



ICD-10-CM: Behavioral Health Providers

DSM-5 Path to Success

July and August 2015

ICD-10-CM: Behavioral Health Focus

- DSM-5* Supports the Behavioral Health Transition to ICD-10
- Claim Submission
 - Dates of Service
 - ICD Indicator
- Authorizations
- Eligibility & Benefits
- Autism / Coordination with ABA Providers
- Readiness and Mitigations
 - System and Process Readiness within Your Practice
 - Electronic Claim Submissions
 - Electronic Payments and Statements
 - Optum Readiness: BPT Testing, Provider Surveys and Post-Implementation

*Fifth Edition of *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) is a publication of the American Psychiatric Association
APA website [DSM-5](#)



DSM-5 removes many of the ICD transition challenges

- Revenue cycle risks associated with timely filing & claim specificity are mitigated
 - Clear documentation requirements
 - Provides industry-standard for the association of ICD billing codes with clinical conditions

Medical

- Physician/Health Professional documentation is key to timely filing
- Coders review files to identify & assign the billing code with the greatest specificity
- When documentation is insufficient, coders must return to providers for more information *before* they file the claim

Behavioral

- Clinician documentation follows DSM-5 criteria
- DSM-5 provides mapping to both ICD-9-CM and ICD-10-CM codes used for billing
- Prior to the transition use the ICD-9 code and after the transition use the ICD-10 code; existing clinical documentation supports use of both

“CM” stands for “Clinical Modification”

The National Centers for Health Statistics (NCHS) developed a clinical modification to the World Health Organization’s ICD code sets for use in the United States

Example from DSM-5

Obsessive-Compulsive Disorder 237

DSM-5: Diagnosis → **Obsessive-Compulsive Disorder**

Diagnostic Criteria **300.3 (F42)**

A. Presence of obsessions, compulsions, or both:

Obsessions are defined by (1) and (2):

1. Recurrent and persistent thoughts, impulses, or images that are intrusive and unwanted, that cause marked anxiety or distress.
2. The individual attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action.

Compulsions are defined by (1) and (2):

1. Repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly.
2. The behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive.

Note: Young children may not be able to articulate the aims of these behaviors or mental acts.

B. The obsessions and compulsions are time-consuming (e.g., take more than 1 hour per week) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

The International Classification of Disease (ICD) is maintained by the World Health Organization (WHO). It is used to track and trend morbidity and mortality world-wide. The DSM, published by the APA, has historically mapped to the ICD-CM codes used in the U.S. for billing.

The current edition, DSM-5, maps conditions to both the ICD-9-CM and ICD-10-CM codes.

Diagnostic Label and Criteria: APA/DSM

- Obsessive-Compulsive Disorder
- Criteria outlined A-D with specifiers to include in documentation

Diagnostic Billing Codes: WHO/ICD

- 300.3
 - ICD-9-CM
 - Use through dates of service 9/30/15
- (F42)
 - ICD-10-CM
 - Use beginning dates of service 10/1/15 and later

Special Call-Out

DSM-5 has had some coding updates, these are available online from the APA:

www.psychiatry.org/dsm5 > DSM-5 Coding Update

DSM-5 maintains familiar process

- While the DSM-5 does bring some changes in categorizations, diagnostic criteria and documentation, much remains familiar

Look at what is NOT changing ~ a billing perspective

DSM-IV

- Presence of a condition in DSM-IV does not indicate:
 - coverage: check eligibility & benefits
 - need for treatment: both symptom severity & functional impairments are important in determining level of care
- Document findings based on criteria listed in the DSM-IV to include noting medical conditions, stressors, and level of functioning
- DSM-IV supplies the ICD-9 code to use for billing; apply the numeric ICD code listed by the condition on your claim submission **

DSM-5

- Presence of a condition in DSM-5 does not indicate:
 - coverage: check eligibility & benefits
 - need for treatment: both symptom severity & functional impairments are important in determining level of care
- Document findings based on criteria listed in the DSM-5 to include noting medical conditions, stressors, and level of functioning
- DSM-5 supplies both the ICD-9 and ICD-10 code to use for billing; apply the appropriate code based on Date of Service**

** DSM-5

Your use of DSM-5 for assessment and documentation now paves the way for your readiness to apply ICD-10 billing codes

DSM-5: Behavioral Health path to understanding ICD-10

DSM-5 as ICD-10 Resource

- Provides current industry-standard criteria for mental health and substance use disorders
- Maps to both ICD-9-CM and ICD-10-CM billing codes
- Includes “Alphabetical Listing of DSM-5 Diagnoses and Codes (ICD-9-CM and ICD-10-CM)” in the Appendix (page 839; provides an easy ICD-9 and ICD-10 side-by-side comparison for conditions listed in the DSM-5)

DSM-5, Documentation and Billing

- DSM-5 provides guidance on documentation of clinical findings and conditions that may affect treatment or prognosis
 - ✓ While the multiaxial system of documentation has been discontinued, it remains important to note medical conditions and psychosocial stressors that are relevant to assessment and care planning
- Clinical documentation with billing information showing both the ICD-9 and ICD-10 codes supports both clinicians and office staff in learning the new codes and determining what system or process changes are needed in order to be ICD-10 ready from a billing perspective

Timeline and Dates of Service

This is a “flip-of-the-switch” change for our industry.

The legislation requires full and immediate transition to ICD-10 for billing for all Dates of Service October 1, 2015 and later. There is no transitional grace period for ICD-10.

What about services spanning the transition date?

- A single claim cannot include both ICD-9 and ICD-10 code sets
- The Date of Service (DOS), not the date of claim submission, determines which ICD code set (ICD-9-CM or ICD-10-CM) should be used



Date of Service (DOS) key to ICD code set selection

Outpatient Services

Client A

- Seen for services on 9/3, 9/10, 9/17 and 9/24: All DOS may be filed on a single claim using ICD-9-CM codes

Client B

- Seen for services on 10/1, /10/8, 10/15 and 10/22: All DOS may be filed on a single claim using ICD-10-CM

Client C

- Seen for services on 9/17, 9/24, 10/1 and 10/8: The September DOS may be filed on a single claim using ICD-9-CM, and the October DOS will need to be submitted on a second separate claim using ICD-10-CM

Inpatient and Residential Services

For services spanning September into October 2015, the Date of Discharge determines which ICD code set to apply. Regardless of admission date:

- Client discharges on or before 9/30/15: bill using ICD-9-CM
- Client discharges on or after 10/1/15: bill using ICD-10-CM

Electronic Data Interchange (EDI) / 837 submissions:

You can submit a batch of claims/encounters within a file that contain both ICD-9 and ICD-10 transactions but each claim or encounter is limited to either ICD-9-CM or ICD-10-CM.

(Use DSM-5 based ICD code mapping for billing with ICD-9-CM or ICD-10-CM)

ICD Indicator Field

- Regardless of your method of claim submission

- Provider Express
- 1500 Claim Form (v 02/12)
- UB-04
- 837 electronic filing

you must indicate whether the specific claim filed is using ICD-9-CM or ICD-10-CM codes

- Only one code set (ICD-9 or -10) may be used on a single claim

Service Information

Related hospitalization dates From: [] To: []

Diagnosis or nature of illness or injury * 1. [] 2. [] 3. [] 4. [] 5. [] 6. [] more than 6?

ICD - 9 ICD - 10

Claim frequency [Original]

Authorization number []

Date of Service mm/dd/yyyy *	Place of Service *	Procedure CPT Code *	Modifier []	Diagnosis Code 1	Diagnosis Code 2	Diagnosis Code 3	Diagnosis Code 4	Diagnosis Code 5	Diagnosis Code 6	Charges *	Unit *	NPI ID
[]	Please Select	[]	[]	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	0.00	1	[]
[]	Please Select	[]	[]	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	0.00	1	[]
[]	[]	[]	[]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	0.00	1	[]
[]	[]	[]	[]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	0.00	1	[]

Patient paid amount \$ 0.00

Preview

ISA*00* *00* *22*
*040812*1504*U*00401*000101537*1*P*;
GS*HC*000001063*NDDHSMED*20040812*1504*10
ST*837*0001
BHT*0019*00*101537*20040812*1504*CH
REF*87*004010X096A1

ICD Indicator Field (cont.)

- Provider Express (outpatient / professional claims)

Diagnosis or nature of illness or injury * ^(?) 1. 2. 3. 4. 5. 6.
 ICD - 9 ICD - 10

- Electronic Data Interchange – 837 file (professional or institutional claims)

BK = ICD-9

ABK = ICD-10

- Paper Claims

9 for ICD-9

0 for ICD-10

– 1500 (v02.12) claim form (outpatient/professional claims): Field 21

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. ←

A. <input type="text"/>	B. <input type="text"/>	C. <input type="text"/>	D. <input type="text"/>
E. <input type="text"/>	F. <input type="text"/>	G. <input type="text"/>	H. <input type="text"/>
I. <input type="text"/>	J. <input type="text"/>	K. <input type="text"/>	L. <input type="text"/>

– UB-04 claim form (institutional claims): Field 66

66 DX 67 ←

Authorizations, Eligibility & Benefits

- Authorizations

- Existing authorizations will not require any action by you to update or change the authorization to reflect ICD-10 codes

- Eligibility & Benefits

- Optum administers a wide range of Benefit Plans. It is always important that you inquire about eligibility and benefits including:
 - During the time of the transition from DSM-IV-TR to DSM-5 (continued use of ICD-9 codes)
 - At the beginning of a benefit year (typically January 1 but some plans operate on a different cycle)
 - During the transition from ICD-9-CM to ICD-10-CM (mandated for October 1, 2015)
- The benefit coverage and limitations for individuals you see is defined by their particular Certificate of Coverage (COC) or Benefit Plan
- As in the past, the presence of a condition, diagnosis or diagnostic category in the DSM does not in itself indicate whether that condition, diagnosis or diagnostic category is covered under a particular Benefit Plan
- A determination about coverage of a particular diagnosis is reliant, in part, on a review of the particular individual's Benefit Plan

In the DSM-5, the primary difference between an “unspecified” and “other specified” condition is that, in the case of “other specified” the clinician documents in the clinical record why the individual does not meet criteria for a more specific condition. In line with ICD-10 goals, Optum expects documentation and billing to represent the greatest specificity possible. Some COCs may exclude some “unspecified” conditions.

Autism / Applied Behavior Analysis

- Diagnosis

- Autism Spectrum Disorder (ASD) introduced with DSM-5

- 299.00 ICD-9 code retained, diagnostic descriptor modified, ASD characterized by 2 core domains
- Other ICD-9 codes listed in the DSM-IV-TR under “Pervasive Development Disorders” removed

- ABA providers notified in September 2014 to work with referral sources to update clinical records to reflect DSM-5 assessment & diagnosis

- DSM-5 provides guidance regarding well-established diagnoses that are subsumed under ASD and for when to evaluate established clients for social (pragmatic) communication disorder (see page 51 “Note” in the DSM-5)

- Coordination of Care

- ABA service providers rely on the assessment and diagnostic information provided by other treating professionals

- ABA providers – remind your referral sources that you need updated diagnostic information
- Clinicians who refer to ABA service providers – update clinical assessments and associated documentation and provide those to the ABA service providers with whom you coordinate care

- Document application of DSM-5 criteria for both existing and new clients – brief transition notes work!

- Billing Codes

DSM-5: Autism Spectrum Disorder and Associated ICD Billing Codes	
DOS prior to 10/1/15	DOS on and after 10/1/15
ICD-9-CM: 299.00	ICD-10-CM: F84.0

Your Office – System Readiness

- Practice Management Systems for Electronic Claim Filing
 - **HIPAA 5010**
 - X12 version 5010 (for electronic transactions) compliance year: 2012
 - Supports ICD-10 Readiness
 - Check with your practice management vendor to make sure your current software is up-to-date
 - Supports both ICD-9 and ICD-10 billing
- Provider Express
 - **Professional claim submission (outpatient MH/SA and EAP services)**
 - **Will prevent submission of a claim with a mismatch between DOS and required ICD code set**
 - **Easy, Fast, Free – must be a registered user of Provider Express**
- Paper Submissions - purchase current forms that include ICD indicator fields and verify ability to process from your office or billing service

Keep demographic and contact information up-to-date

We can and will email or fax information for “same day” notification of ICD implementation news!

Outpatient Providers: Provider Express > Log In > My Practice Info

Facility Providers: Keep your Contract Manager informed of any changes in contact information.

Your Office – Process Readiness

- Clear out your ICD-9 inventory as much as possible before 10/1/15
 - Limits the amount of back and forth selection of ICD code sets
 - Mitigates cash-flow worries
- Focus on your high volume diagnoses first
 - Use DSM-5 Appendices to help clinical and billing teams understand and talk about changes, again focus first on high volume diagnoses
 - “Highlights of Changes from DSM-IV to DSM-5”(page 809)
 - “Alphabetical Listing of DSM-5 Diagnoses and Codes (ICD-9-CM and ICD-10-CM)” (page 839)
 - Have you identified any clients assessed under DSM-IV criteria whose condition & associated ICD billing code is no longer present in the DSM-5? (e.g., 296.90, Mood Disorder NOS)
 - Update assessments & associated clinical & administrative documentation using the current edition of the DSM
- Communicate
 - Clinical and billing teams should be sharing information about DSM-5 and ICD-10
 - Create a plan to ensure that both the ICD-9 and ICD-10 codes are available in records of established patients so that billing staff can handle claim submissions for dates of service both before and after October 1, 2015
 - Talk with practice management and clearinghouse vendors to ensure ICD-10 readiness
 - Visit Provider Express often to check for updates from Optum

Your Office – Process Readiness

- Checklist Items – Documentation & Communications

- Review your current process for updating an existing client’s diagnosis

- Will that same process work for the transition dates - applying an ICD-9 code for DOS before October 1 and an ICD-10 code for DOS on and after October 1?
- Is there a better or more efficient way to prepare in advance for the change?

- Make sure everyone involved in the billing process (from assessment through claim submission) understands the connection between the DSM and ICD

- Review and update Policies, Procedures, Forms, Job Aids, Clinical Templates to ensure ICD-10 readiness

- Dual period of documenting both the ICD-9 and ICD-10 codes as listed in DSM-5 supports billing now and on October 1, 2015 and helps everyone get more accustomed to the new codes – you may be surprised how quickly you learn the top 5-10 codes that you use most frequently!

Go electronic – shorten your revenue cycle

- Electronic claim submission
 - **It's fast** - eliminates mail and paper processing delays
 - **It's convenient** - easy set-up and intuitive process, even for those new to computers
 - **It's secure** - data security is higher than with paper-based claims
 - **It's efficient** - electronic processing helps catch and reduce pre-submission errors, so more claims auto-adjudicate
 - **It's complete**- you get feedback that your claim was received by the payer
 - **It's cost-efficient** - you eliminate mailing costs, the solutions are free or low-cost
- Provider Express: professional claims for MH/SA and EAP services
- EDI: professional and institutional claims, use vendor of your choice
- Additional information
 - Provider Express > Admin News > [EDI/Electronic Claims](#)

Go electronic – shorten your revenue cycle (cont.)

- Electronic Payments and Statements (EPS)

- Claims payments made by electronic funds transfer (EFT) from health plans are deposited directly to your designated bank. You may be paid five to seven days faster than if you received paper checks by mail.
- Claims information is posted online one business day prior to the bank deposit, so you always know what's coming. You also receive an email once a day when claims payments have been made.
- Electronic remittance advices (ERAs) are posted three to five days faster than mailed information, too. This lets you identify patient responsibility for care sooner.
- Unique payment identifier — EFTs and ERAs are tied together with a unique payment identification number to make reconciliation faster and easier.
- Claims payment histories are available and searchable on our website for up to 13 months.

- Additional information

Provider Express > Admin News > [Shorten revenue cycles with direct claim payment deposits](#)

Claim Testing

- **What testing has Optum done to prepare for ICD-10?**
 - We have completed testing of our online claim entry available on Provider Express for Professional (outpatient) MH/SUD and EAP service claims
 - We are in the process of analyzing results of “end-to-end” testing that includes activities such as submission through Electronic Data Interchange (EDI) clearinghouses
- **What is end-to-end testing?**
 - “End-to-end” testing assesses the “behavior” of the claim from the point at which a provider generates the claim in their office, then passes through a clearinghouse over to Optum and then through our claim system for adjudication. This testing allows us to assess whether or not a test claim using an ICD-10 code adjudicates in the same way as the original submission.
 - In the event something does not adjudicate “as expected” then we will conduct a root cause analysis to identify and correct any problems in coordination with the provider
- **Testing specific practice management software and clearinghouse vendors?**
 - Providers engaged in testing are submitting outpatient and inpatient claims using a wide range of practice management software
 - We are working closely with the different clearinghouse vendors with whom providers routinely work

Resource Links

Provider Express

[ICD-10 and DSM-5 Resources](#)

[Electronic Payments & Statements](#)

[Electronic Data Interchange](#)

American Psychiatric Association (DSM-5)

[APA Practice: DSM-5](#)

[APA Coding Update: March 2014](#)

[APA DSM-5 Implementation and Support](#)

[APA Understanding ICD-10-CM and DSM-5: A Quick Guide](#) (Feb 2014)



You Asked, We Answered

We compiled all of the questions providers raised during the Q & A portion of the our ICD-10-CM webinar. The following slides include some of the most frequently asked questions along with answers.

- **Two of the most Frequently Asked Questions**

- *Do I use DSM-5 or ICD-10 to bill?*

- A: Use the DSM-5 to assess, diagnose and document your client's condition. Then apply the ICD code listed in the DSM-5 for condition, use the ICD-9 code listed for Dates of Service (DOS) through 9/30/15 and use the ICD-10 code listed for DOS 10/1/15 and later. *See slide 4 for an example.*

- *Are ICD-10-PCS codes replacing CPT (e.g., 90834) codes?*

- A: No. The ICD-10-PCS applies to facility reporting and do not affect use of CPT codes by outpatient providers.

Facility Note: ICD-9-PCS codes are transitioning to ICD-10-PCS codes for specified facility-based services. However, Optum does not use PCS codes. So facilities should continue to bill Optum using Rev Codes as aligned with your Agreement. Facilities will need to work with other payers to determine whether and how the ICD-PCS transition affects claim submissions to those other payers.

You Asked, We Answered

Continued

• When does ICD-10 actually go into effect?

- **October 1, 2015** – ICD-10 codes MUST be used for Dates of Service (Date of Discharge for inpatients) ON or AFTER 10/1/15
- For Dates of Service (or Date of Discharge for inpatient) prior to 10/1/2015 you MUST continue using ONLY ICD-9 codes
- This is an industry-wide change – all providers, insurance companies and clearing houses
- All information necessary to process claims must be received by Optum no more than 90 calendar days from the date of service (date of discharge for inpatients), or as required by state or federal law or specific Member benefit plans

- **How do I know which code set to use?**

- **Inpatient**

- Inpatient coding is based on discharge date: Discharge on or before September 30 uses only ICD-9; discharges on or after October 1 uses only ICD-10
- Do not split your claims; submit a single claim based on date of discharge for a single episode of care

- **Outpatient**

- Outpatient coding is determined by Date of Service: Dates of Service on or before September 30 uses ICD-9 codes; Dates of Service on or after October 1 uses ICD-10 codes

- **In all cases**

- Neither date of claim submission nor date of claim receipt matter in determining which ICD code set to use for billing
- You may NOT use both ICD-9 and ICD-10 codes in the same claim: Outpatient services are based on Date of Service; Inpatient services are based on Date of Discharge

How do I indicate which code set I'm using when submitting claims?

Paper claims:

- Enter ICD indicator code of "9" to indicate ICD-9; enter "0" to indicate ICD-10
- 1500 (v.02.12) claim form (outpatient/professional claims): Field 21
- UB-04 claim form (institutional claims): Field 66

Electronic claims:

- **837 Electronic Claims:** Check with your Practice Management Software vendor
- **Provider Express:** Optum's online provider portal, providerexpress.com, will use radio buttons and correlate selection with Date of Service

Note: This is industry-standard and not specific just to Optum. See slide #9 and #10 for examples of ICD indicator fields on Provider Express and on paper claim forms.

You Asked, We Answered

Continued

What exactly is changing on the claim submission?

- An illustration using a standard 1500 form used for outpatient/professional services may help. This example has entered *only those elements that are changing* as part of the ICD-10-CM transition. This could be the same client seen one week apart (Diagnosis is Major Depression, Single Episode Moderate).

DOS in September – only the 3 key elements on the claim related to the ICD transition are entered here

Condition listed in “21A” is Major Depression, Single Episode, Moderate (296.22), ICD Indicator is “9”:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Please A-L to service line below (24E))										22. RESUBMISSION CODE		ORIGINAL REF. NO.													
A. 29622										B. _____		C. _____		IND. 9											
E. _____										F. _____		G. _____		H. _____											
I. _____										J. _____		K. _____		L. _____											
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. SPEC. FREQ. #		I. ID. QUAN.		J. RENDERING PROVIDER ID.#	
1 09 25 15																									
2																									

DOS in October – only the 3 key elements on the claim related to the ICD transition are entered here

Condition listed in “21A” is Major Depression, Single Episode, Moderate (F321), ICD Indicator is “0”:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Please A-L to service line below (24E))										22. RESUBMISSION CODE		ORIGINAL REF. NO.													
A. F 321										B. _____		C. _____		IND. 0											
E. _____										F. _____		G. _____		H. _____											
I. _____										J. _____		K. _____		L. _____											
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. SPEC. FREQ. #		I. ID. QUAN.		J. RENDERING PROVIDER ID.#	
1 10 02 15																									
2																									

You Asked, We Answered

Continued

- **Are both ICD-9 and ICD-10 Codes allowed on the same claim submission form?**
 - *The short answer is, **No***
 - Each claim is limited to either the ICD-9 *or* ICD-10 code set. Claim forms now have an ICD Indicator field that must be completed to reflect which code set that particular claim is using (*see previous slide*)
 - Please refer to slides #7, #8 and #9 for information related to this limitation and to the ICD Indicator field

You Asked, We Answered

Continued

How do I indicate what code set – ICD-9 or ICD-10 – I’m using? Is this just for Optum or an industry standard?

The inclusion of an ICD Indicator is an industry standard. All forms of claim submission will require you enter an ICD Indicator.

Paper Claims, Industry Standard:

Enter “9” to indicate ICD-9

Enter “0” to indicate ICD-10

837 Electronic Claim Submissions

What you see in your Practice Management System for claim entry may vary depending on your vendor’s software. If you are not sure where the ICD Indicator is on your e-form or how to complete the field, talk with your Practice Management or Software vendor.

Industry Standard translation for the ICD Indicator (how it appears on the 837):

BK indicates ICD-9

ABK indicates ICD-10

Part two of answer next slide

You Asked, We Answered

How do I indicate what code set – ICD-9 or ICD-10 – I'm using?

Is this just for Optum or an industry standard? Continued from previous slide

Provider Express, Optum Only

The Claim Entry feature on Provider Express is a secure transaction available to in-network or contracted providers for submission of Professional (outpatient MH/SA or EAP services) claims. We are using a radio buttons labeled ICD-9 or ICD-10 and you click the appropriate code set based on *Date of Service*. Take a brief Guided Tour for more information on submitting a claim, [Click Here](#).

Diagnosis or nature of illness or injury *  1. 2. 3. 4. 5. 6.

ICD - 9 ICD - 10



Thank You

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