

The CMS ICD-10 Announcement: What It Means to Your Practice



First, the game-changing announcement below means that a sigh of relief is in order. Some of the anxiety surrounding potential financial disaster should be abated. CMS announced:

*“Medicare review contractors [MACs and RACs] 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.**” (see FAQ2 below)*

Second, we think it means that the sword rattling coming from the AMA and other individuals should subside. The fact that the CMS changes are based on recommendations from the AMA, which has been adamantly opposed to the ICD-10 mandate for years, is no less unexpected than the lion laying down with the lamb.

Regardless of the changes, the AMA’s previous assertion that ICD-10 “will create significant burdens on the practice of medicine with no direct benefit to individual patients’ care” still stands. The transition is inevitable, in my mind, but the changes **will** lessen the burden on physicians.

In the announcement from CMS, the clarification was made that

“In accordance with the coming transition, the Medicare claims processing systems will not have the capability to

accept ICD-9 codes for dates of services after September 30, 2015, nor will they be able to accept claims for both ICD-9 and ICD-10 codes.”

Third, CMS will name a CMS ICD-10 Ombudsman to triage and answer questions about the submission of claims. The ICD-10 Ombudsman will be located at CMS’s ICD-10 Coordination Center.

Also, mark your calendars! CMS will have a provider call on August 27th to discuss these changes.

See the answers below provided by CMS in their new FAQs published this week.

Q1. What if I run into a problem with the transition to ICD-10 on or after October 1st 2015?

A1. CMS understands that moving to ICD-10 is bringing significant changes to the provider community. CMS will set up a communication and collaboration center for monitoring the implementation of ICD-10. This center will quickly identify and initiate resolution of issues that arise as a result of the transition to ICD-10. As part of the center, CMS will have an ICD-10 Ombudsman to help receive and triage physician and provider issues. The Ombudsman will work closely with representatives in CMS’s regional offices to address physicians’ concerns. As we get closer to the October 1, 2015, compliance date, CMS will issue guidance about how to submit issues to the Ombudsman.

Q2. What happens if I use the wrong ICD-10 code, will my claim be denied?

A1. While diagnosis coding to the correct level of specificity is the goal for all claims, 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. However, a valid ICD-10 code will be required on all claims starting on October 1, 2015. It is possible a claim could be chosen for review for reasons other than the specificity of the ICD-10 code and the claim would continue to be reviewed for these reasons. This policy will be adopted by the Medicare Administrative Contractors, the Recovery Audit Contractors, the Zone Program Integrity Contractors, and the Supplemental Medical Review Contractor.

Q3. What happens if I use the wrong ICD-10 code for quality reporting? Will Medicare deny an informal review request?

A3. For all quality reporting completed for program year 2015 Medicare clinical quality data review contractors will not subject physicians or other Eligible Professionals (EP) to the Physician Quality Reporting System (PQRS), Value Based Modifier (VBM), or Meaningful Use 2 (MU) penalty during primary source verification or auditing related to the additional specificity of the ICD-10 diagnosis code, as long as the physician/EP used a code from the correct family of codes. Furthermore, an EP will not be subjected to a penalty if CMS experiences difficulty calculating the quality scores for PQRS, VBM, or MU due to the transition to ICD-10 codes. CMS will not deny any informal review request based on 2015 quality measures if it is found that the EP submitted the requisite number/type of measures and appropriate domains on the specified number/percentage of patients, and the EP's only error(s) is/are related to the specificity of the ICD-10 diagnosis code (as long as the physician/EP used a code from the correct family of codes). CMS will continue to monitor the implementation and adjust the timeframe if needed.

Q4. What is advanced payment and how can I access this if needed?

A4. When the Part B Medicare Contractors are unable to process claims within established time limits because of administrative problems, such as contractor system malfunction or implementation problems, an advance payment may be available. An advance payment is a conditional partial payment, which requires repayment, and may be issued when the conditions described in CMS regulations at 42 CFR Section 421.214 are met. To apply for an advance payment, the Medicare physician/supplier is required to submit the request to their appropriate Medicare Administrative Contractor (MAC). Should there be Medicare systems issues that interfere with claims processing, CMS and the MACs will post information on how to access advance payments. CMS does not have the authority to make advance payments in the case where a physician is unable to submit a valid claim for services rendered.

NOTE: *Watch for upcoming posts on ICD-10 websites and apps that I am rating for their usefulness. We will also be producing free webinars on translating the diagnoses on your superbills, picklists and cheat sheets for ICD-10 – stay tuned!*

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