Transition to ICD-10: What Does It Mean for You?

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There is now less than a year to prepare for the coding transition from ICD-9 to ICD-10. What exactly does this mean and how does it affect you as a mental & behavioral health care provider?

First, a quick primer: **ICD codes are used for diagnosis**—they support the CPT billing codes that describe what action was taken. For example, the ICD-9 code for major depressive disorder (MDD), recurrent episode is 296.3; and this diagnosis code would support a CPT code of 90837, 60 minute psychotherapy session.

DSM are also diagnosis codes, and because most psychologists were trained to diagnose using some form of DSM code, the **2 sets of diagnosis codes (DSM and ICD) have been harmonized over the years**. Often, they are even identical; for example, 296.3 is both the ICD-9 and DSM-IV code for MDD (296.36 is MDD recurrent full remission; 296.35 is partial remission, etc).

Often, when a psychologist uses DSM diagnosis codes, they are recognized by payers as ICD-9 codes, and currently a mental health biller will automatically convert the psychologist's DSM diagnosis codes to ICD if they aren't the same. The difference between DSM and ICD is that ICD-9-CM codes have been mandated for third-party billing and reporting by HIPAA for all electronic transactions for the past 10 years. While DSM has been the industry standard for mental health, those codes aren't technically acceptable for billing, and **with current updates to both DSM and ICD, the parallel & familiar coding situation is chang-ing**. (Click here for details about how DSM, ICD & CPT codes interact for mental health.)

In May 2013, the DSM-5 was released, causing significant changes to mental & behavioral health diagnoses and generating huge political buzz. At the same time, **a mandatory change in ICD codes is taking place: by October 1st, 2014, all healthcare providers covered by HIPAA (including mental & behavioral health) must convert to using the ICD-10-CM diagnosis code sets.** The US is one of the last industrialized countries to make the transition to ICD-10, even though it was published in 1990. The international adoption of ICD-10-CM should facilitate data comparisons to track disease and treatment data; it may also decrease the need for claim supporting documentation as it includes severity indicators (and morbidity details) within each code.

Whereas previously DSM and ICD closely paralleled each other and were simple to convert for billing, these revisions in both sets of codes mean that mental health billing is getting ready to change significantly. First is the easier transition: making a decision about whether or not to use DSM-5 and, if so, training your biller to convert it to ICD-9. Some providers are choosing to stick with DSM-IV to diagnose their clients: there has been a huge backlash against the DSM-5, and because billers are familiar with converting DSM-IV to ICD-9, this method will remain in place for some providers until the ICD transition date. If you choose to adopt DSM-5, your biller will need to learn how to convert these codes into ICD-9 and of course use these codes in combination with the new mental health CPT codes that were changed in January of 2013. (**One important thing to note is that the change to ICD-10 does not affect CPT coding for outpatient procedures and physician services**).

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Converting to DSM-5 lays potential groundwork for the future, as the CDC has stated that they are working with the World Health Organization (WHO) to link the DSM-5 with the mental and behavioral disorders section of the ICD-11. The proposed long term plan is that DSM-5 and ICD-11 will parallel one another like DSM-IV and ICD-9 did for over a decade. In the meantime, until these changes are in place, the gap between DSM and ICD is widening, and some providers are ditching DSM altogether and diagnosing with ICD themselves: this makes a lot of sense, since it saves a conversion step and makes billing easier. This method of documenting client sessions for mental health will simplify the transition to ICD-10, which is the second, and more complex, change.

Industry experts warn that this conversion will be massive, far greater than the update to 5010 and more extensive in scope than any previous code updates. Essentially, the number of codes is increasing dramatically: the current set of approximately 12,000 medical diagnosis codes will expand to over 60,000, increasing the detail available in each code and bringing the US in alignment with the current worldwide standard. While it appears to be a valuable transition for healthcare, it certainly means a lot of work for those having to implement the switch.

It's easy in our already overloaded practices to put this necessary update on the backburner until the October deadline, but it's necessary to confront this task *now.* Researching and implementing a plan of action for 2014 is time consuming, but it's essential. As of midnight on Oct. 1, 2014, any claims filed for dates of service on or after this date must contain ICD-10 -CM codes. Because this is a HIPAA mandate, penalties for failure to comply will be enforced. Civil and criminal penalties may include heavy fines and imprisonment. Due to the scope of changes, this isn't something that can be ignored or addressed last minute.

How do you get started? Check out the following tools:

Centers for Medicare and Medicaid Services (CMS) ICD-10 Provider Resources
ICD-10 Implementation Guide for Small and Medium Practices
Small and Medium Practices ICD-10 Checklist
ICD-10 Implementation Guide for Large Practices
American College of Physicians ICD-10 Resource Center
ICD-10 Conversion Tool and Resources
AAPC Coding Books
PIMSY EHR ICD-10 Resource Center

A final note: **what about ICD-11 that was mentioned!?** Are we going to have to go through this all over again in a few years? Hopefully not: WHO will be completing the preparation of ICD-11 at about the same time that the US will be adopting ICD-10, but through a series of updates over the next few years, the US is expected to bring ICD-10 in line with ICD-11. These updates are supposed to be smooth and gradual to avoid another sudden and major change in diagnosis classification.

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