MetroPlus Health Plan

Frequently Asked Questions

To help get you ready for ICD-10, check out our list of Frequently Asked Questions here.

1. **How will MetroPlus handle authorization of services that occur on or after the ICD-10 compliance date of October 1, 2015?**

   MetroPlus will follow its current process, which is to issue authorizations based on the request date.

Type of Service	Begins	Ends	Pre-Authorization	Claim
Inpatient	Admission begins on or after 10/1/2015	Discharge on or after 10/1/2015	Preauthorization must be requested with ICD-10 codes.	Claim for services rendered on or after 10/1/2015 must be billed with ICD-10 codes.
Inpatient with Unknown discharge date	Admission begins before 10/1/2015	Unknown at the time of admission, then discharge occurs on or after 10/1/2015	Preauthorization must be requested with ICD-9 codes. This authorization will be valid for the entire admission.	The code set used on the claim will be based on the discharge date, so the facility claim must be billed with ICD-10 codes. Physicians providing services must submit claims with ICD-9 codes for dates of service before 10/1/2015. Claims submitted on or after 10/1/2015 must use the ICD-10 code set. Claims with both code sets or mixed claims will not be accepted
Inpatient with Known discharge date	Admission begins before 10/1/2015	Known discharge on or after 10/1/2015	Preauthorization should be requested with ICD-10 codes.	Claim must be filed with ICD-10 codes.
Outpatient Services	Service begin on or after 10/1/2015	N/A	Preauthorization should be requested with ICD-10-CM codes.	Claims must be filed with ICD-10 codes.

Ambulatory Surgery	Service begin on or after 10/1/2015	N/A	Preauthorization should be request with CPT-4 /HCPC Code and ICD-10-CM codes	Claims must be filed with CPT/HCPC codes set and ICD-10-CM codes.
Long-term Outpatient Services (i.e. Chemotherapy, PT, OT, ST, RT, etc.)	Services begin before 10/1/2015	Services end on or after 10/1/2015	Preauthorization obtained in ICD-9 will be valid for services rendered on or after 10/1/2015.	The claims for these services need to be separated and filed with the correct code set for the date(s) of service. Claims with both codes sets, or mixed claims will not be accepted.

2. **How does the ICD-10 implementation affect providers that file paper claims?**

   The ICD-10 code set must be used on all claims with dates of service — and inpatient claims with a date of discharge — on or after October 1, 2015. The method used to submit the claim (i.e., paper or electronic) has no impact on the code set that should be used on the claim.

3. **Has MetroPlus medical and claim payment policies been updated with ICD-10 codes?**

   Yes. MetroPlus has added ICD-10 procedure and diagnosis codes to medical and claim payment policies. As new policies are written and existing policies are reviewed and updated, medical management will assess each policy and add appropriate ICD-10 codes.

4. **Will the ICD-10 transition affect CPT or HCPCS codes?**

   The transition does not affect the Current Procedural Terminology (CPT®) code set, which will continue to be used for outpatient services.

5. **Where can the provider find valid ICD-10 codes?**

   A complete list of the 2016 ICD-10-CM valid codes and code titles is posted on the CMS website at:

   http://www.cms.gov/Medicare/Coding/ICD10/2016-ICD-10-CM-and-GEMs.html.'
   The codes are listed in tabular order (the order found in the ICD-10-CM code book). This list should assist providers who are unsure as to whether an additional 4th, 5th, 6th or 7th character is needed. Using this free list of valid codes is straightforward.

6. **Will MetroPlus observe the one-year period of claims payment review leniency for ICD-10 codes that are from the appropriate family of codes?**

   The official CMS Guidance only applies to Medicare fee-for-service claims from physician or other practitioner claims billed under the Medicare Fee-for-Service Part B physician fee schedule. MetroPlus will only accept a valid ICD-10 codes.

7. **What is the submission process for ICD-10 compliant prior approval requests?**

   Requests for prior authorization before October 1, 2015 for dates of service after October 1, 2015 require ICD-9 codes. The authorization will be good for dates of service after October 1, 2015. Claims submitted after October 1, 2015 require ICD-10 codes.

8. **What should providers do if their claims are rejected? Will the provider know whether it was rejected because it is not a valid code versus denied due to a lack of specificity required or other claim edit?**

   Yes, providers will know that they were rejected because the claim did not have a valid code versus a denial for lack of specificity required or other claim edit. Providers should follow existing procedures for correcting and resubmitting rejected claims and issues related to denied claims.