BlueCross BlueShield of Montana

ICD-10: Frequently Asked Questions (FAQs)

This FAQ document was developed to help answer provider questions about the mandated transition to ICD-10. This document may be updated as additional information becomes available.

Also, visit the ICD-10 page in the Standards and Requirement section of the Blue Cross and Blue Shield of Montana (BCBSMT) website at bcbsmt.com, under the Provider tab.

These FAQs are organized by category as follows:

BCBSMT Readiness

1. **Describe BCBSMT's approach to ICD-10 compliance (e.g., conversion, remediation, etc.).**
   BCBSMT has diligently worked to be prepared to meet mandated ICD-10 timelines and requirements. We have implemented system and business process changes to help accommodate transactions with ICD-10 codes for dates of service or discharge dates on or after Oct. 1, 2015, using a "pure" environment (i.e., processing and business rules will be based on the ICD-10 codes). During an appropriate run-out period, the duration of which has not yet been determined, we will continue to process ICD-9 transactions through our existing environment for dates of services or discharge dates prior to Oct. 1, 2015.

2. **Did BCBSMT have an ICD-10-specific implementation plan?**
   Yes. The implementation plan, in place since 2009, began with the completion of an impact assessment. System and business process changes to help accommodate transactions with ICD-10 codes have been implemented and we have conducted testing with selected providers and clearinghouses. BCBSMT began accepting ICD-10 codes as of Sept. 21, 2015, for benefit preauthorization requests for services rendered on or after Oct. 1, 2015. Valid ICD-10 codes must be included on claims submitted to BCBSMT for dates of service or inpatient discharge dates on or after Oct. 1, 2015. Claims without valid ICD-10 codes, as required, will not be accepted by BCBSMT.

3. **Did BCBSMT update its medical policies consistent with ICD-10 prior to Oct. 1, 2015?**
   The BCBSMT Medical Policies are described in narrative terms and are not coded in ICD codes. As a result, changes to be consistent with ICD-10 are not required.

Provider Readiness

4. **Will BCBSMT provide training for my office or clinical staff? Do providers require the same level of ICD-10 training as medical coders?**
   In our opinion, training is indeed necessary. However, BCBSMT will not conduct coding training sessions. It is important for providers and clinical staff to understand the new ICD-10 code environment. Physicians and other health care providers should review the Centers for Medicare & Medicaid Services (CMS) suggestions about documenting patient encounters to facilitate and provide sufficient detail to meet the needs of the increased specificity and granularity of ICD-10 codes. Professional and institutional providers should look into training programs with organizations such as the American Health Information Management Association (AHIMA), the American Association of Professional Coders (AAPC), the Healthcare Information Management Systems Society (HIMSS), America's Health Insurance Plans (AHIP) and others.

   Please note that all certified medical coders may have been required to take a minimum number of ICD-10-specific Continuing Education Units (CEUs) before the compliance date to maintain their certifications with certifying organizations. CEU requirements can vary by certifying organization. Contact the certifying organization to get specifics about these requirements.

5. **How can I get a list of valid ICD-10 diagnosis codes?**
   File downloads can be found on the CMS website at: http://www.cms.gov/Medicare/Coding/ICD10/index.html. To purchase ICD-10 coding books or subscribe to online coding tools, you can conduct an Internet search for vendors that offer electronic coding, billing and reimbursement products and training resources. Additional information is also available on the CMS website. It is suggested to use coding books from U.S. publishers because U.S. codes have been modified with the permission of the World Health Organization (WHO). If you need to look up individual codes by description, you may wish to use the CMS Code Lookup tool at https://www.cms.gov/medicare-coverage-database/staticpages/icd-10-code-lookup.aspx, as one resource.

6. **Which version of the ICD-10 code book should I use?**
   We cannot recommend a specific book; however, we do recommend use of ICD-10 code books published in the U.S. To maintain consistency in your coding manuals, you may want to contact the same sources you relied on for ICD-9 manuals and coding tools, and consider switching to an electronic coding tool to help improve your medical coding productivity.

7. **Can the General Equivalence Mappings (GEMs) be used solely for coding charts and medical records?**
   In our opinion, no. GEMs should be used as a starting point to convert large databases and large code lists from ICD-9 to ICD-10 or backward from ICD-10 to ICD-9. When coding medical charts, medical records and so forth, medical coders should continue to use the ICD-10 coding books or coding software to produce the most accurate code selection. If you need to look up individual codes by description, you may wish to use the CMS Code Lookup tool at https://www.cms.gov/medicare-coverage-database/staticpages/icd-10-code-lookup.aspx, as one resource.

8. **As a solo practitioner, I don't have staff to help me get ready for ICD-10. What do you suggest?**
   As a one-physician "team," consider seeking suggestions from your peers, local and state medical societies, other smaller-practice physician offices, your vendors and clearinghouses. One good place for smaller practices to start is the CMS roadto10.org website.

9. **Are there factors to consider when referring patients to other providers for services rendered after Oct. 1, 2015?**
   If you refer patients to other providers or write orders for other providers, consider if the referral or order will involve dates of service on or after Oct. 1, 2015. If so, the appropriate ICD-10 codes must be included.

10. **It's not likely; but it seems to be a possibility that small, rural providers will retire because of the mandate to transition to ICD-10. What would a large organization like BCBSMT be prepared to do in the event this happened and it's widespread?**
    There has been no evidence to date that large numbers of providers will retire due to ICD-10. There are numerous regulatory initiatives that happened concurrently with implementation of ICD-10, including Meaningful Use, the Affordable Care Act and Medicare payment reform – any of these initiatives could be perceived to put pressure on smaller providers to exit their practice. BCBSMT will continue to monitor the strength and reach of our independently contracted provider network and will work to ensure we have network coverage in all of our target markets.

11. **If I'm not ready to submit claims using ICD-10, can I instruct my patients to submit their own claims to BCBSMT for reimbursement?**
No. You are not allowed to request that our members submit their own claims for services you provide. Claims for services rendered to our members must be filed according to the terms and conditions of your provider agreement with BCBSMT.

Contacts

12. **Who is my primary contact at BCBSMT for assistance with initiatives such as the ICD-10 transition?**
Information on ICD-10 is available in the Standards and Requirements section of our website at bcbsmt.com/provider. Also watch the News and Updates section of our Provider website, as well as our provider newsletter. If you need personalized assistance, contact your BCBSMT Provider Network Representative.

Industry Alignment

13. **Is BCBSMT following the CMS-mandated timelines?**
Yes. We are following the implementation guidelines that have been adopted as part of the industry coalition, which includes: the Centers for Medicare & Medicaid Services (CMS), the Workgroup for Electronic Data Interchange (WEDI), the North Carolina Healthcare Information and Communications Alliance, Inc. (NCHICA), the Healthcare Information Management Systems Society (HIMSS), America's Health Insurance Plans (AHIP), the American Health Information Management Association (AHIMA), the American Association of Professional Coders (AAPC) and others. This industry timeline includes the recommended schedules for providers, vendors and payers.

14. **Are State-run programs required to transition to ICD-10?**
All HIPAA-covered entities are required to transition to ICD-10. State-run programs that are considered a covered entity are required to transition to ICD-10.

15. **Doesn't ICD-10 pertain only to Medicare?**
No. ICD-10 is a federal mandate for all HIPAA-covered entities under the HIPAA Transaction and Code Set (T&CS) regulations, which became effective in 2003. These regulations have been modified several times since then, including new requirements, such as the national provider identifier (NPI), the move to ANSI v5010 from ANSI v4010, and the national health plan identifier. Although the T&CS regulations are enforced by CMS, they apply to all payers, providers, clearinghouses and other HIPAA-covered entities and are not limited to Medicare payers and providers.

16. **What is the essence of the ICD-10 announcements from CMS and the joint message with the American Medical Association (AMA)?**
In a joint announcement on July 6, 2015, CMS and AMA confirmed Oct. 1, 2015, as the ICD-10 compliance date, while also announcing a12-month transition period for Medicare Part B fee-for-service providers. According to the CMS guidance, modest flexibility will be offered to these providers during this time, as Medicare will not penalize providers in post-pay quality reviews or deny a claim during complex medical claim review solely due to the lack of specificity of the ICD-10 code, as long as the ICD-10 code is valid and from the right family. All other front-end claims edits checking for code validity and National/Local Coverage rules and other claims edits will continue to be applied to ICD-10-coded claims, just as they were with ICD-9-coded claims.

Updates to the original CMS announcement were published on July 27, July 31 and Sept. 22, 2015. CMS will maintain a "communication and collaboration center" to monitor the Medicare ICD-10 implementation and CMS ombudsman Dr. William Rogers will help triage and resolve physician and provider issues related to Medicare's transition to ICD-10. Additional information is available on the CMS website at https://www.cms.gov/Medicare/Coding/ICD10/ICD-10-Provider-Contact-Table.pdf. For answers to frequently asked questions, refer to the updated CMS guidance document at https://www.cms.gov/Medicare/Coding/ICD10/Clarifying-Questions-and-Answers-Related-to-the-July-6-2015-CMS-AMA-Joint-Announcement.pdf.

17. **What is BCBSMT's response to the CMS transition period announcement and guidance?**
BCBSMT will apply claim edits to ICD-10-coded claims, just as we have with ICD-9-coded claims. Currently, we do not automatically penalize providers due to lack of coding specificity; but we encourage providers to use the most specific codes possible for the most appropriate claim outcome and to help avoid requests for medical records. As a commercial payer, BCBSMT has diligently worked to be prepared to meet mandated ICD-10 timelines and requirements. System and business process changes to accommodate ICD-10 transactions have been completed and we intend to maintain our current approach regarding the transition to ICD-10. As announced previously, valid ICD-10 codes must be included on claims submitted to BCBSMT for dates of service/inpatient discharge dates on and after Oct. 1, 2015. BCBSMT is not permitted to accept claims without required valid ICD-10 codes and such erroneous submissions will not be accepted by BCBSMT.

18. **CMS created an ICD-10 contingency plan. Is BCBSMT following that plan?**
The CMS ICD-10 Contingency Plan is for its Medicare fee-for-service claims only. BCBSMT has developed our own contingency plans designed to correct a variety of potential ICD-10-related issues. While we do not publish our contingency plans, providers, trading partners and other customers will be notified quickly if any of our plans need to be activated.

19. **Will BCBSMT accept ICD-9 codes on claims after Oct. 1, 2015?**
No. BCBSMT will only accept ICD-9 codes for claims with dates of service/inpatient discharge dates prior to Oct. 1, 2015. BCBSMT is adhering to federal mandate requirements regarding implementation of ICD-10 and we are prepared to process transactions containing valid ICD-10 codes on all professional and outpatient claims with dates of service on or after Oct. 1, 2015.

Testing

20. **When did BCBSMT conduct testing with providers?**
BCBSMT has completed end-to-end or "round-trip" testing of electronic claims (837 transactions) submitted with ICD-10 codes with a select group of providers. Enrollment in the ICD-10 Testing Program was open to all interested contracted providers who met necessary prerequisites. End-to-end testing began in May 2015 and test claims were accepted through Aug. 14, 2015.

21. **Who participated and how was testing conducted?**
Providers were selected for testing based on a series of criteria, including volume of transactions generated, specialty, ability to test, types of claims generated and other attributes to help ensure that a balanced mix of claims was tested. The testing process offered providers and their staff the opportunity to practice coding with ICD-10. Participants submitted "twin" claims for testing – one with ICD-9 codes and the other with ICD-10 codes. BCBSMT then processed both claims with the intention of taking all submitted and accepted test claims to a finalized status.

22. **How were testing results communicated to providers?**
For each finalized test claim, BCBSMT returned an 835 Electronic Remittance Advice (835 ERA). Participants also received testing summary results for each set of twin claims. Upon completion of the testing period, an overview and results summary of our ICD-10 testing program was published on our Provider website and in our provider newsletter.

Contracting

23. Will new Trading Partner Agreements be needed?
No. New Trading Partner Agreements will not be required.

24. Will BCBSMT need to re-contract with network providers?
Generally, no. However, some providers with contracts dependent on specific DRG versions may need re-contracting to a version that supports ICD-10.

25. My contract does not require that I use ICD-10. Why is BCBSMT requiring it?
Your agreement as an independently contracted network provider with BCBSMT includes language that stipulates you will comply with all state and federal regulations. ICD-10 is a federal regulation covered by this provision of your contract. According to the federal mandate, all payers, providers, clearinghouses and other HIPAA-covered entities must adopt ICD-10 and use it as of the compliance deadline. The health industry in the U.S. is required to move to ICD-10 at the same time, for dates of service/inpatient discharge dates on or after Oct. 1, 2015.

Benefit Preauthorization

26. When did BCBSMT begin accepting ICD-10 codes for benefit preauthorization requests for dates of service Oct. 1, 2015, and later?
BCBSMT began accepting ICD-10 codes as of Sept. 21, 2015, for benefit preauthorization requests for services to be rendered on or after Oct. 1, 2015. Prior to submitting a benefit preauthorization request, we encourage you to check eligibility and benefits through your preferred online vendor portal.

27. If I need to request benefit preauthorization for a from-through date range that spans the Oct. 1, 2015, compliance date, do I need to split my request so that ICD-9 is used for services to be rendered on or before Sept. 30, 2015?
No. You may request the entire date span using ICD-10 for inpatient admissions, and ICD-9 for all other services. BCBSMT will be able to apply an ICD-9 coded benefit preauthorization to a corresponding claim coded in ICD-10 for dates of service on or after Oct. 1, 2015.

28. If I already received approval for a benefit preauthorization coded in ICD-9, but the date of service is Oct. 1, 2015, or later, do I need to request "re-approval" using ICD-10 codes?
No. An approved benefit preauthorization coded in ICD-9 does not need to be reapproved in ICD-10 if the date of service falls on or after the compliance date. Please note that any benefit preauthorization request submitted on or after Oct. 1, 2015 must use ICD-10 codes.

Claim Submission

29. **What codes are required as of the ICD-10 compliance date, and will the use of all other codes end at that time?**
    ICD-10-CM diagnosis codes are required on all professional and outpatient claims with dates of service on or after Oct. 1, 2015. Both ICD-10-CM diagnosis and ICD-10-PCS procedure codes are required on all inpatient institutional claims with discharge dates on or after Oct. 1, 2015. Service dates or discharge dates prior to Oct. 1, 2015, require ICD-9 codes. Use of other codes – such as Current Procedural Terminology (CPT®), HCPCS, Revenue Codes, etc. – will not be impacted by this change.

30. **Could claims coded in ICD-10 be submitted before Oct. 1, 2015?**
    No. Current federal regulations required the use of ICD-9 codes for dates of service through Sept. 30, 2015. Providers were instructed to begin using ICD-10 codes on or after Oct. 1, 2015, for claims with dates of service Oct. 1, 2015, and later.

31. **How will ICD-9 codes be disabled once ICD-10-CM and ICD-10-PCS are in full effect?**
    BCBSMT expects there will be late filings and adjustments for several months after Oct. 1, 2015, for claims incurred before that date. We will continue to accept ICD-9 for dates of service Sept. 30, 2015, and earlier. Claims containing ICD-9 codes with a date of service or discharge date of Oct. 1, 2015, or later will be returned.

    ***Please note**: An adjusted claim must be submitted using the code set in which it was originally filed.*

32. **I need to resubmit a claim after the compliance date that was correctly coded in ICD-9. Do I need to convert to ICD-10?**
    Use of ICD-10 is service-date driven. Inpatient institutional claims with discharge dates on or after Oct. 1, 2015, and outpatient or professional claims with dates of services on or after Oct. 1, 2015, must be coded using ICD-10 codes. ***Resubmissions or adjustments to previously filed claims must be submitted in the same code set used in the originally submitted claim.***

33. **Will CPT or HCPCS codes change or continue to be used as in the past?**
    CPT and HCPCS codes will continue to be used on outpatient and professional claims.

34. **On and after Oct. 1, 2015, do we submit Worker's Comp, auto and disability claims in ICD-9 or ICD-10?**
    According to the U.S. Department of Health and Human Services (HHS), only HIPAA-covered entities are required to comply with the mandate. Worker's Comp, auto and disability claims are NOT considered covered entities under HIPAA. Therefore, they are NOT subject to the Final Rule regarding ICD-10. But, HHS strongly encourages converting to ICD-10 codes. Check with your specific carrier to determine if they will accept ICD-9 after the compliance date. Here's a link for more information:
    http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/workerscomp.html

35. **Do I split a claim if it's submitted after Oct. 1, 2015, and the dates of service span the compliance date?**
    CMS has clarified that only one code set per claim is allowed; i.e., all ICD-9 or all ICD-10. Claims will be returned if they contain both ICD-9 and ICD-10 codes. Depending on the type of claim (e.g., inpatient institutional, facility outpatient, or professional), there are different rules for how to code a claim with dates of service that span the ICD-10 compliance date. Please refer to the following MLN Matters® articles on the CMS website for additional information, according to the type of claim:
    - *All claims (institutional and professional) – http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1408.pdf*
    - *Institutional claims (extra examples and clarifications for certain types of claims) – http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1325.pdf*

36. Do I need to use ICD-10 codes for Durable Medical Equipment (DME) rentals and monthly supplies that span the compliance date?

No. BCBSMT follows MLN Matters® ICD-10 date of service use guidelines as they relate to DME rentals. DME rentals and monthly supplies follow the "from" date of service rule. For example, for a one-month wheelchair rental from Sept. 15, 2015, through Oct. 15, 2015, use ICD-9-CM for the entire claim, rather than submitting two sets of claims (one for Sept. 15, 2015 – Sept. 30, 2015, and another for Oct. 1, 2015 – Oct. 15, 2015). This applies only to HCPCS codes on the DMEPOS list found at https://www.cms.gov/medicare/medicare-fee-for-service-payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html. All other medical supply claims must be split if they span the compliance date.

37. When will ICD-10 codes be required on claims?

ICD-10 codes must be used on all claims – paper or electronic – with dates of service on or after Oct. 1, 2015, and inpatient institutional claims with a date of discharge on or after Oct. 1, 2015. The media (paper or electronic) used to submit the claim does not affect the code set used on the claim. BCBSMT will return claims that contain ICD-10 codes with dates of service and discharge dates prior to Oct. 1, 2015.

38. What preparation is needed prior to submitting electronic claims with ICD-10?

Make sure you know which electronic trading partner(s) (practice management software vendor, billing service and/or clearinghouse) is involved in submitting claims to BCBSMT on your behalf. Contact your electronic trading partner(s) to confirm ICD-10 readiness and compliance by asking:

- *Are system upgrades necessary?*
- *Are the necessary upgrades included in your contract?*
- *When will the necessary upgrades be completed?*
- *Are there any associated costs to you?*

If your electronic trading partner(s) cannot confirm ICD-10 readiness, you may need to consider finding a new electronic trading partner(s) who will be prepared to submit compliant electronic claims on your behalf.

39. Are there any special considerations when submitting ICD-10 on electronic claims?

There are indicators to specify if the code that follows is ICD-9 or ICD-10. Your electronic trading partner(s) (practice management software vendor, billing service and/or clearinghouse) should be aware of this change.

40. Is ICD-10 required on other electronic transactions besides claims?

Yes. ICD-10 codes must also be used on other transactions, such as benefit preauthorization requests.

41. How do I indicate if I am using ICD-9 or ICD-10 on the paper claim forms (CMS-1500 and UB-04)?

As of April 1, 2014, the National Uniform Claim Committee (NUCC) released an updated version of the CMS-1500 form (version 02/12) that supports inclusion of ICD-10 codes. Field 21 of the revised form gives providers the ability to indicate whether they are using ICD-9 or ICD-10 diagnosis codes on the form, using a single-digit numeric value in the top right of the field. The UB-04 form includes a space for the version indicator in field 66. For both forms, the valid values for these qualifiers are "0" and "9." An indicator of "9" means that all diagnosis codes that follow are in ICD-9 and an indicator of "0" means that all diagnosis codes that follow are in ICD-10. There is only one ICD indicator per form, and providers cannot mix ICD-9 and ICD-10 codes on the same claim form.

42. How does implementation of ICD-10 impact the filing of paper claims?

ICD-10 codes must be used on all claims – paper or electronic – with dates of service on or after Oct. 1, 2015, and inpatient institutional claims with a date of discharge on or after Oct. 1, 2015. We will return claims that contain ICD-10 codes with dates of service and discharge dates prior to Oct. 1, 2015. The media (paper or electronic) used to submit the claim does not impact the code set used on the claim.

43. How is DSM-5 used to identify ICD-10 codes for behavioral health claims?
The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) was published in May 2013 by the American Psychological Association (APA). This manual represents the industry standard used by health care providers for the classification and diagnoses of behavioral health disorders. According to the description on the APA website:

'DSM-5 contains the standard criteria and definitions of mental disorders now approved by the American Psychiatric Association (APA), and it also contains both ICD-9-CM and ICD-10-CM codes (in parentheses) selected by APA. Since DSM-IV only contains ICD-9-CM codes, it will cease to be recognized for criteria or coding for services with dates of service of October 1, 2015, or later. Updates for DSM-5 criteria and their associated ICD-10-CM codes (identified by APA) can be found at DSM5.org.'

To view a brief tutorial on Using DSM-5 in the Transition to ICD-10, go to http://psychiatry.org/psychiatrists/practice/dsm/icd-10.

44. My practice management system, billing service or clearinghouse is having a problem and can't send my ICD-10 claim to BCBSMT. Is there another way I can submit an ICD-10 claim to you?
Yes. A direct data entry option is available to registered HeW users for one-at-a-time submission of electronic claims.

Here are the steps for HeW users:
1. *Confirm that you have access to the HeW software to enter claims*
2. *Log on to the HeW software via the link on the BCBSMT website at bcbsmt.com/provider*
3. *Add the Subscriber, Patient, Referring Provider or Facility information, creating a database within the HeW software*
4. *Enter in the claim using the Enter Quick Claim feature*
5. *Select the claim from the Claims List area, and then select Process Claims*
6. *Select the Update Claims button to see if the claim passed all edits (OK system status), or if errors were encountered (Error, or ER system status)*
7. *Select Claims Management/Inbox Message to see HeW Reports as well as BCBSMT payer reports*
8. *Log off the software*

45. My ICD-10 claim is getting returned to me by my clearinghouse. What should I do?
Non-compliant claims will likely be returned by your clearinghouse before they get to BCBSMT. It is important to review all response reports so that you are aware when claims submitted on your behalf are not accepted. You will need to work with your clearinghouse to correct any coding errors prior to re-submitting claims for adjudication.

46. I am having issues getting my ICD-10 claims into the system. Can you help me?
Contact your clearinghouse and explain that your claims are not getting through to BCBSMT. Ask for their help to determine where and why your claim is being returned, along with what can be done to fix it. Check your electronic data interchange (EDI) acknowledgment reports to verify if your claim was accepted or returned. Most EDI reports should be available on your clearinghouse/electronic vendor portal. Your clearinghouse can advise you on where to find and how to use these reports.

Reimbursement

47. Does BCBSMT anticipate any changes in policies or delays in claim processing to result from the transition to ICD-10?
Overall, we have updated our policies to refer to ICD-10, but no major changes to policies have been implemented. We do not anticipate delays for claims that are submitted correctly.

48. Does BCBSMT anticipate any changes in the payment of claims as a result of the transition to ICD-10?
Due to the nature of ICD-10 coding guidelines and the specificity of the codes, there could be some variances due to new episode of care indicators, sequence of primary/secondary diagnoses, sifts in Diagnosis Related Groups (DRGs), and other factors. The WEDI Coding and Translation subworkgroup (SWG) has compiled a list of commonly reported scenarios and potential DRG shifts – this information is available in the Coding and Translation section of the WEDI website at http://wedi.org/workgroups/icd-10/coding-and-translation.

Additional Information

49. Where can I go to obtain additional information on ICD-10?

Continue to visit the ICD-10 page in the Standards and Requirements section of our Provider website at bcbsmt.com/provider for updates. Information also may be posted in the News and Updates and published in our provider newsletter.

Below is a list of external websites for additional information on ICD-10:

- *American Academy of Family Physicians (AAFP) – http://www.aafp.org/practice-management/payment/coding.html*
- *AAPC (formerly American Academy of Professional Coders) – https://www.aapc.com/icd-10/*
- *American Health Information Management Association (AHIMA) – www.ahima.org/icd10*
- *America's Health Insurance Plans (AHIP) – www.ahip.org*
- *American Hospital Association (AHA) – http://www.ahacentraloffice.org/codes/ICD10.html*
- *American Medical Billing Association (AMBA) – http://www.ambanet.net/icd10.htm*
- *Centers for Disease Control and Prevention (CDC) – www.cdc.gov/nchs/icd/icd10.htm*
- *Centers for Medicare & Medicaid Services (CMS) – www.cms.gov/Medicare/Coding/ICD10*
- *Healthcare Information and Management Systems Society (HIMSS) – http://www.himss.org/*
- *World Health Organization (WHO) – www.who.int/classifications/icd/en*
- *Workgroup for Electronic Data Interchange (WEDI) – http://www.wedi.org/topics/icd-10/*

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Please note that the fact that a guideline is available for any given treatment, or that a service has been preauthorized, is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered. If you have any questions, please call the number on the back of the member's ID card.

The BCBSMT Medical Policies are for informational purposes only and are not a replacement for the independent medical judgment of physicians. Physicians are to exercise their own clinical judgment based on each individual patient's health care needs. Some benefit plans administered by BCBSMT, such as some self-funded employer plans or governmental plans, may not utilize BCBSMT Medical Policies. Members should contact their local customer service representative for specific coverage information.

This material is for educational purposes only and is not intended to be a definitive source for what codes should be used for submitting claims for any particular disease, treatment or service. Health care providers are instructed to submit claims using the most appropriate code based upon the medical record documentation and coding guidelines and reference materials.