

ICD-10 KNOWLEDGE BRIEFS

Diagnosis: Indicator Field/Qualifier Codes

Declares the code set you are using, must match service dates & diagnosis codes

When submitting claims on and after October 1, 2015, you must indicate on the claim whether the code set you are using is ICD-9 or ICD-10.

EDI Submissions – ICD Indicator (or Qualifier for eSubmissions)*

All claim submissions require a principal diagnosis. Be aware of your system set-up. Some systems are defaulting to one code set. For example, if your billing system defaulted to ICD-10 on October 1, 2015, and you want to submit for Dates of Service (DOS) prior to that, you must change the default qualifier(s) to ICD-9.

EDI Transaction	837P		8371	
ICD Code Set	ICD-9	ICD-10	ICD-9	ICD-10
Principal Diagnosis Qualifier	BK	ABK	BK	ABK
Additional Diagnosis Qualifier**	BF	ABF	BF	ABF
Admitting Diagnosis Qualifier	Not Applicable		BJ	ABJ

^{*}Billing software views may vary by vendor in terms of what your input prompts look like for things like qualifiers. This table reflects the final output that appears on the actual claim or transaction submission.

** Additional Diagnosis Qualifier applies to a different condition listed on a claim. Your principal diagnosis should only be listed one time; ICD-10-CM codes cannot be duplicated.

Paper Submissions – ICD Indicator

- Inpatient/Facility claims submitted on UB-4; Field 66
- Outpatient/Professional claims submitted on 1500 (v02/12); Field 21

9=ICD-9 code set







Provider Express (Outpatient/Professional claim submissions only)

You select either ICD-9 or ICD-10 radio button; prevents ICD Indicator entry errors

Attention Superbill Users:

- All claim submissions require an ICD indicator code, including superbills
- Modify your superbill forms to include an ICD Indicator field
- On each superbill, use a "9" or "0" for ICD-9 or ICD-10, respectively
- Failure to include a valid ICD Indicator code will delay or prevent claim processing