Approved

UHIN STANDARDS COMMITTEE

ICD-10 Standard v1.2

Purpose: The purpose of this Standard is to create the business requirement for payers and providers to implement the International Classification of Diseases 10th Revision (ICD-10) within the administrative transactions.

Applicability: All HIPAA covered entities that submit, pay or process claims, are required to use ICD-10 coding, in HIPAA Transactions, no sooner than the implementation date.

Basic Concepts: ICD-10 code sets are used to report medical diagnoses and inpatient procedures. ICD-10 consists of two parts; ICD-10.CM for diagnosis coding (approximately 68,000 codes), and ICD-10.PCS for inpatient procedure coding (approximately 72,000 codes). ICD-10.PCS codes are required to be used for hospital inpatient procedures while ICD-10.CM codes are required for all other health care services provided in the United States.

Codes:

The basic structure for the ICD-10 codes are as follows: Characters 1-3 (the category of disease); 4 (etiology of disease); 5 (body part affected); 6 (severity of illness) and 7 (placeholder for extension of the code to increase specificity).

ICD-10.CM codes may use 3 to 7 digits

ICD-10.PCS codes use 7 alphanumeric digits

Code Qualifiers:

In the electronic claim, the ICD version indicator is in the HI – Health Care Diagnosis Code segment.

- Professional Claim (837P) ICD Code Set Qualifiers:
  HI – Health Care Diagnosis Code segment / loop 2300
  - ABK = ICD-10-CM – Principal Diagnosis
  - BK = ICD-9-CM – Principal Diagnosis
  - ABF = ICD-10-CM – Diagnosis
  - BF = ICD-9-CM – Diagnosis

- Institutional Claim (837I) ICD Code Set Qualifiers:
  HI – Health Care Diagnosis Code segment / Loop 2300
  - ABK = ICD-10-CM – Principal Diagnosis
  - BK = ICD-9-CM – Principal Diagnosis
  - ABJ = ICD-10-CM – Admitting Diagnosis
  - BJ = ICD-9-CM – Admitting Diagnosis
  - APR = ICD-10-CM – Patient's Reason for Visit
  - PR = ICD-9-CM – Patient's Reason for Visit
  - ABN = ICD-10-CM – External Cause of Injury
  - BN = ICD-9-CM – External Cause of Injury

ABF = ICD-10-CM – Diagnosis
BF = ICD-9-CM – Diagnosis
BBR = ICD-10-PCS – Principal Procedure Code
BR = ICD-9-CM – Principal Procedure Code
BBQ = ICD-10-PCS – Other Procedure Code
BQ = ICD-9-PCS – Other Procedure Code

- Dental Claim (837D) ICD Code Set Qualifiers:
  HI – Health Care Diagnosis Code segment / loop 2300
  ABK = ICD-10-CM – Principal Diagnosis
  BK = ICD-9-CM – Principal Diagnosis
  ABF = ICD-10-CM – Diagnosis
  BF = ICD-9-CM – Diagnosis

- Health Care Services Review – Request for Review and Response (278) Code Set Qualifiers:
  HI – Health Care Diagnosis Code segment / loop 2000E
  ABF = ICD-10-CM – Diagnosis
  ABJ = ICD-10-CM – Admitting Diagnosis
  ABK = ICD-10-CM – Principle Diagnosis
  APR = ICD-10-CM – Patient's Reason for Visit
  BF = ICD-9-CM – Diagnosis
  BJ = ICD-9-CM – Admitting Diagnosis
  BK = ICD-9-CM – Principal Diagnosis
  PR = ICD-9-CM – Patient's Reason for Visit

- Health Care Eligibility Benefit Inquiry and Response (270/271) Code Set Qualifier:
  HI – Health Care Diagnosis Code segment / loop 2100C
  ABK = ICD-10-CM – Principal Diagnosis
  BK = ICD-9-CM – Principal Diagnosis
  ABF = ICD-10-CM – Diagnosis
  BF = ICD-9-CM – Diagnosis

Definitions:

Implementation Date: Per the CMS Final Rule, as of this writing the implementation date is 10/1/2015.

HIPPA Covered Entities: See section 160.103 of title 45, Code of Federal Regulations.

ICD: International Statistical Classification of Diseases and Related Health Problems.

ICD-10.CM: Codes for clinical modification.

ICD-10.PCS: Codes for the inpatient procedure coding system.

Receivers: Entities that receive HIPAA transactions.

Senders: Entities that send HIPAA transactions.

World Health Organization (WHO): Publishes the International Classification of Diseases (ICD) code set, which defines diseases, signs, symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or disease.

Receiver Requirements:

1. Receiver (Payer) systems must be able to receive and process ICD-10 codes.

2. Receivers (Payers) must maintain updated coding rules and payment policies for ICD-10.

Sender Requirements:

1. Senders must use ICD-10 codes for reporting diagnosis in all HIPAA Transactions.

2. ICD-10 procedure codes must be used for all hospital inpatient procedures.

3. Providers are encouraged to submit the most specific diagnosis codes based on the information available.

4. For outpatient professional claims (837P), ICD-10.CM codes may only be used for services provided on or after the implementation date.

5. For inpatient claims (837I) with a discharge date on or after the implementation date, only ICD-10.CM codes are allowed to be sent. There will however be a period of time following the implementation date where adjustments, filings, and services spanning the implementation date will still use ICD-9 codes for claims with a date of service prior to the implementation date.

6. ICD-10.PCS codes may only be used on inpatient claims with Dates of Discharge on or after the implementation date.

7. ICD-9 codes become obsolete no sooner than the implementation date and must not be sent in HIPAA transactions when exchanging with HIPAA covered entities with dates of service beginning on the implementation date. For inpatient institutional claims the discharge date will be used to determine the code set.

8. When sending transactions to a non-HIPAA covered entity including P&C and small TPAs after the implementation the sending entity must coordinate with the receiver to identify the appropriate code set.

Implementation Issues

1. Providers and payers should check with their internal technical support, billing services, clearinghouse, and/or practice management software vendors about their product development, testing and readiness.

2. Providers who handle billing and software development internally should plan for medical records/coding, clinical IT, and finance staff to coordinate on ICD-10 transition efforts.

3. ICD-9 and ICD-10 codes cannot be submitted on a single claim. Only ICD-10 codes must be used after the implementation date. Date of service (DOS) will be used to determine which code set is used. Professional Claims must be split based on the date of service. After the implementation date, the usage of ICD-9 codes will only be for those services that were provided prior to the implementation date. Those transactions for services done before the cutoff date may include; claim filing, claim correction and appeals.

4. UHIN may send ICD-9 codes forward to the payer if they are received. It will be up to the payer to either accept or reject at the UHIN level or the payer level.

5. For Institutional (hospital) inpatient claims, the date of discharge is the determining factor for which diagnosis coding set must be used. For discharges on or after the implementation date, ICD-10 codes must be used. For discharge dates prior to the implementation date, ICD-9 codes must be used.

6. Payers should update payment policies and coding rules to reflect any changes that the ICD-10 Code Set would require for correct processing of HIPAA Transactions.

7. Payers must maintain rules and triggers for the evaluation of prior authorizations and referrals based on ICD-10 procedure and diagnosis codes.

8. Payers must review benefits to make sure coverage determinations and eligibility reference ICD-10 codes.

9. Prior Authorization transactions (Placeholder): TBD

10. Eligibility transactions (Placeholder): TBD

History: (MM/DD/CCYY)

	Original V1.0	V1.1	V1.2	V1.3	V1.4
ORIGINATION DATE	7/2/2013	4/9/2014	6/11/2014		
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* A = Amendment