Timing of Change: It's a "flip-of-the-switch"

Are all insurance companies making this change to ICD-10 on October 1, 2015?

Yes, this is an industry change and the timing of October 1, 2015 is mandated by federal law under HIPAA.

The Date of Service (DOS), *not* the date of claim submission, determines which code set to use. Note that for inpatient services spanning the transition date, you should use the date of discharge as your "DOS."

Refer to slide 7 (industry change, high level points) and to slide 8 for examples of both outpatient and inpatient use of ICD-9-CM versus ICD-10-CM.

Common questions we receive about whether ICD-10-CM codes may be used prior to October 1

- If we can get ready to use the ICD-10-CM codes before October 1, can we start using them?
- Will Optum (UBH/USBHPC) accept ICD-10-CM claim submissions prior to October 1?
- Will Provider Express accept ICD-10 claims prior to October 1?
- Can we start putting ICD-10 codes in addition to ICD-9 codes on claims now for billing**?**
- What are the rules related to when we use ICD-9 versus ICD-10 Codes?

You cannot bill using ICD-10-CM codes prior to October 1, 2015. This is an industry standard and the industry, including Optum, will make a "hard" switch on October 1. Use only ICD-9-CM codes for billing dates of service through September 30, 2015. Refer to slide 7.

If we have inpatients in September and know that they will not discharge until October, can we bill interim visits for September using ICD-10 before the October 1 date?

No. The industry standard for inpatient services is to rely on the date of discharge to determine which code set to use. In addition, there should be a single claim filed for the episode of care – in other words, you should not split the bill. So, regardless of the date of admission, for inpatient services:

- If your patient discharges on or before September 30, 2015, then bill using ICD-9-CM codes.
- If your patient discharges on or after October 1, 2015, then bill using ICD-10-CM codes.

Refer to slide 8.

I am confused on which code to use for inpatient. Is the code determined by discharge date?

Yes. This is an industry standard. Inpatient services will use the discharge date to determine which code set to apply. Regardless of the date of admission, for inpatient services:

- If your patient discharges on or before September 30, 2015, then bill using ICD-9-CM codes.
- If your patient discharges on or after October 1, 2015, then bill using ICD-10-CM codes.

I am confused about the timing. I typically send in a whole month of outpatient service claims at once. If I continue to do that, you may not get some of the claims until after 10/1. How will that work?

Neither the date of claim submission nor the date of claim receipt matters in determining which ICD code set to use for billing.

- Outpatient services: it is the Date of Service (DOS) that determines which code set to use
- Inpatient services: it is the Date of Discharge which determines which code set to use

Providers must bill using ICD-9 codes for dates of service (or date of discharge for inpatient services) on and before September 30, 2015 even if you are submitting that claim on or after the transition date of October 1. And likewise, payers must process claims with ICD-9 codes for September dates of service (or date of discharge for inpatient services) even if the claim is received on or after the October transition date.

Refer to slide 8 for examples.

If we are doing Applied Behavior Analysis (ABA) billing for months at a time but we enter them all at once, the September and October claims have to be entered separately. Correct?

Yes. Use your dates of service to determine which ICD code set to use. For any given client, dates of service in September would be submitted using the ICD-9-CM code and the October dates of service would be submitted on a separate claim using the ICD-10-CM code.

Should I start documenting both the ICD-9 and ICD-10 codes in my clinical record?

Yes. Begin to document in your clinical records both the ICD-9-CM and ICD-10-CM code that is associated with the DSM-5 clinical condition. You may see this referred to as a "period of dual coding" but it refers only to your clinical records and any administrative records that you deem appropriate *within* your office or organization. The value of this documentation in your clinical record is that it supports both clinical and billing staff in learning the new codes. In addition this practice will support your hospital or practice with billing at the time of the transition when services span the transition date.

Refer to slide 4 to see an example showing both the ICD-9-CM and the ICD-10-CM codes that are "mapped" to conditions and their associated clinical criteria in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5).

How long do have to submit claims under ICD-9 for dates of service on and before September 30, 2015?

All information necessary to process claims must be received by Optum no more than 90 calendar days from the date of service, or as required by state or federal law or specific Member benefit plans.

See slide 14 for information about mitigating cash flow concerns by submitting as much of your ICD-9 claim inventory before October 1, 2015.

Procedure Code Clarification (CPT, HCPCS, Rev Codes and ICD-10-PCS)

Common questions we receive about whether ICD-10-CM codes may be used prior to October 1

- Are procedure codes changing?
- Will the billing procedure codes be changing when ICD-10 is implemented?
- Are there new procedure codes that we need to use in conjunction with ICD-10?
- Are the time codes changing (e.g., 90837, 90834)?
- Do we need to use new procedure codes starting October 1? Right now we mostly use 90791, 90847 and 90834.
- Will procedure codes change for outpatient individual psychotherapy under ICD-10?
- Are there any CPT code changes associated with this change?
- Are procedure codes going to remain the same (example 90791 = initial evaluation)
- The diagnosis codes are really the only ones switching (e.g., 296.33) but the CPT codes aren't (e.g., H2017, T1017, 90834), just clarification.
- Are billing codes staying the same?

Outpatient – there is no ICD-related industry-wide change for service or procedure codes. Outpatient providers currently billing with CPT or HCPCS codes will continue to use those.

Facility – ICD-9-PCS codes are transitioning to ICD-10-PCS codes for specified facility-based services. However, Optum does not use ICD-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.

I keep hearing that pay for services will be based on the ICD-10 code and not the CPT code? Is this true and when will it start?

There are two different ICD-9 code sets that are both changing to ICD-10 on October 1, 2015. The first is the ICD-10-CM codes (U.S.-based Clinical Modification of the ICD-10 diagnostic codes). That is changing for everyone. The second is the ICD-10-PCS codes used to indicate procedures or services.

Outpatient providers do not use ICD-9-PCS codes, instead they bill using CPT codes as referenced in questions above. There is no ICD-related change for outpatient procedure codes (e.g., 90834).

Facility providers may use ICD-9-PCS codes with other payers. Optum does not use ICD-9-PCS codes and will not be using ICD-10-PCS codes. Facilities should continue to bill Optum using Rev Codes in alignment with your Agreement as you do today. You will need to work with other payers to determine whether and how the transition to ICD-10-PCS affects claim submissions to those other payers.

A note about CPT codes:

The Current Procedural Terminology (CPT) code set is maintained by the American Medical Association with an established process for annual review and updates. The new CPT manuals are usually available in October. Behavioral health providers will recall that there were significant CPT code changes effective January 2013. If there are changes to the behavioral health CPT codes reported in October of this year, we will post a notice to Provider Express. Those changes, if any, would not go into effect until January 1, 2016.

Billing – DSM-5 and ICD-10

Are ICD-10 codes replacing DSM-5 codes?

No. ICD-10-CM codes are replacing ICD-9-CM codes used for billing.

Many behavioral health clinicians may not be aware that the codes listed in the DSM are actually ICD codes that have been "mapped" to the DSM in order to support a standardized code set for billing. The code you enter on a claim today to represent a DSM defined diagnosis is an ICD-9-CM code.

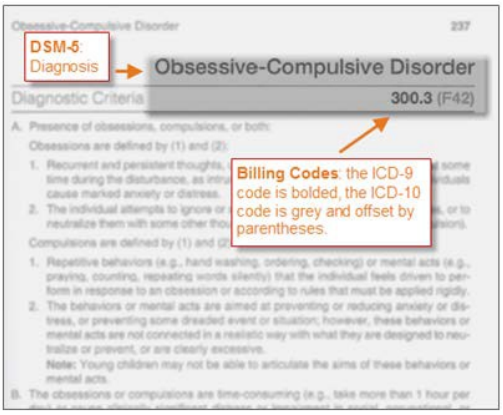
Optum implemented DSM-5 on October 1, 2014 and you should be using ICD-9-CM as it is applied within the DSM-5, to represent the diagnosis on claim submissions through dates of service September 30, 2015 (or date of discharge for inpatient). The ICD-10-CM codes are also mapped to DSM-5 defined conditions. The mandated (and therefore industry-standard) date for transitioning to ICD-10-CM begins for dates of service (or date of discharge for inpatient) on and after October 1, 2015.

Will we have to list the diagnosis in the DSM-5 and ICD-10 for billing? Right now I only use the DSM-5 diagnosis for billing.

Continue to use the DSM-5 for clinical assessment, diagnosis and billing. The DSM-5 "maps" to both ICD diagnostic code sets for each condition within the DSM-5. Apply the listed ICD-9-CM code for billing dates of service before October 1, 2015 and use ICD-10-CM for billing dates of service on and after October 1, 2015. (For inpatient care, the date of discharge determines the code set to use.)

Note: most of the ICD-10-CM codes come from Chapter 5 of the ICD-10-CM and therefore begin with letter "F." If you look in your DSM-5, you will see ICD-9 codes listed in a bold font and the ICD-10 codes listed in grey font within parentheses. For example, Major Depressive Disorder, Single Episode Mild is shown as **296.21** (F32.0).

From slide 4, another example from the DSM-5, OCD is the DSM diagnosis, the ICD codes are listed for in the book as well.



Some of the ICD-10 codes in the DSM-5 are only 3 characters. I thought ICD-10 was 7 characters.

The DSM-5 maps to a subset of the codes that are available in the ICD-10-CM. Many of the behavioral health codes are only 3-5 characters in length. For example, Obsessive-Compulsive Disorder is F42; only those three characters are listed in the diagnosis field of the claim.

Billing with ICD-10 – Claim Submission

Can I have both an ICD-9 and ICD-10 code on one claim?

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. Refer to slides 7, 8 and 9 for information related to this limitation and to the ICD Indicator field.

Common questions about the ICD Indicator field

- Could you clarify when I enter the ICD Indicator (e.g., for paper claims a "9" or "0")?
- Regarding the ICD Indicator, is entering a "9" or "0" just for Optum or is that universal?

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

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 radio buttons labeled "ICD-9" or "ICD-10" and you click the appropriate code set based on Date of Service (DOS). View this presentation for additional information.

How long after October 1, 2015 will we be required to indicate whether we are filing an ICD-9 or ICD-10 claim?

An end date for this industry requirement has not been announced. For now, you should consider this a new required field and include the ICD Indicator going forward unless notified otherwise.

Will the radio buttons on Provider Express that indicate ICD-9 or 10 be available continuously, or just during this transition period?

We anticipate retaining the radio buttons for an extended period. Other forms of claim submission will require the indicator and prolonged availability will mirror that industry standard.

Any changes to this will be announced on Provider Express.

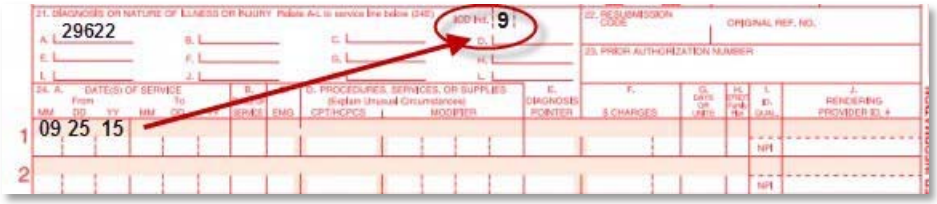
When billing, do we include the letter at the beginning of the ICD-10-CM codes as part of the diagnosis code?

Yes. The letter at the beginning of the code tells us what chapter of the ICD-10-CM the code comes from. Most of the ICD-10-CM codes used by behavioral health come from Chapter 5 and therefore begin with the letter "F." The full code, including the letter, should be entered on the claim.

What is changing, exactly, 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":



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":

We are continuing to add questions and answers. Updates will be made until we complete the You Asked, We Answered document. We are starting with the most frequently asked categories of questions.