Introduction to ICD-10 Diagnosis and Procedure Codes

The U.S. Department of Health and Human Services (HHS) announced a final rule that will facilitate the United States’ ongoing transition to an electronic health care environment through adoption of new healthcare code sets for use in electronic health care transactions. This rule adopts updated versions of the code sets, under the authority of HIPAA (ICD-10 final rule). The ICD-10 code sets replace the current ICD-9-CM code set. 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, 2013. Otherwise, claims and other transactions will be rejected, and will need to be resubmitted.

It is important to start now to prepare for the changeover to ICD-10 codes. Delays may negatively impact provider reimbursements.

ANSI X12 version 4010 is the current HIPAA electronic transaction standard. However, version 4010 is not capable of handling ICD-10 Procedure and Diagnosis Codes. By Federal mandate, ANSI X12 version 5010 will be the HIPAA electronic transaction standard as of January 1, 2012. Version 5010 includes support for ICD-10 diagnosis and procedure codes.

Today, the industry uses about 13,500 unique ICD-9-CM volume 1 & 2 codes to describe diagnosis. ICD-9 diagnosis codes are 3-5 digits in length (e.g., 821.01 – Closed Fracture of shaft of femur). With the ICD-10-CM mandate, the length of diagnosis codes will increase to 3-6 alphanumeric characters plus a qualifier (e.g., S72.344 – Displaced spiral fracture of shaft of right femur). There will be about 69,000 codes with a much greater level of specificity.

The industry currently uses about 4,000 unique ICD-9-CM volume 3 codes to describe inpatient procedures. ICD-9 procedure codes are 3-4 digits in length (e.g., 47.01 – Laparoscopic appendectomy). With the ICD-10-PCS mandate, the length of inpatient procedure codes will increase to 7 alphanumeric characters (e.g., ODTJ4ZZ – Laparoscopic appendectomy). There will be about 72,000 unique codes with much greater detail than the current procedure codes.

According to the Centers for Medicare and Medicaid Services (CMS), the benefits of compliance with the ICD-10 mandate include that ICD-10:

- Incorporates much greater specificity and clinical information, which results in:
  - Improved ability to measure health care services;
  - Increased sensitivity when refining grouping and reimbursement methodologies;
  - Enhanced ability to conduct public health surveillance; and
  - Decreased need to include supporting documentation with claims;
- Includes updated medical terminology and classification of diseases;
- Provides codes to allow comparison of mortality and morbidity data; and
- Provides better data for:
  - Measuring care furnished to patients;
  - Designing payment systems;
- Processing claims;
- Making clinical decisions;
- Tracking public health;
- Identifying fraud and abuse; and
- Conducting research.

The switch from using ICD-9 to using ICD-10 will fundamentally change the way providers describe patient diagnosis and inpatient procedures. Providers should review how they communicate diagnosis and inpatient procedures internally, with other health care providers, hospitals, and groups. Providers should also review communications with government agencies, accreditation organizations, and researchers. Finally, providers should examine their communications with payers to determine how the communications will be impacted.

In order to be ready to operate using ICD-10, providers should start to examine how ICD-9 is used in their organization. According to CMS, providers should:

- Identify potential changes to workflow and business processes.
- Assess staff training needs. Identify the staff in your office who code, or have a need to know the new codes.
- Talk with your practice management system vendor about accommodations for ICD-10 codes.
- Contact your payers, clearinghouses, and billing services. Ask about their plans for the Version 5010 and ICD-10 compliance.
- Budget for time and costs related to ICD-10 implementation. Assess the costs of any necessary software updates, reprinting of superbills, training, etc.
- Conduct test transactions using ICD-10 codes with your vendors and payers. Check to see when they will begin testing, and the test days they have scheduled.

To be compliant with the Federal ICD-10 regulations, BCBSNC will only accept claims with ICD-10 diagnosis codes for services rendered on or after 10/1/2013. Additionally, BCBSNC will only accept claims with inpatient procedures that have been coded using ICD-10 for services rendered on or after 10/1/2013. BCBSNC will change all media, including electronic, web, paper, FAX and telephonic communications to use ICD-10 codes.

To support timely provider reimbursement, BCBSNC recommends that providers switch to using HIPAA 5010 transactions by 1/1/2012, change business processes to describe diagnosis using ICD-10-CM, and change inpatient business processes to describe inpatient procedures using ICD-10-PCS. Some impediments to timely reimbursement will be the use of ICD-9 codes after 10/1/2013, the use of truncated codes, and the use of “Not Otherwise Specified” codes where specificity is available.

Blue Cross and Blue Shield of North Carolina (BCBSNC) understands this period of change will be challenging and we are committed to working closely with our network of health care professionals to ensure a seamless transition. We will continue to keep you updated as more information becomes available. In the interim, you can visit the following websites for additional information:
- CMS: www.cms.gov/ICD10/
- AHA: www.ahacentraloffice.com/ahacentraloffice_app/ICD-10/resources.jsp
- AHIMA: www.ahima.org/icd10/
- AAPC: www.aapc.com/ICD-10/
- NCHICA: www.nchica.org/HIPAAResoures/icd10.htm