ICD-10
Frequently Asked Questions
Revised on October 30, 2015

Send your ICD-10 questions to icd10project@dch.ga.gov

ICD-10 FAQs – General Information

1. What is ICD-10?

A: ICD-10 is a diagnostic coding system implemented by the World Health Organization (WHO) in 1993 to replace ICD-9. The system was developed by WHO in the 1970s and is now used in almost every country in the world. In the United States, ICD-10 usually refers to the U.S. clinical modification of ICD-10: ICD-10-CM. The code set is scheduled to replace ICD-9-CM, our current U.S. diagnostic code set on October 1, 2015. Another designation, ICD-10-PCS, for "procedural coding system," will also be adopted in the U.S. on October 1, 2015. ICD-10-PCS will replace Volume 3 of ICD-9-CM as the inpatient procedural coding system.

2. When must claims be submitted with ICD-10 (diagnosis) codes?

A: All claims with dates of service on October 1, 2015, or later must be submitted with a valid ICD-10 code.

3. What is a valid ICD-10 code?

A: A valid ICD-10 code is one prescribed in the ICD-10 code book. ICD-10-CM diagnosis is composed of codes with 3, 4, 5, 6 or 7 characters.

4. Do I have to enter the decimal point?

A: Do not enter any decimals within the ICD-10 diagnosis code when submitting claims on the GAMMIS web portal or on e-file transactions. The decimal point is implied or embedded in the e-file transactions and the GAMMIS web portal. If a decimal point is received within the diagnosis code using the EDI or web portal method of submission, it will fail compliance within EDI and populate error status code 4040 on the transmitted file. The submitter will then have to resubmit the electronic claim with the ICD-10 diagnosis code but without any decimal point.

TR3 Notes:	1. Do not transmit the decimal point for ICD codes. The decimal point is implied.

5. If External Cause of Injury Codes (E-Codes) are billed on an Inpatient or Outpatient claim where the date of service is on or after October 1, 2015, how many E-Codes are required?

A: Three E-Codes are required when billing on an Inpatient or Outpatient claim in order to fully describe an injury using ICD-10-CM. This is a federal mandate that Inpatient and Outpatient claims transmitted electronically must contain three (3) external cause of injury codes to fully describe an injury using an ICD-10 CM (diagnosis) code.

6. Will ICD-10-PCS procedure codes be used for both inpatient and outpatient hospital services?
A: No. ICD-10-PCS procedure codes are designed only for hospital reporting of inpatient services. Current Procedural Terminology (CPT) codes will continue to be used for physician and outpatient services.

7. I use a Clearinghouse/ Billing Service. Who do I contact about ICD-10 claims transmission questions?
A: Contact your Clearinghouse or Billing Service directly about ICD-10 claims transmission questions. It is not the responsibility of the clearinghouse to change or provide the ICD-10 diagnosis codes or address any ICD-10 related errors.

8. Are the Care Management Organizations (CMOs) also transitioning on October 1, 2015? Do we have to contact our CMO about the transition?
A: All HIPAA entities, including the CMOs, are affected by the October 1, 2015, federally mandated compliance date. Providers should contact ALL of their payers (including CMOs), trading partners, clearinghouses or billing companies regarding their plans for the ICD-10 transition. DCH recommends that providers contact their CMO(s) as soon as possible so that they do not experience any disruptions in reimbursements on and after October 1, 2015.

9. How do you bill Inpatient Hospital Procedure codes?
A: If billing an Inpatient Services UB-claim with revenue code 360 (operating room), you must have a PCS code (ICD-10 procedure code) and a data procedure that was performed submitted on the claim. PCS codes have seven digits either alpha or numeric. For example ICD-9 procedure 33.20 Thoracoscopic lung biopsy will now have several codes that are more specific than the ICD-9 procedure code. Some examples of PCS or ICD-10 procedure codes are listed below:

ICD-9 code:
- 33.20 Thoracoscopic lung biopsy

PCS codes:
- 0BBC4ZX Excision of Right Upper Lung Lobe, Percutaneous Endoscopic Approach Diagnostic
- 0BBD4ZX Excision of Right Middle Lung Lobe, Percutaneous Endoscopic Approach Diagnostic
- 0BBF4ZX Excision of Right Lower Lung Lobe, Percutaneous Endoscopic Approach Diagnostic
- 0BBG4ZX Excision of Left Upper Lung Lobe, Percutaneous Endoscopic Approach Diagnostic

- 0BBH4ZX Excision Lung Lingula, Percutaneous Endoscopic Approach Diagnostic
- 0BBJ4ZX Excision of Left Lower Lung Lobe, Percutaneous Endoscopic Approach Diagnostic
- 0BBK4ZX Excision of Right Lower Lung, Percutaneous Endoscopic Approach Diagnostic
- 0BBL4ZX Excision of Left Lung, Percutaneous Endoscopic Approach Diagnostic

ICD-10 FAQs – Georgia Medicaid Policy

10. Are there system failures related to ICD-10 claims that are submitted on an 837 Institutional or Professional electronic files via GAMMIS?

A: There are no system failures related to ICD-10 claims that are submitted as 837 Institutional or Professional electronic files via the GAMMIS web portal. The 837 file failures are denying due to submitter errors. A few examples of submitter errors include, but are not limited to the following:

- E-files being submitted with both ICD-9 and ICD-10 codes
- ICD-10 diagnosis codes billed where dates of service were prior to October 1, 2015
- ICD-9 diagnosis codes billed where dates of service were on or after October 1, 2015
- Outdated PES software

The HPES EDI team is working with providers with these EDI compliance errors for resubmission of a correct e-files.

11. What version of Provider Electronic Solutions (PES) is required to submit ICD-10 claims?

A: Provider Electronic Solutions version 1.03 was released on May 1, 2014. This version has the ability to submit ICD-10 claims. All PES users are required to upgrade to version 1.03. To apply the 1.03 upgrade and for the updated manual please visit www.mmis.georgia.gov and select the Software and Manuals page from the Electronic Data Interchange (EDI) menu.

12. Does HIPAA Version "4010/4010A1" support ICD-10 codes?

A: No. To process ICD-10 claims or other transactions electronically, providers, payers and vendors must implement the "Version 5010" health care transaction standards mandated by HIPAA. This implementation was effective January 1, 2012. The previous HIPAA "Version 4010/4010A1" transaction standards do not support the ICD-10 codes.

13. Are CPT and HCPCS codes affected by ICD-10?

A: The Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding Systems (HCPCS) codes are not changing nor are they affected by ICD-10.

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

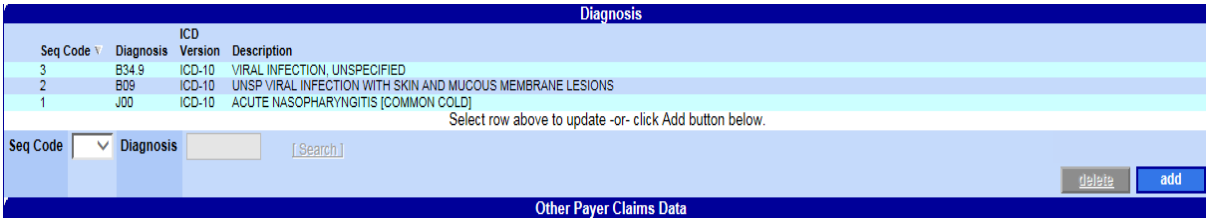
A: If the date of service on a claim is before October 1, 2015, and contains ICD-9 codes, then the claim will be accepted for payment. If the date of service is on or after October 1, 2015, and uses ICD-9 codes, then this claim will be rejected. If a claim is submitted with both ICD-9 and

ICD-10 diagnosis codes on or after October 1, 2015, the claim will also be denied. 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. If a practice continues to use ICD-9 codes on claims with dates of service on or after the October 1, 2015, ICD-10 compliance date, the practice will have denied claims and there will be no reimbursement for this billing error.

15. If a provider bills multiple procedures with both specified and unspecified diagnoses on the same line on a 1500 professional claim form, will the claim deny?

A: Yes, all professional claims submitted with ICD-10 unspecified diagnosis codes (as listed and posted on the GAMMIS web portal, which is updated periodically) will deny regardless of the diagnosis code position, Dx Rel 1, Dx Rel 2, Dx Rel 3, etc. When billing ICD-10 diagnosis codes, the code should support the level of specificity and laterality being billed based on the physician's medical evaluation and treatment plan. The physician is required to bill at the highest specificity or diagnosis code level by selecting the most appropriate specified code. The physician's documentation must support and justify the level of ICD-10 diagnosis code being billed. Below are several examples of a diagnosis code billed on the 1500 claim form at the detail line:

1. If the claim consists of multiple diagnosis codes on the first line (diagnosis pointers include all diagnoses) with the procedure code and one of the ICD-10 diagnosis codes is unspecified then the entire professional claim will deny in GAMMIS.



Diagnosis

Seq Code	Diagnosis	ICD Version	Description
3	B34.9	ICD-10	VIRAL INFECTION, UNSPECIFIED
2	B09	ICD-10	UNSP VIRAL INFECTION WITH SKIN AND MUCOUS MEMBRANE LESIONS
1	J00	ICD-10	ACUTE NASOPHARYNGITIS [COMMON COLD]

Select row above to update -or- click Add button below.

Seq Code | Diagnosis | [Search] | delete | add

Other Payer Claims Data

Detail

Item	1	Emergency	
From DOS	10/15/2015	EPSDT/Fam Plan	
To DOS	10/15/2015	PA/Precert Number	
POS	11	Mammogram Certification Number	
Procedure	99214	DME Serial Number	
Procedure Description	OFFICE/OUTPATIENT VISIT EST	Ordering Provider ID	
Modifiers	,,,	Ordering Provider Name	
Diagnosis Pointers	1,2,3	NDC	
Units	1.00	Drug Name	
Charges	$195.00	Drug Unit Count	
Rendering Provider ID		Drug Unit of Measure	
Referring Provider ID		Status	DENIED
Referring Provider Name		Allowed Amount	$0.00
Primary Care Provider ID		CoPay Amount	$0.00
Primary Care Provider Name		Paid Amount	$0.00

Claim Status Information

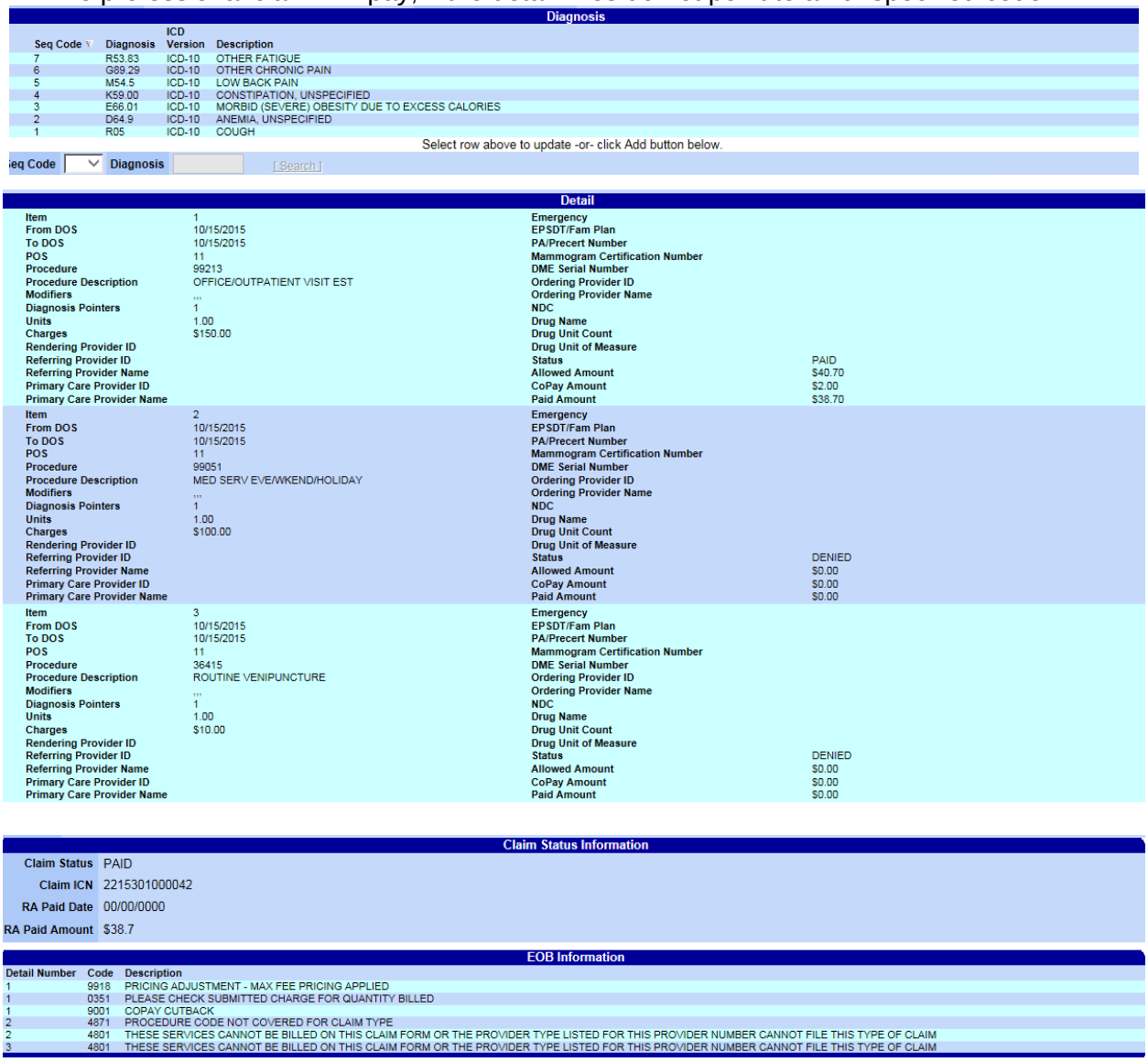
Claim Status	DENIED
Claim ICN	2215301000040
Denied Date	00/00/0000
RA Paid Amount	$0.00

EOB Information

Detail Number	Code	Description
1	1431	2ND ICD-10 DIAGNOSIS IS NOT SPECIFIC
1	1432	3RD ICD-10 DIAGNOSIS IS NOT SPECIFIC

2. Claims with multiple detail lines billed, the ICD-10 diagnosis pointer on line #1 should only list the primary DX Rel1 or specified diagnosis code. The other unspecified codes of Dx Rel 2 and DX Rel 3 should be listed below the detail line #1 without the diagnosis pointer on those unspecified diagnosis codes.

The professional claim will pay, if the detail lines do not point to an unspecified code.



Diagnosis

Seq Code	Diagnosis	ICD Version	Description
7	R53.83	ICD-10	OTHER FATIGUE
6	G89.29	ICD-10	OTHER CHRONIC PAIN
5	M54.5	ICD-10	LOW BACK PAIN
4	K59.00	ICD-10	CONSTIPATION, UNSPECIFIED
3	E66.01	ICD-10	MORBID (SEVERE) OBESITY DUE TO EXCESS CALORIES
2	D64.9	ICD-10	ANEMIA, UNSPECIFIED
1	R05	ICD-10	COUGH

Select row above to update -or- click Add button below.

Seq Code | Diagnosis | [Search]

Detail

Item	1	Emergency	
From DOS	10/15/2015	EPSDT/Fam Plan	
To DOS	10/15/2015	PA/Precert Number	
POS	11	Mammogram Certification Number	
Procedure	99213	DME Serial Number	
Procedure Description	OFFICE/OUTPATIENT VISIT EST	Ordering Provider ID	
Modifiers	,,,	Ordering Provider Name	
Diagnosis Pointers	1	NDC	
Units	1.00	Drug Name	
Charges	$150.00	Drug Unit Count	
Rendering Provider ID		Drug Unit of Measure	
Referring Provider ID		Status	PAID
Referring Provider Name		Allowed Amount	$40.70
Primary Care Provider ID		CoPay Amount	$2.00
Primary Care Provider Name		Paid Amount	$38.70
Item	2	Emergency	
From DOS	10/15/2015	EPSDT/Fam Plan	
To DOS	10/15/2015	PA/Precert Number	
POS	11	Mammogram Certification Number	
Procedure	99051	DME Serial Number	
Procedure Description	MED SERV EVE/WKEND/HOLIDAY	Ordering Provider ID	
Modifiers	,,,	Ordering Provider Name	
Diagnosis Pointers	1	NDC	
Units	1.00	Drug Name	
Charges	$100.00	Drug Unit Count	
Rendering Provider ID		Drug Unit of Measure	
Referring Provider ID		Status	DENIED
Referring Provider Name		Allowed Amount	$0.00
Primary Care Provider ID		CoPay Amount	$0.00
Primary Care Provider Name		Paid Amount	$0.00
Item	3	Emergency	
From DOS	10/15/2015	EPSDT/Fam Plan	
To DOS	10/15/2015	PA/Precert Number	
POS	11	Mammogram Certification Number	
Procedure	36415	DME Serial Number	
Procedure Description	ROUTINE VENIPUNCTURE	Ordering Provider ID	
Modifiers	,,,	Ordering Provider Name	
Diagnosis Pointers	1	NDC	
Units	1.00	Drug Name	
Charges	$10.00	Drug Unit Count	
Rendering Provider ID		Drug Unit of Measure	
Referring Provider ID		Status	DENIED
Referring Provider Name		Allowed Amount	$0.00
Primary Care Provider ID		CoPay Amount	$0.00
Primary Care Provider Name		Paid Amount	$0.00

Claim Status Information

Claim Status	PAID
Claim ICN	2215301000042
RA Paid Date	00/00/0000
RA Paid Amount	$38.7

EOB Information

Detail Number	Code	Description
1	9918	PRICING ADJUSTMENT - MAX FEE PRICING APPLIED
1	0351	PLEASE CHECK SUBMITTED CHARGE FOR QUANTITY BILLED
1	9001	COPAY CUTBACK
2	4871	PROCEDURE CODE NOT COVERED FOR CLAIM TYPE
2	4801	THESE SERVICES CANNOT BE BILLED ON THIS CLAIM FORM OR THE PROVIDER TYPE LISTED FOR THIS PROVIDER NUMBER CANNOT FILE THIS TYPE OF CLAIM
3	4801	THESE SERVICES CANNOT BE BILLED ON THIS CLAIM FORM OR THE PROVIDER TYPE LISTED FOR THIS PROVIDER NUMBER CANNOT FILE THIS TYPE OF CLAIM

16. Could you explain the Medicaid policy on unspecified codes and the requirements for ICD-10 effective October 1, 2015?

A: NOS, or "not otherwise specified" codes may be denied as there is not enough clinical documentation to determine the diagnosis. NEC codes, or "not elsewhere classified" will be supported as this means there is not an appropriate or an existing ICD-10 code to support it. Clinical justification is required if providers use an NEC code. The physician is required to bill at the highest specificity or diagnosis code level selecting the most appropriate specified code. The physician's documentation must be clear, complete and concise to support the code billed. Example: A patient is seen for injury to the right and/or left eye, but the provider bills using a diagnosis code of "other" as an unspecified code. Unless the provider has documentation that there is a third eye, then this claim with an unspecified diagnosis code of "other" would be denied.

17. Can you provide further information about non-specified and unspecified codes?

A: ICD-10 coding allows providers to capture more details about the health status of their patients. Physicians' documentation should support the level of details based on the medical evaluation and treatment. Billing of ICD-10 diagnosis codes should support the level of code specificity and laterality being billed based on the physician's medical evaluation. Some of the ICD-10 unspecified diagnosis codes are not acceptable in GAMMIS and may deny when billed. Please see the list of unspecified diagnosis codes on the GAMMIS web portal, www.mmis.georgia.gov, under Provider Notices. Providers should invest in an ICD-10 CM diagnosis code book to fully review the diagnosis codes within a family of codes. In reviewing the complete list of diagnosis codes within a section of the reference book, unspecified diagnosis (highlighted in yellow) is often the lowest level of code choice. However, 'Other' (unspecified) diagnosis code in the ICD-10 CM diagnosis code (highlighted in gray) book is an alternative code choice to bill.

To address expressed concerns voiced by our provider community, there are some medical conditions that may warrant the use of unspecified diagnoses codes. DCH has posted on the GAMMIS web portal under Provider Notices a list of the unspecified diagnosis codes that may deny in GAMMIS when billed on ICD-10 claims. Every effort should be made to select the most appropriate specified diagnosis code in the ICD-10 code reference manual that is based on the documentation in the patient's medical record. Physicians must document all requirements in their patients' medical record (anatomical location, laterality, time perimeter, and severity) so that their billers and coders can select the most appropriate ICD-10 code based on concise, complete, and clear documentation.

HPES Customer Call Center staff, field reps or billing agents, and clearinghouses are not able to provide crosswalk ICD-10 codes for your claims because the codes are based on a patient's medical record. We encourage providers to obtain an ICD-10 code reference manual to assist with their code selections. Total reliance on a General Equivalent Mapping (GEM) tool is not preferable. It may map to unspecified codes which may or may not be appropriate. A GEM tool

also may not provide the full listing of ICD-10 diagnosis codes within a code category or family of codes.

18. What do I need to know about Prior Authorizations (PAs)?
A: Prior authorization (PA) requests already approved prior to the ICD-10 transition before October 1, 2015, will not need to be resubmitted. If the PA request is submitted for approval on or after October 1, 2015, the request form must have ICD-10 diagnosis (CM) codes for claim processing. Any PA renewals or requests submitted on or after October 1, 2015, will need to have ICD-10-CM (diagnosis) codes.

NOTE: The PA start date is the key to which code set (ICD-9 or ICD-10) to submit on a PA. The correct diagnosis code set must be used on the claim to be adjudicated in GAMMIS.

19. What do I need to know about Pre-certification (Pre-cert) for inpatient admissions?
A: All inpatient pre-cert requests must meet the InterQual admission standards. The current Pre-cert process for obtaining inpatient requests is not changing. ICD-10 codes do not have an impact on Pre-certification.

20. Does ICD-10 have an impact on Georgia Medicaid's diagnosis-related group (DRG) Version 30 grouper for UB-04 claims?
A: Based on 3M™ Tricare Grouper documentation and configuration in GAMMIS, there will be no ICD-10 impact of DRG assignment on inlier claims.

21. Will Georgia Medicaid's edits and audits be affected by ICD-10 as they relate to claims adjudication?
A: No. Georgia Medicaid's current claims processing procedures, system edits and audits and front-end verification editing will not change with the transition to ICD-10.

22. In ICD-10, what is the difference between "Subsequent" codes and "Sequela" codes?
A: A subsequent visit is any encounter beyond the initial visit for the same diagnosis. A sequela is the residual effect (condition produced [by]) the acute phase of an illness or injury. There is no limit on the sequela codes that can be used. The sequelae may be apparent early or may occur months or years later from a previous injury. Coding of sequela generally requires two codes sequenced in the following order:

- The condition or nature of the sequela [illness or injury that caused the sequela] is sequenced first.
- The sequela code is sequenced second.

Example: A person with a Cerebral Infarction due to embolism of the right posterior cerebral artery, initial visit you would code I63.431. The same patient as above that has hemiplegia G81.04 (A; initial visit). Six months later patient is seen in the physician's office for care, code I63.431D. (D; subsequent visit) with hemiplegia and hemiparesis code I69.354 (S; sequela). This is the sequela code.

23. Does the new ICD-10 Code change affect the current Medicaid rates?
A: No.

24. What is meant by a "family of codes"?
A: "Family of codes" is the same as the ICD-10 three-character category. Codes within a category are clinically related and provide differences in capturing specific information on the type of condition. For instance, category H25 (Age-related cataract) contains a number of specific codes that capture information on the type of cataract as well as information on the eye involved. Examples include: H25.031 (Anterior subcapsular polar age-related cataract, right eye), which has six characters; H25.22 (Age-related cataract, morgagnian type, left eye), which has five characters; and H25.9 (Unspecified age-related cataract), which has four characters. In many instances, the ICD-10 diagnosis code will require more than three characters in order to be valid.

Another example, K50 (Crohn's disease) has codes within the category that require varying numbers of characters to be valid. The ICD-10-CM code book clearly provides information on valid codes within this and other categories. Providers can also check the list of valid 2016 ICD-10-CM codes to determine if all characters have been selected and reported.

Examples of valid codes within category K50 include:
- K50.00 Crohn's disease of small intestine without complications
- K50.012 Crohn's disease of small intestine with intestinal obstruction

A header diagnosis example is C81 (Hodgkin's lymphoma) – which by itself is not a valid code. Examples of valid codes within category C81 contain five characters, such as:
- C81.00 Nodular lymphocyte predominant Hodgkin lymphoma, unspecified site
- C81.03 Nodular lymphocyte predominant Hodgkin lymphoma, intra-abdominal lymph nodes

ICD-10 FAQs – GAMMIS Claims Submission

25. Is there a change to the ICD Version Field (Diagnosis Search at the Header) on the Web Claim Page?

A: The ICD Version field is now enabled and is available on each claim form header. You must change the ICD Version Field before entering the diagnosis code. When entering NEW claims, the ICD Version Field is defaulted to ICD-10 as of October 1, 2015. If the date of service requires the submission of ICD-9 codes, select ICD-9 from the ICD Version Field prior to entering any ICD-9 codes.

If you have copied your claim from a previously paid version for dates of service prior to 10/1/15 and your copied claim is for dates of service 10/1/15 or later, the Version field will need to be changed. Refer to the functionality of the field as noted below when billing ICD-9 historic claims. When viewing EXISTING claims, the ICD Version Field will continue to reflect the version of the

ICD codes previously submitted. For instance, claims submitted 6 months ago with ICD-9 codes will show as "ICD-9" in the ICD Version field.

A message will appear above the claim if the user attempts to submit a claim with the incorrect ICD code versions in relation to the date of service. The claim cannot be submitted until the error message is resolved by the user. If the user already has ICD codes on the claim and THEN changes the ICD Version, the user will get a pop-up screen to confirm the ICD-Version Field change and instruct what actions are required next.

NOTE: If your date of service requires you to submit ICD-9 diagnosis codes, select the ICD-9 from the ICD Version Field (at the header) prior to entering any ICD-9 codes. Remember if copying a claim that was previously billed, note which ICD version or code set that you are entering (either ICD-9 or ICD-10). Otherwise you will receive an error – FAILED transmission.

ICD-10 FAQs - Program Specific

26. How much of this will actually affect my agency as we deal with the behavioral health aspect?
A: If you are currently submitting ICD-9/DSM-IV codes for behavioral health services to DCH for reimbursement, you will be required to submit the corresponding DSM-5/ICD-10 code effective October 1, 2015. The ICD-10 diagnosis codes effective on or after October 1, 2015, correspond to the behavioral health codes in the DSM-5 Manual; however the DSM-IV does not include ICD-10 codes. If you have specific questions related to the behavioral health policies, contact the Georgia Department of Behavioral Health and Developmental Disabilities directly.

27. Will the transition to ICD-10 for Community Mental Health Center providers be applied to a DBHDD encounter?
A: Yes, the transition to ICD-10 will be applied to all claims.

28. Will Behavioral Health authorization requests accept DSM-V codes in lieu of ICD-10?
A: No. DSM-V codes will not be accepted in lieu of ICD-10 codes. In accordance with federal billing policy, all submissions for Behavioral Health must be submitted with ICD-10 codes for dates of service on or after the federal ICD-10 compliance date. ICD-9 and DSM-IV codes will not be accepted by the Georgia Medicaid Management Information System (GAMMIS) on or after the federal ICD-10 compliance date. We understand that some ICD-10 codes are the same as the DSM-V codes.

For Psychiatric Residential Treatment Facilities and Community Mental Health Centers, the electronic authorization process will be modified to add ICD-10 diagnosis codes. The Department of Behavioral Health and Developmental Disabilities will provide technical instructions directly to those providers.

29. Will dental claims require ICD-10 codes?
A: No. The Georgia Medicaid Dental Services Program does not currently use ICD-9 or include ICD-10 codes in October 1, 2015. The Dental Services Program uses the current year of the Code on Dental Procedures and Nomenclature (CDT codes) published by the American Dental

Association. Maxillary and Oral Surgeons who currently use ICD-9 codes will have to transition to ICD-10 and choose the most appropriate ICD-10 code(s).

30. As of October 1, 2015, the health care industry will be using ICD-10. In Georgia Medicaid Home and Community Based Waiver programs some existing level of care documentation for direct service providers may contain ICD-9 codes until their annual review. How should the direct service providers handle this issue?
A: The direct service provider should work with the case management agency for the waiver to establish a valid associated ICD-10 code. The Case manager should confer with the physician's office to encourage the use of an appropriate ICD-10 code, rather than an ICD-9 code or an inappropriate or non-specific ICD-10 code. After October 1, 2015, the case management entity should ensure an appropriate ICD-10 code is available for all annual reviews and initial approval. The ICD-10 code should be reflected on the level of care documentation.

ICD-10 Split-Billing

31. When do I split bill?
A: A claim cannot contain both an ICD-9 and ICD-10 code; therefore, you will need to split bill to prevent the claim from denying. The date of service on the claim determines which code set to use. For Hospital Services (inpatient and outpatient), the date of discharge determines which code set to use. Please see below program specific instructions for split billing of several programs: home health and DME claims.

32. Will split billing be insurance specific? For example, if a patient is admitted on September 29, 2015 and discharged on October 3, 2015, will we have to do split billing?
A: If an inpatient UB-04 claim has a date of discharge on or after October 1, 2015, then the entire claim must be billed using ICD-10 codes.

33. What is the split-claim billing rule for Inpatient Hospitals for claims on or after October 1, 2015?
A: Inpatient (UB-04) claims may be billed with both a FROM and THROUGH (discharge) date that may span both date spans with the ICD-10 transition. The driver of which code set to bill is the THROUGH (discharge) date. UB-04 inlier claims with a date of discharge on or after October 1, 2015, must be submitted with a valid ICD-10 code. Inpatient claims may not contain a combination of ICD-9 and ICD-10 codes.

34. How will changing from ICD-9 to ICD-10 in the middle or at the beginning of an episode affect home health agencies and billing?
A: Home Health agencies will still need to reflect an appropriate ICD-9 or ICD-10 diagnosis code regardless of the episode. The episode and/or any Home Health treatments provided to the member will be billed based on the date of service. Home Health agencies will not be able to submit both ICD-9 and ICD-10-CM (diagnosis) codes on the same CMS 1500 claim form. The combined code sets on one claim will deny in GAMMIS. The claim will have to be split billed – ICD-9 diagnosis code(s) for the episode occurring prior to October 1, 2015, and ICD-10 diagnosis code(s) for the episode occurring on or after October 1, 2015.

35. Durable Medical Equipment (DME) prescriptions come to the provider of DME services with a diagnosis that sometimes contains a description of the diagnosis and an ICD-9-CM code. After October 1, 2015, how will this be handled as previous prescriptions will contain ICD-9 diagnosis codes?
A: There is no change in this DME Policy or to the current process. The member's diagnosis is not changing, but rather the code set for documenting the diagnosis. This means that a prescription that states "Pneumonia," etc., will result in an actual claim on or before September 30, 2015 that is submitted with ICD-9 codes, and for dates of service on or after October 1, 2015 that contain ICD-10 codes. DME providers need to make sure to use the correct codes based on the DME documentation and the actual date of service.

ICD-10 Medicare Crossover Claims

36. If a Medicare paid claim is crossed over to Medicaid for a dual-eligible beneficiary, is Medicaid required to pay the claim if it only has ICD-9 codes reflected?
A: The current crossover policy will not change with the transition to ICD-10. Claims processing verifies that the individual is eligible, that the claimed service is covered and that all administrative requirements for a Medicaid claim have been met. If these tests are met, payment can be made, taking into account the amount paid or payable by Medicare. Consistent with those processes, GA Medicaid can deny claims based on system edits indicating an invalid ICD-10 diagnosis code. The current GA Medicaid crossover claims policy and payment logic are not changing with the transition to ICD-10. The recent publications of July 7 and July 27, 2015, by the Centers for Medicare and Medicaid (CMS) provided guidance for the Medicare processing of crossover claims. The two CMS' bulletins DO NOT impact GA Medicaid's crossover claims processing or policy with the transition of ICD-10.

37. Will CMS permit state Medicaid agencies to issue interim payments to providers unable to submit a claim using valid, billable ICD-10 codes?
A: Federal matching funding is not available for provider payments that are not processed through a compliant MMIS and supported by valid, billable ICD-10 codes. Georgia Medicaid will not be issuing interim or advance payments as a result of the ICD-10 implementation.

ICD-10 FAQs – Resources

38. What is the General Equivalence Mapping (GEM) tool?
A: The GEM is a tool used to convert data from ICD-9-CM to ICD-10-CM and ICD-10-PCS and vice versa. Using GEM is not a substitute for learning how to use ICD-10-CM and ICD-10-PCS. It is very helpful during the transition to ICD-10, but should not be considered total validity for code selections. There are various GEM tools available to assist with your clinical mappings.

39. If an ICD-9 code is found using the GEM tool, is it still necessary to use reference material to verify the converted ICD-10 code?
A: GEM tool is not a substitute for learning how to use ICD-10-CM and ICD-10-PCS. In coding claims, it will be more efficient and accurate to work from the medical record documentation and then select the appropriate code(s) from the appropriate coding book. Although the GEM tool has been designed for the code conversions, it does not map all codes. We encourage you to use your ICD-10 reference coding book because with the new ICD-10 codes, approximately 669

ICD-10 diagnosis codes have no ICD-9 alternative, and about 5 percent have one to several conversions.

40. What is the best resource from which to purchase an affordable ICD-10 coding book?
A: DCH cannot make recommendations for the best resource in purchasing ICD-10 coding books. It is up to the provider to do the research and decide. There are various online resources for purchasing ICD-10 coding books, including but not limited to www.amazon.com, www.contexomedia.com, www.aapc.com.

41. Does DCH anticipate holding ICD-10 trainings?
A: No, not specifically on coding guidelines. DCH has provided training on ICD-10 regarding claims submission. DCH has conducted webinar presentations and testing with providers. These webinar sessions have been recorded and can be found on our ICD-10 events web page https://dch.georgia.gov/icd-10-events.

42. Does DCH have any resources available?
A: Yes. DCH has a dedicated ICD-10 page with links and a repository of recorded webinars. Please visit the website at https://dch.georgia.gov/icd-10. Additionally, we encourage you to visit the CMS website at www.CMS.gov or other online resources such as www.aapc.com or www.ahima.com where you can find other ICD-10 resources about the transition to ICD-10.

43. If we experience significant delays in our reimbursement from Georgia Medicaid, we could be out of business. Is there any contingency plan in place to help us through the transition to ICD-10?
A: It is the provider's responsibility to submit clean claims and DCH's responsibility to pay those clean claims in a timely manner. Depending on your level of ICD-10 readiness, industry experts are advising providers to have several months of cash reserves or access to cash through a loan or line of credit to avoid potential cash flow challenges. DCH highly recommends ICD-10 coding training.

44. If I have an issue specific to ICD-10 after October 1, 2015, who should I call or contact? Is there a phone number to call?
A: If you are sending specific claims inquiry requests, please include the claim's ICN (13 digit claim number). Note: The DCH mailbox contact information listed below should only be used for ICD-10 questions. Please continue to send your normal claims inquiry questions via the HPES Contact US contact or call the HP Call Center at 1-800-766-4456.

Send us your ICD-10 questions to icd10project@dch.ga.gov.