



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? (*revised 09/22/2015*)

Answer 1:

The ICD-10 Ombudsman is Dr. William Rogers. You can submit inquiries to him by sending an email to ICD10_Ombudsman@cms.hhs.gov.

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? (*revised 7/31/15*)

Answer 3:

All claims with dates of service of October 1, 2015 or later **must be submitted with a valid ICD-10 code**; ICD-9 codes will no longer be accepted for these dates of service. 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. While diagnosis coding to the correct level of specificity is the goal for all claims, for 12 months after ICD-10 implementation, if a valid ICD-10 code from the right family (see question 5) is submitted, Medicare fee-for-service will process and not audit valid ICD-10 codes unless such codes fall into the circumstances described in more detail in Questions 6 & 7.

An example is C81 (Hodgkin's lymphoma) – which by itself is not a valid code. Examples of valid codes within category C81 contain 5 characters, such as:

C81.00	Nodular lymphocyte predominant Hodgkin lymphoma, unspecified site
C81.03	Nodular lymphocyte predominant Hodgkin lymphoma, intra-abdominal lymph nodes
C81.10	Nodular sclerosis classical Hodgkin lymphoma, unspecified site
C81.90	Hodgkin lymphoma, unspecified, unspecified site

During the 12 months after ICD-10 implementation, using any one of the valid codes for Hodgkin’s lymphoma (C81.00, C81.03, C81.10 or C81.90) would not be cause for an audit under the recently announced flexibilities.

In another example, a patient has a diagnosis of G43.711 (Chronic migraine without aura, intractable, with status migrainosus). Use of the valid codes G43.701 (Chronic migraine without aura) or G43.719 (Chronic migraine without aura, intractable without status migrainosus) instead of the correct code, G43.711, would not be cause for an audit under the audit flexibilities occurring for 12 months after ICD-10 implementation, since they are all in the same family of codes.

Many people use the terms “billable codes” and “valid codes” interchangeably. 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 an additional 4th, 5th, 6th or 7th character is needed. Using this free list of valid codes is straightforward. Providers can practice identifying and using valid codes as part of acknowledgement testing with Medicare, available through September 30, 2015. For more information about acknowledgement testing, contact your Medicare Administrative Contractor, and review the Medicare Learning Network articles on testing, such as [SE1501](#).

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 National Coverage Determination (NCD) or Local Coverage Determination (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? (revised 7/31/15)

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.

Another example, K50 (Crohn's disease) has codes within the category that require varying numbers of characters to be valid. The ICD-10-CM code book clearly provides information on valid codes within this, and other categories. And if in doubt, providers can check the list of valid 2016 ICD-10-CM codes to determine if all characters have been selected and reported. Examples of valid codes within category K50 include:

K50.00	Crohn's disease of small intestine without complications
K50.012	Crohn's disease of small intestine with intestinal obstruction
K50.90	Crohn's disease, unspecified, without complications

To include the Crohn's disease diagnosis on the claim, a valid code must be selected. If the paid claim were to be selected later for audit by a Medicare review contractor, the Guidance makes it clear that the claim would not be denied simply because the wrong code was included, so long as the code was in the same family. As long as the selected code was within the K50 family, then the audit flexibility applies.

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: *(revised 09/22/015)*

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

Answer 9:

No, the Medicare fee-for service 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.

MEDICARE ADVANTAGE

Question 14: *(new 09/22/2015)*

Do the Medicare fee-for-service audit and quality program flexibilities apply to Medicare Advantage?

Answer 14:

No, the Guidance applies only to Medicare fee-for-service claims from physicians or other practitioners billed under the Medicare Fee-for-Service Part B physician fee schedule. Medicare Advantage risk adjustment payment and audit criteria remain unchanged.

Question 15: *(new 09/22/2015)*

Does the Guidance change coding guidelines?

Answer 15:

No, coding guidelines are unchanged.

Question 16: *(new 09/22/2015)*

Will the Medicare review contractors be auditing the Medicare Advantage services according to this Guidance?

Answer 16:

The Medicare review contractors only review Medicare fee-for-service claims. This Guidance does not apply to the Medicare Advantage plans.

MEDICARE EXPANSION TO OTHER PROVIDER TYPES

Question 17: *(new 09/22/2015)*

Currently the guidance document only applies to services paid under the Medicare Fee-for-service Part B physician fee schedule. Will the Guidance be expanded to other provider/claim types?

Answer 17:

No, the Medicare fee-for-service audit and quality program flexibilities have not been expanded to other claim types. They only apply to physicians and other practitioners who bill under the Medicare Fee-for-Service Part B physician fee schedule.

The reason we focused on claims billed under the Part B physician fee schedule is because many physicians are in small practices that need additional flexibility to gain experience with the ICD-10 coding set. Claims billed under the Part B physician fee schedule are paid using CPT codes and not ICD-10 codes. Other services, such as institutional services, are paid based on the ICD-10 codes.

The ICD-10 Ombudsman will listen to issues raised by all suppliers and providers and will evaluate any specific issues that are raised during implementation. CMS's ICD-10 Coordination Center will be actively monitoring for any problems that may develop after October 1. This center will quickly identify and initiate resolution of issues that arise as a result of the transition to ICD-10.

ADVANCED and ACCELERATED PAYMENTS

Question 18: *(new 09/22/2015)*

Will physicians be allowed to submit a single advance payment request for multiple claims for services provided over a period of time?

Response 18:

CMS and its Medicare Administrative Contractors have conducted extensive testing for ICD-10 and are ready for the transition on October 1, 2015. If the Part B Medicare Administrative Contractors (MACs) 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. Physicians would be allowed to submit a single advance payment request for multiple claims for an eligible period of time. Note 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 physician is required to submit the request to their appropriate Medicare Administrative Contractor. 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.

Question 19: *(new 09/22/2015)*

What are the “established time limits” to process claims?

Response 19:

Section 1842(c)(2) of the Social Security Act requires Medicare contractors to make payment on not less than 95% of “clean claims” within 30 calendar days.

If there are Medicare systems issues that interfere with claims processing, CMS and the MACs will post information on how to access advance payments.

Question 20: *(new 09/22/2015)*

Will institutional providers (Part A) be able to submit requests for accelerated payments from Medicare?

Answer 20:

CMS regulations at 42 CFR Section 413.64(g) allows accelerated payments for Part A providers not receiving periodic interim payments. This authority can be applied in the event of a contractor(s) delay in making payments or in “exceptional situations” where a provider has experienced a temporary delay in preparing and submitting bills beyond its normal billing cycle. Note an accelerated payment is a conditional partial payment, which requires repayment, and may be issued when the conditions described in CMS regulations at 42 CFR Section 413.64(g) are met and subject to contractor and CMS approval.

MEDICARE CROSSOVER CLAIMS

Question 21: *(new 09/22/2015)*

Will anything change during the one-year period of Medicare fee-for-service audit and quality program flexibilities with respect to Medicare crossover claims and the crossover process?

Answer 21:

No, Medicare’s processes regarding what elements are crossed over to supplemental payers (including commercial payers and State Medicaid Agencies) will be unchanged as a result of the flexibilities.

MEDICARE 24-MONTH AUDIT LOOK-BACK PERIOD

Question 22: *(new 09/22/2015)*

How does the CMS 24-month look-back period for Medicare fee-for-service audits intersect with the 12-month period of audit flexibility? Will the auditors review and deny claims from the October 2015-October 2016 period for ICD-10 code specificity after October 2016?

Answer 22:

Contractors conducting medical review (Medicare Administrative Contractors/Recovery Auditors/Supplemental Medical Review Contractor) will not deny claims solely for the specificity of the ICD-10 code as long as there is no evidence of potential fraud. This is consistent with current medical review policies and is not applicable to prepayment denials because of a National Coverage Determination or a Local Coverage Determination.