Superbill for ICD-10? Unspecified Codes?

As of today, we know that the implementation of ***ICD-10 has been delayed until at least October 1, 2015***. However, we would be foolish not to use the extra time to make sure that we will be ready. t is not too soon to be continuing our preparation for the new code set. One way to continue our preparation for ICD-10 is to analyze and revise our encounter form or superbill, whichever term you use to describe your charge entry sheet.

There is no one universal ICD-10 superbill for any specialty or at least not a really good one. This is because there are ±68,000 diagnosis codes in ICD-10-CM compared to ±16,000 in ICD-9-CM. There is not a 1:1 ratio in mapping the codes. There are GEM mapping tools which get you in the right neighborhood for converting codes. Some of the mapping tools and quick guides that are being published are mapping nonspecific codes in ICD-9 to nonspecific codes in ICD-10. Although this is a quick fix, I am afraid that payers will not tolerate overuse of the nonspecific or unspecified codes. The coding principles state that you must code to the highest level of specificity in the documentation. So, technically, even if a claim paid with an unspecified code, it would not be correct if the documentation were more specific and a more specific code was available. This is true now for principles of ICD-9 coding as well as for future use in ICD-10.

It is our understanding that CPT coding will still apply to all outpatient settings even after ICD-10 implementation, so the codes for office visits and procedures will not change. The purpose of the paper superbill is to serve as a charge sheet for manual entry. The dx code is noted on it, just as a shortcut for the billing staff. Since the superbill is not part of the medical record, it alone does not support the diagnosis for the encounter. With the advent of EHRs and the integration of EHRs and the practice management systems, the paper superbill is being replaced with an electronic version within the EHR. More and more providers are assigning the codes within the systems and the need for a superbill has been greatly reduced except in practices with manual systems still in place. It is however important to know and follow the official coding guidelines which can be downloaded from **http://www.cdc.gov/nchs/data/icd/icd10cm_guidelines_2014.pdf**

What I recommend is that practices look at their top 50 or 100 diagnosis codes and actually map those from 9 to 10. That way they can get a list of ICD-10 codes that is pertinent to their own practice as well as see where the CDI concerns will be. There are standalone tools for mapping which are available on the CMS website and from private vendors. Several organizations and publishers have quick guides by specialty, but I have found these to be less robust than expected. Since services among RHCs can vary greatly (peds, women's health, visiting specialists, adult primary care, family practice), it would be difficult to have a standard superbill.

Please be mindful that anything you do now to improve your coding accuracy and clinical workflow will be paving the way for an easier ICD-10 transition when it comes. Let's not let the delay give us a false sense of confidence or foster complacency.

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