ICD-10 Implementation Frequently Asked Questions

Information in this FAQ is adapted from the CMS FY 2022 ICD-10-CM Official Guidelines for Coding and Reporting along with information from the Centers for Disease Control and Prevention (CDC), Centers for Medicare and Medicaid Services (CMS), and ICD10Data.com, a free ICD-10 coding database. All sources can be found at the end of this resource.

What are ICD-10 codes?
The International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) is a medical coding system published by the United States that is used to classify different health conditions. The ICD-10-CM is based on the ICD-10, which is published by the World Health Organization (WHO).

Why are ICD-10 codes required?
On January 16th, 2009, the US Department of Health and Human Services published a federal regulation requiring that all entities covered by the Health Insurance Portability and Accountability Act (HIPAA) report ICD-10 codes for services delivered on or after October 1st, 2015. Schools, school districts, and LEAs that bill Medicaid for medical services provided in the school setting are covered under HIPAA.

How are ICD-10 codes organized?
The ICD-10-CM Tabular List organizes ICD-1-CM codes into 22 chapters based on either the category that the code falls under or the body system that the code is related to. Each of the 22 chapters organizes related ICD-10-CM codes into categories, subcategories and codes. All ICD-10-CM codes start with a letter which corresponds with the chapter that the code comes from.

For example:

*G82: Paraplegia (paraparesis) and quadriplegia (quadriparesis) ← **Category***

- *G82.2: Paraplegia ← **Subcategory***
    - *G82.20: Paraplegia unspecified ← **Code***
    - *G82.21: Paraplegia complete ← **Code***
    - *G82.22: Paraplegia incomplete ← **Code***

Only codes can be used for ICD-10-CM reporting purposes. If a category or subcategory is not further subdivided into codes, then it is considered a code and can be reported.

For example:

*G82 and G82.2 above **cannot** be reported because they represent a category or a subcategory. The codes G82.20, G82.21, and G82.22 **can** be reported because they cannot be further subdivided and are therefore codes.*

Who should choose the appropriate ICD-10-CM code?
The decision as to who should choose the ICD-10-CM code reported on each claim is up to the individual school and/or school district based on what makes the most sense within existing Medicaid billing processes. Generally, ICD-10-CM codes can be assigned in two different ways:

1. By the billing administrator
2. By the individual service providers upon submission of their individual claims

Each option has pros and cons. If service providers are choosing their own codes, more training may be required to ensure that service providers know how to choose the appropriate code. In some cases, it may be appropriate for supervising or ordering providers to choose the ICD-10 codes associated with claims for services that they are delegating. It may also be beneficial for the student's care team as a whole to determine which ICD-10 code(s) should be used for each service based on the student's related medical documentation, and for this information to then be communicated to the billing administrator or related service providers.

How should I choose the appropriate ICD-10-CM code?
ICD-10-CM code assignment is based on medical documentation by the student's provider(s). In this case, the provider must be a physician or other qualified healthcare practitioner who is legally accountable for establishing the student's diagnosis. The ICD-10-CM code itself does not need to be chosen by the provider(s), but the person choosing the ICD-10-CM code must use documentation from the student's provider(s) to decide which code is most appropriate to use.

The goal of ICD-10-CM coding is to choose the most specific ICD-10-CM code supported by the documentation from the student's provider(s). All medical documentation and information should be reviewed to determine the specific reason that the student received a specific service.

For example:

*A student has a documented diagnosis of autism spectrum disorder (ASD). Because of this, it has been determined by the student's care team that they should receive applied behavioral analysis (ABA) services. Therefore, when submitting claims for documented ABA services, the appropriate ICD-10 code to use on the claim is **F84.0: Autistic disorder**.*

Steps to choose the most appropriate ICD-10-CM code:

1. Determine the diagnosis or reason that the student is receiving services. This should be documented in the student's file through their IEP/504/Care Plan, related doctor's orders, or other supporting documentation.
2. Locate the term or terms related to the reason that the student is receiving a service in the ICD-10-CM Alphabetic Index. The Alphabetic Index is a list of terms related to diseases and conditions and the ICD-10-CM codes that are associated with them. This will provide codes that may be appropriate to report along with descriptions for each code.
3. Verify the appropriate code by using the ICD-10-CM Tabular List. The Tabular List is a list of ICD-10-CM codes divided into chapters based on the body system that they relate to.

This process should be repeated for **each** different service that the student is receiving. In some cases, a student may be receiving multiple services related to one diagnosis. In other cases, a student may be receiving services related to more than one diagnosis or condition.

For example:

A student has a documented diagnosis of cerebral palsy. Because of this, it has been determined by the student's care team that they should receive physical therapy, occupational therapy, and speech therapy services. Because the student is receiving all of these services for the same diagnosed reason, the code ***G80.9: Cerebral palsy, unspecified*** *should be reported on all claims.*

For example:

A student has a documented diagnosis of generalized anxiety disorder (GAD) in addition to a diagnosis of spina bifida. Because of this, it has been determined by the student's care team that they should receive psychotherapy services for GAD and physical therapy services for spina bifida. Therefore, the code ***F41.1: Generalized anxiety disorder*** *should be used when billing claims for psychotherapy services and the code* ***Q05.9: Spina bifida, unspecified*** *should be used when billing claims for physical therapy services.*

When should I use a code that has "other" or "unspecified" in the code title?
In some cases, ICD-10-CM codes may be titled using the words "other" or "unspecified", and these codes should only be used in specific situations:

"Other" or "other specified" codes should be used when the student's medical documentation describes a known condition, but there is no existing ICD-10-CM code for that condition.

"Unspecified" codes should be used when there is not enough information in the student's medical documentation to assign a more specific code.

Unspecified codes should be reported when they are the codes that most accurately reflect what is known about the student's condition. It would be inappropriate to select a specific code that is not supported by medical documentation or conduct medically unnecessary diagnostic testing in order to determine a more specific code.

What if the provider assigns the F81.9 code to a student's order?
We recognize some providers may still assign this ICD-10 code in practice, in this case, it is recommended to:

- follow up with the provider to clarify if there is a more specific code,
- attach a more specific secondary code in addition to F81.9, or
- ensure the documentation supports the use of this code

What ICD-10-CM codes can be used if the patient has not been diagnosed with a specific condition?
Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider. **Chapter 18 of ICD-10-CM: Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (codes R00.0 - R.99)** contains signs and symptoms codes that should be used when a formal diagnosis has not been confirmed by a provider.

Specific diagnosis codes should be reported when they are supported by the available medical record documentation and clinical knowledge of the student's health condition. However, there are instances when signs/symptoms or unspecified codes are the best choices for accurately reflecting the reason that the student is receiving medical services.

Where can I go to find more information about ICD-10 coding?

Several free online resources are available to assist with ICD-10 coding:

- ICD10Data.com: Free online resource that can be used to look up all current ICD-10-CM codes using the Tabular List and Alphabetic Index. This website also contains information about ICD-10-CM coding rules.
- ICDList.com: Similar to ICD10Data.com; free online ICD-10-CM coding resource.

References

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