendering provider taxonomy and NPI are different.

Q: How are Prior Approvals affected by ICD-10?

If a provider has an existing prior approval (PA) with ICD-9 codes, you do not need to obtain a new one, but when a new PA is needed on or after October 1, you will use ICD-10 codes in the PA request. The exception is PA for DPH services for Sickle Cell and EHDI. Providers must obtain a new PA for Sickle Cell and EDHI services rendered on or after October 1.

For more information, please refer to the NCTracks ICD-10 web site.