ICD-10 Frequently Asked Questions: (resource CMS website)

1. Will ICD-9-CM codes be accepted on claims with FROM dates of service or dates of discharge/THROUGH dates on or after October 1, 2015?

No. ICD-9-CM codes will no longer be accepted on both electronic and paper claims with FROM dates of service (on professional and supplier claims) or dates of discharge/THROUGH dates (on institutional claims) on or after October 1, 2015. (FAQ12494)

2. Can a claim contain both ICD-9-CM and ICD-10-CM/PCS codes?

No. A claim cannot contain both ICD-9-CM and ICD-10-CM/PCS codes. Medicare will return as unprocessable all claims billed with both ICD-9-CM and ICD-10-CM/PCS diagnosis and procedure codes on the same claim.

For more information about split claims billing, refer to MLN Matters® articles Medicare FFS Claims Processing Guidance for Implementing ICD-10 and Institutional Services Split Claims Billing Instructions for Medicare FFS Claims that Span the ICD-10 Implementation Date on the CMS.

3. 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.

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

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? (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, 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:**
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.
Provider Resources

ICD-10 Compliance Date: October 1, 2015

The ICD-10 transition will affect every part of your practice, from software upgrades, to patient registration and referrals, to clinical documentation and billing. With the compliance date quickly approaching, now is the time to get ready.

New ICD-10 Video

To respond to myths and common misperceptions about ICD-10, CMS has developed a new video. The animated short features a countdown with 10 facts about the new code set and transition.

Two other CMS animated shorts explain key ICD-10 concepts:

- “Introduction to ICD-10 Coding”
- “ICD-10 Coding and Diabetes”

ICD-10 Quick Start Guide

The ICD-10 Quick Start Guide outlines 5 steps health care professionals should take to prepare for ICD-10 by the October 1, 2015, compliance date.

ICD-10 Infographics

The Get Ready Now infographic offers a simple, step-by-step plan for how to prepare for ICD-10. The infographic can be broken down into individual steps:

Step 1: Make a Plan
Step 2: Train Your Staff
Step 3: Update Your Processes
Step 4: Talk to Your Vendors and Health Plans
Step 5: Test Your Systems and Processes

Another Infographic, Test and Get Ready Now provides tips just about testing, and information about why it is important to be testing now. This infographic can also be broken down into individual sections:
Test Now
How to Get Started
Testing with Trading Partners
Types of Testing
Testing Tips

The Get the Facts infographic includes facts about coding, reimbursement, testing, and resources that are essential for preparing for the ICD-10 transition.

“Road to 10” Online Resource for Small Practices

Get ready with “Road to 10,” an online resource created with input from providers in small practices. “Road to 10” includes specialty references and gives providers the capability to build ICD-10 action plans tailored for their practice needs.

Medscape Education Resources

Continuing medical education (CME) and nursing continuing education (CE) credits are available to health care professionals who complete the learning modules. Anyone can earn a certificate of completion. First-time visitors to Medscape will need to create a free account to access these resources.

• Video: ICD-10: Getting From Here to There -- Navigating the Road Ahead
• Video: ICD-10 and Clinical Documentation
• Expert Column: Preparing for ICD-10: Now is the Time

Understanding the Basics
These fact sheets provide a foundation for ICD-10. They explain why the code set is important, why it is necessary for providers today, and other useful information for office transitions and implementation.

• Intro Guide to ICD-10
• The ICD-10 Transition: An Introduction
• ICD-10 Basics for Medical Practices
• Talking to Your Vendors About ICD-10: Tips for Medical Practices
• ICD-10 and CMS eHealth: What’s the Connection?
• ICD-10 Basics for Small and Rural Practices
• Online ICD-10 Implementation Guide
Communicating About ICD-10

Communication between health care providers, software vendors, clearinghouses, and billing services is an important part of the transition process. Learn how to get the conversation started.

- Talking to Your Vendors About ICD-10: Tips for Medical Practices
- Questions to Ask Your Systems Vendors about ICD-10
- The Role of Clearinghouses in ICD-10

Educational ICD-10 Videos

CMS has developed videos on a variety of topics to help you prepare for the ICD-10 transition:

- Road to 10: The Small Physician Practice's Route to ICD-10
- Estimating the Impact of the Transition to ICD-10 on Medicare Inpatient Hospital Payments
- Medicare's Testing Plan for ICD-10 Success

Conferences, Meetings, and Webinars

CMS has partnered with several organizations to offer educational webinars on ICD-10:

  - Presentation Video
  - PDF Presentation
  - Written Transcript
- ICD-10 and Clinical Documentation (Dec. 10, 2014)
  - Webinar Recording (register to access)
  - PDF Presentation
- Transitioning to ICD-10 (Nov. 5, 2014)
  - PDF Presentation
  - Audio Recording [ZIP, 18MB]
  - Written Transcript
- ICD-10 Code-a-thon (Sep. 15, 2014)
  - Presentation Video
  - Presentation Audio Transcript
ICD-10 Resources: Get on the Road to 10

- Q&A Audio Transcript
- PDF Presentation
- Webinar Recording (Recording ID: DWGQ5G: Key:eHealth)

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