ICD-10 Implementation FAQ's

Q1. What does ICD-10 compliance mean? Who is affected by this transition?

ICD-10 compliance means that all HIPAA covered entities are able to successfully conduct health care transactions using ICD-10 codes. This includes state Medicaid agencies and insurance payers.


No. Implementation of ICD-10 does not affect CPT or HCPCS code reporting for professional services and outpatient procedures.

Continue reporting CPT and HCPCS code for these services. ICD-10- PCS codes are for hospital inpatient procedures only.

Q3. What happens if I am not ICD-10 compliant by October 1, 2015?

If you are not ICD-10 ready by the compliance date, it will disrupt all of your business operating practices. Your claims will be denied, authorizations/pre-certification processes will be denied resulting in loss revenue.

Q4. If I transition to ICD-10 prior to the implementation date, will health insurance plans process my claims?

No. CMS, state Medicaid agencies and most health insurance plans that meet the definition of covered entities will not be able to process claims using ICD-10 until the compliance date. Continue submitting claims with ICD-9 codes through September 30, 2015 and begin using ICD-10 codes on October 1, 2015.

Q5. Codes change every year, so why is the transition to ICD-10 any different from the annual code changes?

ICD-10 codes are different from ICD-9 codes and have a completely different structure. Currently, ICD-9 codes are mostly numeric and have 3 to 5 digits. ICD-10 codes are alphanumeric and contain 3 to 7 characters.

ICD-10 codes will be reviewed and updated annually as applicable.

Q6. Why is the transition to ICD-10 happening?

ICD-9 codes provide limited data about patients’ medical conditions and hospital inpatient procedures. This code system is 30 years old, it has outdated and obsolete terms and is inconsistent with current medical practices and advanced technology.

Additionally, the structure of ICD-9 limits the number of new codes that can be created and many ICD-9 categories are full. Transitioning to the new code set is vital to transforming our nation’s health care system.

Q7. What should providers do to prepare for the transition to ICD-10?

Providers should not wait until the last minute to prepare for ICD-10 systems early.
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Planning should include:

1-Internal testing of all data systems
2- Coordination with payers to assess readiness
3-Project plan launch by data management and IT teams

For these providers who have not yet started to transition to ICD-10, below are action steps to take now:

1-Develop an implementation plan
2- Communicate the new system changes to your organization
3-Prepare your business plan
4-Ensure that leadership and staff understand the extent of the effort the ICD-10 transition requires
5-Secure a budget that accounts for software upgrades/software license costs, hardware procurement, staff training costs, work flow changes during and after implementation, and contingency planning
6-Talk with your payers, billing and IT staff, and vendors to confirm their readiness status
7-Coordinate your ICD-10 transition plans among your partners and evaluate contracts with payers and vendors for policy revisions, testing timelines, and costs related to the ICD-10 transition.
8-Create and maintain a timeline that identify tasks to be completed and crucial milestones/relationships, task owners, resources needed, and estimated start and end data

Q8. Where can I find the ICD-10 code sets?

The ICD-10-CM, ICD-10-PCS code sets and the ICD-10-CM official guidelines are available free of charge at www.cms.gov/ICD10.

Q9. Why should I prepare now for the ICD-10 transition?

The transition to ICD-10 is a major undertaking for providers, payers, and vendors. Ultimately, it will drive business and system changes throughout the health care industry, from large national health plans to small provider offices, laboratories, medical testing centers, hospitals, and more.

Ample time is necessary to ensure a smooth transition if you plan ahead and prepare now.

Q10. What type of training will providers and staff need for the ICD-10 transition?

AHIMA recommends training should begin no more than six (6) months before the compliance deadline. Training varies for different organizations but is projected to take 15-50 hours. For example, physician practice coders will need to learn ICD-10 diagnosis coding only, while hospital coders will need to learn both ICD-10 diagnosis and ICD-10 inpatient procedure coding.

Search for specialty-specific ICD-10 training offered by specialty societies and other professional organizations such as AHIMA, AAPC, AMA, etc

Take into account that ICD-10 coding training will be integrated into the CEU's that certified coders must take to maintain their credentials.

ICD-10 resources and training materials are available through CMS, professional associations and societies, and software/system vendors.
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Visit www.cms.gov/ICD10 regularly throughout the course of the transition to access the latest information on training opportunities.

Q11. What if my office obtains authorization/pre-certification for patient care prior to September 30, 2015 and the authorization end date is on or after October 1, 2015? Are we required obtain a new authorization?

No, the authorization should be valid for the dates/total days specified on the authorization. However, you should check with each payer as the rules may vary from payer to payer. We recommend that in this instance you submit a paper claim with a copy of the authorization attached.

Q12. What if my office obtains authorization/pre-certification for patient care prior to September 30, 2015 and the level of care changes on or after October 1, 2015? Are we required obtain a new authorization?

Since the level of care provided may be linked to the type of codes you requested during the authorization/pre-certification, you may need to obtain a new authorization/pre-certification. You should contact the payer for advice and further clarification. If their response is no, request written documentation for your records so that in the event the services are denied, you can submit the information received to appeal your denied claims.

Q13. What is Version 5010?

This is an update to ASC X12 Version 4010/4010A1 standards for electronic administrative transactions (such as eligibility inquiries and remittance advices). For more information, please visit http://www.x12.org.

Q14. Why did the upgrade to Version 5010 happen? What steps can I take now if I haven’t upgraded to Version 5010?

Version 4010 transaction standards does not have the capability to handle electronic claims that contain ICD-10 codes, among other things. On the other hand, version 5010 offers improved standardization for administrative and clinical data.

If you haven’t completed the Version 5010 upgrade, please visit CMS’ website at www.

Q15. How does the Version 5010 upgrade affect my transition to ICD-10?

Version 5010 supports both the ICD-9 and the ICD-10 code set structures. The use of this platform will ensure that there is no disruption of your claims submission processes for services submitted with ICD-9 or ICD-10 codes.

Q16. What happens if I did not upgrade to Version 5010?

If you are not using version 5010, your claims will be denied which will have a negative impact on revenue to your practice. Additionally, your practice will be subject to monetary fines and penalties for failure to comply.
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If you use a billing service or clearinghouse to process HIPAA transactions, verify that these entities are 5010 compliant. Your practice is also subject to monetary fines and penalties if the billing service or clearinghouse is not submitting claims in version 5010.

Q17. What steps can I take now if I haven’t upgraded to Version 5010?

If you haven’t completed your Version 5010 upgrade, a fact sheet is available on the Version 5010 page with steps you can take now.

Q18. Are there any resources available to assist me with the version 5010 implementation?

CMS provides resources to help you prepare for your upgrade to Version 5010. Visit CMS’ website for information on version 5010 fact sheet. There is also a CMS-WEDI webinar available on the website.

Additional resources focused on the needs of Medicare fee-for-service (FFS) providers can be found at www.cms.gov/Versions5010andD0/40_Educational_Resources.asp.

Q19. What should providers do to verify compliance with Version 5010?

Providers who use practice management and other applicable software programs should make sure that their software features the updated Versions 5010 and D.0 transaction standards. (If you are a Medicare FFS provider, please contact your Medicare Administrative Contractor (MAC) or legacy contractors to ask about their software/testing protocols.)

Talk to your software vendor, clearinghouse, or billing service to verify that you are compliant.