

Insights to Coding and Data Quality

D-day for coders–October 1, 2014

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D-day is a designation for dropping claims with a new code set. Changes in the reporting of codes will be different in that the number of digits will change to the number of characters in the ICD-10 code set. Different coding guidelines will govern the specificity required for submission of ICD-10-CM/PCS diagnoses and procedures. It will be imperative that all providers/suppliers are aware of such requirements and assure that their staffs are up-to-date with these requirements. While only inpatient claims will require ICD-10 procedure codes, the transition from the present ICD-9 procedure codes will be a significant change and a very different knowledge base will be required in the areas of medical terminology and anatomy/physiology. This will be quite a challenge for all inpatient coders.

But inpatient coders alone will not be the only personnel needing additional medical terminology education but also all other providers who currently use diagnosis coding to report services and procedures in the various health care settings.

After the October 1, 2014, D-day for coders, claims will be returned with the RTP/return as unprocessable, if billed with the ICD-9 code set or with both the ICD-9 and ICD-10 code sets. This will certainly be an extra expense for the provider/supplier as reprocessing claims with the required codes will be an additional expense that health care does not need at this time. So the rule is clear, any services/procedures provided prior to October 1, 2014, will need to be coded with the ICD-9-CM code set and those provided on or after October 1, 2014, must be submitted with ICD-10-CM/PCS codes. Coding is a kind of translation from one language to another (words to numbers). As of October 1, 2014, the language we use for translating our narrative for diagnoses and procedures is changing to a different language than we have had in the ICD-9 code set.

It is very clear as to how coders must code diagnoses and procedures before and after D-day of October 1, 2014. Coders must take it upon themselves to be very well-versed and well-educated in anatomy and physiology and the pathophysiology of diseases before the change to the new code set. It is a daunting assignment but it can also be an exciting and educational process as we will all learn so much more about the health care world we live in.

Thus, we now have the dilemma of what to do about those services that may span D-day!

The Centers for Medicare and Medicaid Services (CMS) has given us some guidance on this type of situation. This can be found in CMS's MedLearn Matters <http://www.cms.gov/Transmittals/downloads/R9500TN.pdf> on the CMS Web site.

For institutional providers, inpatient hospitals (including TERFHA hospitals, IPPS hospitals, LTCHs, CAHS) have the requirement of coding the entire claim using ICD-10 when the discharge date is on or after October 1, 2014. This includes coding for the entire claim no matter when the admission may have occurred. Bill Type 11X.

For Inpatient Part B Hospital Services, Outpatient Hospital Services and Non-patient Laboratory Services, split claims will be required. This means that claims should be split with one claim containing the dates of service (DOS) through September 30, 2014 coded with ICD-9 codes; ICD-10 codes should be submitted on the claim for services beginning October 1, 2014 and later. Bill Types 12X, 13X and 14X.

For Swing Beds and Skilled Nursing (Inpatient Part A), the claim for services provided with a discharge date on or through the date of October 1, 2014 would be billed using ICD-10 codes. Bill Types 18X and 21X.

For Skilled Nursing Facilities (Inpatient Part B and Outpatient) should submit split claims so that ICD-9 codes are submitted with dates of service through September 30, 2014; dates of service for October 1, 2014 and after should be submitted on a separate claim. Bill Types 22X and 23X

For Home Health (Inpatient Part B), they will be allowed to use the payment group code derived from ICD-9 codes on claims which span October 1, 2014 but require those claims to be submitted using ICD-10 codes. Bill Type 32X.

For Home Health claims that are a Request for Anticipated Payment (RAPs), these may be submitted with either an ICD-9 or an ICD-10 code based on the one date for which anticipated payment is requested. The corresponding final claim will need to use an ICD-10 code if the HH episode spans beyond October 1, 2014. Bill Type 3X2.

For Home Health (Outpatient), Rural Health Clinics, End Stage Renal Disease (ESRD), Outpatient Therapy, Comprehensive Outpatient Rehab Facilities, Community Mental Health Clinics, Federally Qualified Health Clinics (effective April 4, 2010), Hospice-Hospital, Hospital-Non-hospital, Critical Access Hospitals, these entities will need to split claims. ICD-9 codes will need to be used on one claim with dates of service through September 30, 2014 and one claim with dates of service beginning October 1, 2014 or after. Bill Types 34X, 71X, 72X, 74X, 75X, 76X, 77X, 81X, 82X, 85X.

For Federally Qualified Health Clinics (prior to April 1, 2010), only ICD-9 code set should be used. Bill Type 73X.

For 3-day/1-day Payment Window, all outpatient services (with a few exceptions) are required to be bundled on the inpatient bill if rendered within three days of an inpatient stay; therefore, if the inpatient hospital discharge is on or after October 1, 2014, the claim must be billed with ICD-10 codes for those bundled outpatient services.

Professional claims for anesthesia will require anesthesia procedures beginning on September 30, 2014 but ending on October 1, 2014, to be coded and billed with ICD-9 diagnosis codes and the date of service must be September 30, 2014 used as the “from” and “through” date.

Stay tuned for further information as we know there are always changes that may occur during the time between today and D-day, October 1, 2014.

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