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?

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 Claim Form has been revised with changes including those to more adequately support the use of the ICD-10 diagnosis code set.

The revised form will give providers the ability to indicate whether they are using ICD-9 or ICD-10 diagnosis codes. In accordance with CMS, the health plan began accepting the revised form on January 6, 2014. Starting October 1, 2015, the health plan will accept only the revised version of the form to comply with CMS. Changes that have been made to the CMS-1500 and UB-04 claim forms are communicated through the National Uniform Claim Committee for the CMS-1500 claim form or the National Uniform Billing Committee for the UB-04, as these groups are responsible for updating paper claim forms on behalf of CMS.

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 4Q 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?

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.

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. Please see “ICD-10 Billing Compliance Scenarios” table.

ICD-10 Billing Compliance Scenarios					
Claim Type	Admit / From Date	Discharge / Through Date	Submission Date	ICD-x Version	Outcome of Claim
Inpatient	9/25/2015	10/3/2015	10/10/2015	• ICD-10 codes	Processed
Inpatient	9/25/2015	10/3/2015	10/10/2015	• ICD-9 codes	Rejected
Outpatient	9/25/2015	10/3/2015	10/10/2015	• ICD-9 codes for claim with "Discharge" date on or before 9/30/2015 • ICD-10 codes for claim with "Admit" date on or after 10/1/2015"	Processed
Outpatient	9/25/2015	10/3/2015	10/10/2015	• ICD-9 codes	Rejected
Outpatient	9/25/2015	10/3/2015	10/10/2015	• ICD-10 codes	Rejected
Inpatient/Outpatient	9/25/2015	9/30/2015	10/3/2015	• ICD-9 codes	Processed
Inpatient/Outpatient	9/25/2015	9/30/2015	10/3/2015	• ICD-10 codes	Rejected
Inpatient/Outpatient	10/3/2015	10/5/2015	10/10/2015	• ICD-9 codes	Rejected
Inpatient/Outpatient	10/3/2015	10/5/2015	10/3/2015	• ICD-10 codes	Processed
Inpatient/Outpatient	9/25/2015	9/25/2015	9/30/2015	• ICD-10 codes	Rejected

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. Please see “ICD-10 Billing Compliance Scenarios” table.

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. Please see “ICD-10 Billing Compliance Scenarios” table.

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. Please see “ICD-10 Billing Compliance Scenarios” table.

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 internal/external testing strategy and timeframes? How do we get involved with testing with you?

Our internal and external testing strategy is finalized and we will be ready to test with select providers starting 1Q 2015.

RAMP testing for HIPAA file format is available today.

Internal integration and external provider end-to-end testing will test the claim submission process from the origination point (Paper, Web, Direct 837) through Centene's core systems to all outputs with ICD codes (EOPs and Encounter files).

Please see the "2014/2015 Testing Detail" table for an overview of the testing types.

2014/2015 Testing Detail		
Testing Type	**Scope**	**Duration**
Internal Integration Testing	• Prepares systems for external provider testing by testing select systems using sample ICD-10 claim data.	7/1/14 – 11/28/14 (5 months)
External Provider End-to-End Testing	• Tests the internal integration systems by having Providers natively re-code claims with ICD-10 codes.	3/2/15 – 3/27/15 (1 month) Test claims will be submitted for all health plans during the March submission window (3/2/15 – 3/27/15). Internal processing of claims will occur on a rolling basis throughout March and April. Provider inquiries and follow-up are expected to continue to the end of May

Providers that submit claims via EDI or are interested in submitting claims via EDI can test with the health plan. Direct submitters can test by going go here and following these directions. Providers that submit claims through a clearinghouse can communicate this request to the EDI service desk at 1-800-225-2573, ext. 25525 or EDIBA@centene.com. Contact the EDI service desk for any questions or requests.

For further information on testing, please visit the health plan ICD-10 Overview page.

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. All first-time authorizations for pre-10/1/2015 dates of service must include ICD-9 codes. Authorizations with dates of service on or after 10/1/2015 service dates must include ICD-10 codes. Beginning in Q3 2015, the health plan can accept authorizations containing ICD-10 codes for expected dates of service on or after 10/1/15.

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 EOP layouts change?

Yes EOPs will have a change in field lengths to accommodate for ICD-10 Code.