CMS and AMA Make ICD-10 “Family” Clarification

Clarifying Questions and Answers Related to the July 6, 2015 CMS/AMA Joint Announcement and Guidance Regarding ICD-10 Flexibilities

Question 1:

When will the ICD-10 Ombudsman be in place?

Answer 1:

The Ombudsman will be in place by October 1, 2015.

Question 2:

Does the Guidance mean there is a delay in ICD-10 implementation?

Answer 2:

No. The CMS/AMA Guidance does not mean there is a delay in the implementation of the ICD-10 code set requirement for Medicare or any other organization. Medicare claims with a date of service on or after October 1, 2015, will be rejected if they do not contain a valid ICD-10 code. The Medicare claims processing systems do not have the capability to accept ICD-9 codes for dates of service after September 30, 2015 or accept claims that contain both ICD-9 and ICD-10 codes for any dates of service. Submitters should follow existing procedures for correcting and resubmitting rejected claims.

Question 3:

What is a valid ICD-10 code?

Answer 3:

ICD-10-CM is composed of codes with 3, 4, 5, 6 or 7 characters. Codes with three characters are included in ICD-10-CM as the heading of a category of codes that may be further subdivided by the use of fourth, fifth, sixth or seventh characters to provide greater specificity. A three-character code is to be used only if it is not further subdivided. To be valid, a code must be coded to the full number of characters required for that code, including the 7th character, if applicable. Many people use the term billable codes to mean valid codes. For example, E10 (Type 1 diabetes mellitus), is a category title that includes a number of specific ICD-10-CM codes for type 1 diabetes. Examples of valid codes within category E10 include E10.21 (Type 1 diabetes mellitus with diabetic nephropathy) which contains five characters and code E10.9 (Type 1 diabetes mellitus without complications) which contains four characters.

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 additional characters are needed, such as the addition of a 7th character in order to arrive at a valid code.

Question 4: What should I do if my claim is rejected? Will I know whether it was rejected because it is not a valid code versus denied due to a lack of specificity required for a NCD or LCD or other claim edit?

Answer 4:

Yes, submitters will know that it was rejected because it was not a valid code versus a denial for lack of specificity

required for a NCD or LCD or other claim edit. Submitters should follow existing procedures for correcting and resubmitting rejected claims and issues related to denied claims.

Question 5:

What is meant by a family of codes?

Answer 5:

"Family of codes" is the same as the ICD-10 three-character category. Codes within a category are clinically related and provide differences in capturing specific information on the type of condition. For instance, category H25 (Age-related cataract) contains a number of specific codes that capture information on the type of cataract as well as information on the eye involved. Examples include: H25.031 (Anterior subcapsular polar age-related cataract, right eye), which has six characters; H25.22 (Age-related cataract, morgagnian type, left eye), which has five characters; and H25.9 (Unspecified age-related cataract), which has four characters. One must report a valid code

and not a category number. In many instances, the code will require more than 3 characters in order to be valid.

Question 6:

Does the recent Guidance mean that no claims will be denied if they are submitted with an ICD-10 code that is not at the maximum level of specificity?

Answer 6:

In certain circumstances, a claim may be denied because the ICD-10 code is not consistent with an applicable policy, such as Local Coverage Determinations or National Coverage Determinations. (See Question 7 for more information about this). This reflects the fact that current automated claims processing edits are not being modified as a result of the guidance.

In addition, the ICD-10 code on a claim must be a valid ICD-10 code. If the submitted code is not recognized as a valid code, the claim will be rejected. The physician can resubmit the claims with a valid code.

Question 7:

National Coverage Determinations (NCD) and Local Coverage Determinations (LCD) often indicate specific diagnosis codes are required. Does the recent Guidance mean the published NCDs and LCDs will be changed to include families of codes rather than specific codes?

Answer 7:

No. As stated in the CMS' Guidance, for 12 months after ICD-10 implementation, Medicare review contractors will not deny physician or other practitioner claims billed under the Part B physician fee schedule through either automated medical review

or complex medical record review based solely on the specificity of the ICD-10 diagnosis code as long as the physician/practitioner used a valid code from the right family of codes. The Medicare review contractors include the Medicare Administrative Contractors, the Recovery Auditors, the Zone Program Integrity Contractors, and the Supplemental Medical Review Contractor.

As such, the recent Guidance does not change the coding specificity required by the NCDs and LCDs. Coverage policies that currently require a specific diagnosis under ICD-9 will continue to require a specific diagnosis under ICD-10. It is important to note that these policies will require no greater specificity in ICD-10 than was required in ICD-9, with the exception of laterality, which does not exist in ICD-9. LCDs and NCDs that contain ICD-10 codes for right side, left side, or bilateral do not allow for unspecified side. The NCDs and LCDs are publicly available and can be found at http://www.cms.gov/medicare-coverage-database/.

Question 8:

Are technical component (TC) only and global claims included in this same CMS/AMA guidance because they are paid under the Part B physician fee schedule?

Answer 8:

Yes, all services paid under the Medicare Fee-for-Service Part B physician fee schedule are covered by the guidance.

Question 9:

Do the ICD-10 audit and quality program flexibilities extend to Medicare fee-for-service prior authorization requests?

Answer 9:

No, the audit and quality program flexibilities only pertain to post payment reviews. ICD-10 codes with the correct level

of specificity will be required for prepayment reviews and prior authorization requests.

MEDICAID

Question 10:

If a Medicare paid claim is crossed over to Medicaid for a dual-eligible beneficiary, is Medicaid required to pay the claim?

Answer 10:

State Medicaid programs are required to process submitted claims that include ICD-10 codes for services furnished on or after October 1 in a timely manner. Claims processing verifies that the individual is eligible, the claimed service is covered, and that all administrative requirements for a Medicaid claim have been met. If these tests are met, payment can be made, taking into account the amount paid or payable by Medicare. Consistent with those processes, Medicaid can deny claims based on system edits that indicate that a diagnosis code is not valid.

Question 11:

Does this added ICD-10 flexibility regarding audits only apply to Medicare?

Answer 11:

The official 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. This Guidance does not apply to claims submitted for beneficiaries with Medicaid coverage, either primary or secondary.

Question 12:

Will CMS permit state Medicaid agencies to issue interim payments to providers unable to submit a claim using valid, billable ICD-10 codes?

Answer 12:

Federal matching funding will not be available for provider payments that are not processed through a compliant MMIS and supported by valid, billable ICD-10 codes.

OTHER PAYERS

Question 13:

Will the commercial payers observe the one-year period of claims payment review leniency for ICD-10 codes that are from the appropriate family of codes?

Answer 13:

The official 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. Each commercial payer will have to determine whether it will offer similar audit flexibilities.

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Coding for the Rest of Us: Why Everyone in Your Practice Needs a Basic Knowledge of

Coding

There is no one, and I do mean no one, in your medical practice who does not need to know the basics of coding. Here is why:

- Providing services to patients is the business of healthcare. Every person who relies on healthcare for their living should understand something about the business they are in. This should not outweigh the fact that we are privileged to care for patients, but as the saying goes “No money, no mission.”
- It takes a team to produce care. The silos of front desk, billing, nursing and scheduling must come together to share their knowledge and produce a high-quality, reimbursable patient visit. Here are the roles each member of the team plays:
    - The patient calls for an appointment and the scheduler matches the patient’s problem to an appropriate appointment type. The scheduler finds out if the patient is **new or established** and **what the patient’s appointment is for.**
    - The patient arrives for the appointment and the front desk assures that all **current demographic and insurance information is collected**.
    - The nurse rooms the patient, taking vitals, reviewing medications and **reviewing the reason for the visit** – the chief complaint.
    - The physician or mid-level provider cares for the patient, documenting the visit and choosing the **appropriate service and diagnosis codes.**
    - The patient completes the visit by paying any deductibles or co-insurance due and making any future appointments needed. The checkout staff **enters the payments and/or charges** if the service codes have not already been posted via the EMR.

- The biller “scrubs” the claim, checking for any errors and **electronically submits the claim to the payer**. The hope is that the claim is clean and will be accepted and paid immediately (within 30 days.)

When staff understands how important their contribution is to the financial viability of the practice and how all the pieces fit together, they are more incentivized to perform.

“Coding” means two things: s**ervice codes** and **diagnosis codes**. Service codes describe office visits, surgery, laboratory, radiology, pathology, anesthesia and medical procedures that are provided by physicians, nurse practitioners, and physician assistants. Diagnosis codes describe signs, symptoms, injuries, diseases, and conditions. **The critical relationship between a service code and a diagnosis code is that the diagnosis supports the medical necessity of the procedure.**

Service codes are called either CPT codes or HCPCS (pronounced “hick-picks) based on the payer/insurer who uses them. Most commercial insurers use CPT (Current Procedural Terminology) codes, but Medicare and Medicaid use HCPCS (Healthcare Common Procedure Coding System.) Codes are globally grouped into Level I and Level II:

- Level I codes include the 5-digit numeric CPT (Current Procedural Terminology) codes. These were developed by the American Medical Association (AMA) in 1966 and remain proprietary to the AMA. The codes are updated in October and become effective as of the next calendar year. They are available as a printed manual or as an electronic file.
- Level II codes are national codes developed by the Centers for Medicare and Medicaid Services (CMS) to describe medical services and supplies not covered in the CPT. They consist of alphabetic characters (A through V) and four digits.

There are two ways that patient services are coded so they can be billed to insurance companies. The first is through the use of a preprinted coding sheet, which goes by many different names: superbill, encounter form, routing sheet, patient ticket, or billing form. The physician or mid-level provider indicates which services were provided and maps specific diagnosis codes to the services.

The second is abstraction from the medical record. A coder reads the documentation provided by the physician or mid-level provider, and matches codes to the services described in the record. Computerized coding abstraction via an electronic medical record (EMR) is also an option

Here are some basic coding rules that apply to every type of practice:

- Always have the latest edition of CPT and HCPCS. Service codes change annually and it is important to use the correct code for the calendar year. Check new, revised and deleted codes annually and change your encounter form and codes in your billing system to match.
- Attend webinars or seminars annually to stay up-to-date on large-scale coding changes for your specialty or for all specialties. For instance, tobacco cessation counseling is reportable to and payable by Medicare for the first time in 2011 – see a **handy guide here** and every specialty can bill it. You may also want to subscribe to coding newsletters for your specialty or check your physician's specialty society to see what they offer.
- Utilize the National Correct Coding Initiative (NCCI) to make sure which codes are to be submitted individually versus being bundled. Many practices do not know about or use the NCCI information for the simple reason that it is complex and confusing and changes regularly. Someone in the field who offers great (free) information on the NCCI edits is Frank Cohen **here.**

- Have an in-house crosswalk for provider abbreviations to make sure that they have signed off on what their abbreviations mean. The best of all worlds is requiring the physician or mid-level provider to supply a code as opposed to a description.
- Use scrubbing software tools to check service and diagnosis code mismatches, Local Coverage Determinations (LCDs) for Medicare, any services without appropriate diagnosis codes and any diagnoses without standard accompanying services.
- Audit your documentation regularly to ensure it matches your level of service ("if you didn't document it, you didn't do it") especially if you are not documenting electronically with decision support tools. Audit yourself or hire a firm to audit for you and document lessons learned and any corrective action taken. This should be part of your practice compliance plan. Note that physician regulatory insurance is now available (Google it) for around $1500 per physician per year.
- It is always the physician or mid-level provider's ultimate responsibility to choose the codes that best correlate with what s/he did. When in doubt, always defer to the provider of the service.

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