

SECTION A. GENERAL BACKGROUND

Q: Why is CMS upgrading to ICD-10?

A: The World Health Organization (WHO) is making the transition from ICD-9 to ICD-10 because:

- **ICD-9 codes provide limited data about patients' medical conditions and hospital inpatient procedures.** ICD-9 is 30 years old. It uses outdated and antiquated terminology. It is inconsistent with current medical practices and produces incorrect, limited patient data. Furthermore, the structure of ICD-9 limits the number of new codes that can be created.
- **ICD-10 codes allow for greater specificity and precision for describing a patient's diagnosis and in classifying inpatient procedures.** ICD-10 will accommodate newly developed diagnoses and procedures, innovations in technology and treatment, performance based payment systems, improved interoperability and more accurate billing. ICD-10 coding provides better insights for optimizing grouping and reimbursement processes. Billing processes become streamlined and efficient, thereby allowing for precise methods of detecting fraud. Finally, there will also be fewer burdens on clinicians to provide detailed supporting documentation.

Q: What is different in ICD-10?

A: ICD-10-CM/PCS (International Classification of Diseases, 10th Edition, Clinical Modification /Procedure Coding System) consists of two parts:

- **ICD-10-CM for diagnosis coding**
- **ICD-10-PCS for inpatient procedure coding**

ICD-10-CM is for use in all U.S. health care settings. Diagnosis coding under ICD-10-CM uses 3 to 7 digits instead of the 3 to 5 digits used with ICD-9-CM.

ICD-10-PCS is for use in U.S. inpatient hospital settings only. ICD-10-PCS uses 7 alphanumeric digits instead of the 3 or 4 numeric digits used under ICD-9-CM procedure coding. Coding under ICD-10-PCS is much more specific and substantially different from ICD-9-CM procedure coding.

Q: Who needs to transition?

A: ICD-10 will affect diagnosis and inpatient procedure coding for everyone covered by Health Insurance Portability Accountability Act (HIPAA), not just those who submit Medicare or Medicaid claims. The change to ICD-10 does not affect CPT coding for outpatient procedures.

SECTION B. CAREOREGON'S ICD-10 TRANSITION PLAN

Q: What existing timelines and plans does CareOregon have for conversion to ICD-10?

A: CareOregon is on track to become ICD-10 compliant by the deadline of Oct. 1, 2015 as established by the Centers for Medicare & Medicaid Services (CMS). We are conducting testing with a number of external provider groups, hospitals, trading partners and vendors to ensure a smooth transition.

Q: When will ICD-10 become effective at CareOregon?

A: Claims with a date of service of October 1, 2015 and after require ICD-10-CM coding. Claims with a date of service of September 30, 2015 or prior will require ICD-9 diagnosis codes.

Q: What resource is CareOregon utilizing to upgrade to ICD-10?

A: CareOregon is utilizing the industry-leading 3M's Code Translation Tool for all its mapping involving medical policies, benefit applications, contract terms, diagnostic edits and historical data tracking. CareOregon is utilizing the Prioritized List from the state of Oregon for its Medicaid line of business and relevant policies from CMS for its Medicare line of business.

Q: What happens if I don't switch to ICD-10?

A: Claims that use ICD-9 diagnosis and inpatient procedure codes for dates of service on or after **Oct. 1, 2015** will be denied. Such claims must use ICD-10 codes. It is important to note, however, that claims for dates of service before Oct. 1, 2015 must use ICD-9 diagnosis and inpatient procedure codes.

Q: Are you planning to accept ICD-10 codes before the compliance date?

A: No.

Q: After the compliance date, can both ICD-9 and ICD-10 codes appear on the same claim?

A: No. Claims which include both ICD-9 and ICD-10 codes will be rejected as CMS guidelines do not allow for both codes on a single claim.

Please review the section entitled "Claims that Span the ICD-10 Implementation Date" in the MLN newsletter number SE1408 that is referenced below for detailed guidelines for different scenarios for claims that span from September-October 2015 dates of service:

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network/MLN/MLNMattersArticles/downloads/SE1408.pdf>

SECTION C. MAPPING / CLAIMS PROCESSING

Q: What format does CareOregon plan to use to transmit and pay claims post-ICD-10?

A: CareOregon will continue to use the HIPAA standard v5010 transaction sets for electronic claims (i.e. X12 EDI formats: 837 I/P), as well as the standard paper format for health care claims (i.e. UB04, HCFA 1500).

Q: If CareOregon utilizes external partners to process claims for its members, will they be prepared, and what steps are you taking to ensure their readiness?

A: CareOregon is working closely with its external partners to ensure that they will be ready to comply with the ICD-10 mandate. We have been involved in mutual end-to-end testing efforts with a variety of provider groups, hospitals, trading partners and vendors.

SECTION D. TESTING PLANS

Q: Do you plan to test with all of your external providers and trading partners? If not, what is the process for determining which partners you will select?

A: CareOregon is attempting to test with as many providers and provider groups as possible. We are also attempting to test with as many trading partners as possible. If you are interested in testing with us, please use any one of the three communication channels listed in section E below. We would love to hear from you.

SECTION E. PROVIDER SUPPORT

Q: I have questions about ICD-10. Who can I ask?

A: You have the following options for contacting CareOregon:

- Contact [CareOregon's Provider Services representative assigned to your practice](#)
- Click this [link to finish our brief survey](#)
- Contact Al Parikh, ICD-10 Project Manager, at parikha@careoregon.org or 503-416-1724