ICD-10 Overview

ICD-10 is the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list by the World Health Organization (WHO). It codes for diseases, signs and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases.\(^1\)

The code set allows more than 14,400 different codes and permits the tracking of many new diagnoses. The codes can be expanded to over 16,000 codes by using optional sub-classifications. The detail reported by ICD can be further increased, with a simplified multi-axial approach, by using codes meant to be reported in a separate data field.

The WHO provides detailed information about ICD online, and makes available a set of materials online, such as an ICD-10 online browser,\(^2\) ICD-10 Training, ICD-10 online training,\(^3\) ICD-10 online training support,\(^4\) and study guide materials for download.

The International version of ICD should not be confused with national Clinical Modifications of ICD that frequently include much more detail, and sometimes have separate sections for procedures. The US ICD-10 CM, for instance, has some 68,000 codes. The US also has ICD-10 PCS, a procedure code system not used by other countries that contains 76,000 codes.

On October 1, 2014, the ICD-9 code sets used to report medical diagnoses and inpatient procedures will be replaced by ICD-10 code sets.

The transition to ICD-10 is required for everyone covered by the Health Insurance Portability Accountability Act (HIPAA). Please note, the change to ICD-10 does not affect CPT coding for outpatient procedures and physician services.

The new HIPAA version 5010 Errata electronic transaction standards drive billing, reimbursement, many administrative functions, and accommodate the larger ICD-10 code sets.

The basic types of changes between ICD-9 and ICD-10 are:

- **Code length** – The presentation of this information has been standardized and revised to allow for increased clarity, accuracy, and to allow for better instruction.
  - ICD-9 currently allows for five (5) characters.
  - ICD-10 will allow for up to seven (7) characters.

- **PCS (Inpatient CPT)** – New data elements have been added, several obsolete elements have been removed, and many elements have been modified to increase or decrease their length.

The U.S. Department of Health and Human Services’ implementation deadline for compliance with ICD-10, Mandate is October 1, 2014.
Optum ICD-10 Timeline

October 1, 2014  ICD-10-CM and ICD-10-PCS compliance date
July 1, 2013  On-Line, self-testing tool “CommunEDI Premium” available

Optum ICD-10 Solutions

Optum has a plan of action and is dedicated to assisting our clients with their ICD-10 implementation. Outlined below you will find Optum’s strategy for supporting and testing ICD-10.

Optum will be adhering to the dates/time line set forth by CMS (unless payer requirements are different):

- ICD-10-CM diagnosis codes will be required on all professional and outpatient claims with dates of service on or after Oct. 1, 2014.
- Both ICD-10-CM diagnosis and ICD-10-PCS procedure codes will be required on all inpatient claims with discharge dates on or after Oct. 1, 2014.
- Service dates or discharge dates prior to Oct. 1, 2014, will require ICD-9 codes.

Optum ICD-10 Solution by Submission Type

X12 BATCH CLAIM SUBMISSIONS

Optum will support incoming X12 Batch Claim transactions from all entities prepared to submit electronic claims according to the new HIPAA mandate for ICD-10.

As of 10/01/2014, Optum will support ICD-10 codes within the X12 5010 production files. Optum will support dual submission of ICD-9 or ICD-10 with in the same file or in separate files. However, Optum will only support a single code set per claim. The Optum on-line Payers lists will indicate when Payers have the ability to support ICD-10 code sets.

- Optum will not be providing conversion from ICD-9 to ICD-10 or vice versa.
- During the dual submission period, Optum will pass diagnosis codes as received.
- Optum will not support dual code sets on a single claim.

Optum provides a self-testing tool, available to direct X12 submitters and Channel Partner/Vendors. This tool will meet all the testing needs of submitters and will be available for the testing of 5010 files with ICD-10 codes on 07/01/2013. If you have questions regarding testing, please contact our Customer Support Team at (866) 367-9778.
How do I access this tool?

- [http://www.enshealth.com/5010landing.html](http://www.enshealth.com/5010landing.html) (user will need to have their Org ID and Password to access the link)
- Vendors will select Channel Partner & Vendors >5010 with ICD-10 codes.
- Providers will select Health E Network >5010 with ICD-10 codes.
  - File upload x12 submitters only.

In addition, Optum will support End to End testing between selected providers and payers. Optum will provide detailed information regarding testing as it becomes available.

**X12 REAL-TIME SUBMISSIONS**

The following outlines supported ICD-10 changes for 5010 versions of eligibility; claim status and referral add transactions.

**270/271 – Health Care Eligibility Benefit Inquiry and Response – 005010X279A1**

ICD-10 codes are situational in the 270/271 transactions if supported by the individual payer. Payer companion guides should indicate which payer supports this functionality.

**270 Requests:**

- Loop 2100C
  - HI0(1-8)-1 – Code list qualifier code
  - HI0(1-8)-2 – ICD-10 diagnosis code
- Loop 2100D
  - HI0(1-8)-1 – Code list qualifier code
  - HI0(1-8)-2 – ICD-10 diagnosis code
- Loop 2110C
  - EQ02-1 – Product/Service ID Qualifier
  - EQ02-2 – ICD-10-PCS Code
- Loop 2110D
  - EQ02-1 – Product/Service ID Qualifier
  - EQ02-2 – ICD-10-PCS Code

**271 Responses:**

- Loop 2100C
  - HI0(1-8)-1 – Code list qualifier code
  - HI0(1-8)-2 – ICD-10 diagnosis code
- Loop 2100D
  - HI0(1-8)-1 – Code list qualifier code
  - HI0(1-8)-2 – ICD-10 diagnosis code
• Loop 2110C
  • EB13-1 – Product/Service ID Qualifier
  • EB13-2 – ICD-10-PCS Code
• Loop 2110D
  • EB13-1 – Product/Service ID Qualifier
  • EBQ13-2 – ICD-10-PCS Code

276/277 – Health Care Claim Status Request and Response – 005010X212

ICD-10 codes are not used in these transactions.


ICD-10 codes are optional in the 278 transaction if supported by the individual payer. Payer companion guides should indicate which payer supports this functionality.

278 Requests:
• Loop 2000E
  • HI0(1-12)-1 – Code list qualifier code
  • HI0(1-12)-2 – ICD-10 diagnosis code
• Loop 2000F
  • SV202-1 – Product/Service ID Qualifier
  • SV202-2 – ICD-10-PCS Code

278 Responses:
• Loop 2000E
  • HI0(1-12)-1 – Code list qualifier code
  • HI0(1-12)-2 – ICD-10 diagnosis code
• Loop 2000F
  • SV202-1 – Product/Service ID Qualifier’
  • SV202-2 – ICD-10-PCS Code

HEALTH-E NETWORK® SUBMISSIONS

HEALTH-E ELIGIBILITY SUBMISSIONS/ REAL-TIME CLAIM STATUS SUBMISSION/ REFERRAL REQUEST SUBMISSIONS

Health-e Eligibility: The User Interface screens for Health-e Eligibility do not currently support the use of ICD-9 codes and will not be remediated to support ICD-10 codes.

Real-Time Claim Status: ICD-10 codes are not supported in these transactions.
Referral Request: The User Interface screens for Referral Request that currently support the use of ICD-9 codes will be remediated to support ICD-10 diagnosis codes. A new select list field described as ‘ICD Indicator’ will be added to the Referral Request screens and contains the values ‘ICD-9’ and ‘ICD-10’. Selecting ‘ICD-10’ will allow the user to add and submit ICD-10 diagnosis codes.

These changes will be deployed to production on 10/01/2014.

Testing Strategy: Optum will provide detailed information regarding testing as it becomes available.

HEALTH-E CLAIM™ SUBMISSIONS

PRINT IMAGE SUBMISSIONS

A new ICD-10 indicator field will be added for use in the map definition files and will support either ICD-9 or ICD-10.

Optum will only support a single code set per single claim.

We will continue to support only four diagnosis codes per claim.

Providers must be working with their practice management system (PMS) to prepare for ICD-10 readiness.

Once the submitter PMS is ICD-10 ready, submitters will need to contact the Optum Service and Support team to update individual maps.

- Service and Support Number: (866)367-9778.

Optum changes will be deployed to production on 10/1/2014.

DIRECT DATA ENTRY (DDE) SUBMISSIONS

A new select list field described as ‘ICD Indicator’ will be added to the upper right section of box 21 for the user to specify which version of ICD diagnosis code(s) will be submitted on the claim. Box 21 will continue to support four diagnosis codes only and all diagnosis codes entered should be ICD-9 or all diagnosis codes entered should be ICD-10.

Optum will support a single code set per single claim.

The new ‘ICD Indicator’ field and related functionality on the DDE screen will also apply to claims that are accessed from View Claim Errors – Advanced View Claim Errors.

These changes will be in production on 10/01/2014.
SECONDARY CLAIMS (ECT) SUBMISSIONS

A new select list field described as ‘ICD Indicator’ will be added to the upper right section of box 21 for the user to specify which version of ICD diagnosis code(s) will be submitted on the claim. Box 21 will continue to support four diagnosis codes only and all diagnosis codes entered should be ICD-9 or all diagnosis codes entered should be ICD-10.

Optum will support a single code set per single claim.

The submitter will have the capability to change a diagnosis code on the secondary claim from either ICD-9 to ICD-10 or ICD-10 to ICD-9.

These changes will be in production on 10/01/2014.

File Upload

Optum will support incoming X12 file upload Claim transactions from all entities prepared to submit electronic claims according to the new HIPAA mandate for ICD-10.

As of 10/01/2014, Optum will support ICD-10 codes within the X12 5010 production files. Optum will support dual submission of ICD-9 or ICD-10 with in the same file or in separate files. However, Optum will only support a single code set per claim. The Optum on-line Payers lists will indicate when Payers have the ability to support ICD-10 code sets.

- During the dual submission period, Optum will pass diagnosis codes as received.
- Optum will not be providing conversion from ICD-9 to ICD-10 or vice versa.
- Optum will not support dual code sets on a single claim.

These changes will be in production on 10/01/2014.

Optum ICD-10 Solution by Transaction Type

HIPAA Transactions:

HEALTH CARE CLAIM PROFESSIONAL

As of 10/01/2014, Optum will support ICD-10 in production.

Optum will support incoming claim transactions from all entities submitting claims containing ICD-10 code sets according to the new HIPAA mandate.

For submitters sending X12 4010A1 claims to payers utilizing the ICD-9 code sets, Optum will continue to up convert to 5010A1 on your behalf and pass on the ICD-9 that is received to payers. Submitters might receive rejections from payers once payers are ICD-
10 compliant. Submitters sending X12 4010A1 version must transition to the X12 5010A1 version to avoid possible payer rejections due to the fact that the X12 4010A1 version does not support ICD-10 code sets.

For submitters sending X12 5010A1 claims to payers utilizing the ICD-9 or ICD-10 code sets, Optum will pass on the ICD-9 or the ICD-10 that is received to payers. Submitters might receive rejections from payers once payers are ICD-10 compliant.

For submitters sending non-X12 claims through Health-e Claims (HEC) to payers utilizing the ICD-9 or ICD-10 code sets, Optum will continue to up convert to 5010A1 on your behalf and pass on the ICD-9 or ICD-10 that is received to payers. Submitters might receive rejections from payers once payers are ICD-10 compliant.

Optum will be adhering to the dates/time line set forth by CMS (unless payer requirements are different):

- ICD-10-CM diagnosis codes will be required on all professional and outpatient claims with dates of service on or after Oct. 1, 2014.
- Both ICD-10-CM diagnosis and ICD-10-PCS procedure codes will be required on all inpatient claims with discharge dates on or after Oct. 1, 2014.
- Service dates or discharge dates prior to Oct. 1, 2014, will require ICD-9 codes.

HEALTH CARE CLAIM INSTITUTIONAL

As of 10/01/2014, Optum will support ICD-10 in production.

Optum will support incoming claim transactions from all entities submitting claims containing ICD-10 code sets according to the new HIPAA mandate.

For submitters sending X12 4010A1 claims to payers utilizing the ICD-9 code sets, Optum will continue to up convert to 5010A2 on your behalf and pass on the ICD-9 that is received to payers. Submitters might receive rejections from payers once payers are ICD-10 compliant. Submitters sending X12 4010A1 version must transition to the X12 5010A2 version to avoid possible payer rejections due to the fact that the X12 4010A1 version does not support ICD-10 code sets.

For submitters sending X12 5010A2 claims to payers utilizing the ICD-9 or ICD-10 code sets, Optum will pass on the ICD-9 or the ICD-10 that is received to payers. Submitters might receive rejections from payers once payers are ICD-10 compliant.

Optum will be adhering to the dates/time line set forth by CMS (unless payer requirements are different):
• ICD-10-CM diagnosis codes will be required on all professional and outpatient claims with dates of service on or after Oct. 1, 2014.
• Both ICD-10-CM diagnosis and ICD-10-PCS procedure codes will be required on all inpatient claims with discharge dates on or after Oct. 1, 2014.
• Service dates or discharge dates prior to Oct. 1, 2014, will require ICD-9 codes.

HEALTH CARE CLAIM PAYMENT/ADVICE

Not impacted, no changes necessary.

Health Care Remittance Advice: Diagnosis codes are not supported in these transactions.

270/271 HEALTH CARE ELIGIBILITY BENEFIT INQUIRY AND RESPONSE

Optum supports x12 270/271 in production today.

ICD-10 codes are situational in the 270/271 transactions if supported by the individual payer. Payer companion guides should indicate which payer supports this functionality.

276/277 HEALTH CARE CLAIM STATUS REQUEST AND RESPONSE

Not impacted, no changes necessary.

Real-Time Claim Status: Diagnosis codes are not supported in these transactions.

278 HEALTH CARE SERVICE REVIEW REQUEST AND RESPONSE

Diagnosis codes are optional in the 278 transaction and can be used when the information is relevant to the inquiry and are based on payer requirements.

Optum will support diagnosis codes for 278 transactions in the x12 5010 format.

Non-HIPAA Transactions:

999 RESPONSES

Optum will continue to support the 999 acknowledgement response to return to submitters, including any error messages containing ICD-10 code sets.
277 RESPONSES

Optum will continue to support the creation and return of the 277 acknowledgement responses for the current X12 submitters which receive this type of reporting today, including any error messages containing ICD-10 code sets.

STANDARDIZED TEXT REPORTING

Optum will continue to support the creation and return of standardized text reports to submitters which receive this type of reporting today. There will be no changes to this reporting as a result of the ICD-10 mandate.

XMLRPT & XMLRPT2

Optum will continue to support the creation and return of XMLRPT and XMLRPT2 reports to X12 submitters. There will be no changes to this reporting as a result of the ICD-10 mandate.

Optum ICD-10 Solution by Submission Method

FILE TRANSFER PROTOCOL (FTP)

Optum will continue to support the receipt of PGP encrypted X12 FTP transactions from X12 submitters. There will be no changes to this submission method as a result of the ICD-10 mandate.

SECURE FILE TRANSFER PROTOCOL (SFTP)

Optum will continue to support the receipt of X12 Secure FTP transactions from X12 submitters. There will be no changes to this submission method as a result of the ICD-10 mandate.

HEALTH-E NETWORK® WEBSITE FILE UPLOAD

Optum will continue to support the upload of ANSI 837I and ANSI 837P transactions from X12 submitters. There will be no changes to this submission method as a result of the ICD-10 mandate.

HTTPS

Optum will continue to support https transactions from X12 submitters. There will be no changes to this submission method as a result of the ICD-10 mandate.
Optum ICD-10 Solution by Online Services

MESSAGE CENTER

As the reports provided in our Message Center are all in our proprietary format, Optum does not anticipate any changes to the User Interface (UI) or to the formats of the reports themselves. Clients will continue to receive all existing reports (Level One, Claim Status/Acknowledgement, Summary, Provider Announcement, etc.) as received today.

ELECTRONIC REMITTANCE ADVICE

Optum does not anticipate any changes to the ERA and EOB formats. Clients will continue to receive all existing data as received today.

ELECTRONIC CLAIMS TRACKING (ECT)

Optum has reviewed and identified the changes necessary to accommodate the ECT User Interface (UI) and primary display for the purpose of tracking your claims and the creation of secondary claims. Optum will support the ICD-10 mandated changes as well as some enhancements for the User Interface (UI) screens.

These changes will be deployed to production on 10/1/2014.

PATIENT STATEMENTS

At present, Optum has not identified any changes due to ICD-10 impacting Patient Statements on our Health-e Network® website.

SIGN UP ONLINE

ERA MANAGER

Optum has not identified any changes due to ICD-10 impacting ERA Manager on our Health-e Network® website

Additional links regarding ICD-10 Preparation:

- Centers for Medicare and Medicaid Services
- Optum Payers Lists
  [http://www.Optum.com/connectivity](http://www.Optum.com/connectivity) - then chose Payers List from the Quick Links section

If you need to request a log-in please contact our Customer Support Team at (866) 367-9778.