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CMS/AMA Guidance on ICD-10 Transition: What Does It Really Mean?

October 1, 2015 is coming quickly upon us and with it the transition from ICD-9-CM to ICD-10-CM/PCS. We do not anticipate further delay as seen in prior years. Information included in a joint announcement from Centers for Medicare and Medicaid Services (CMS) and the American Medical Association (AMA) on July 6, 2015 may make the transition a little easier as it establishes some elements of flexibility that were not previously specified.

In the announcement, CMS indicates that the agency will not deny 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 diagnostic code, as long as a physician/practitioner used a valid code from the right family of codes."* This transition policy will be in effect for 1 year from the October 1, 2015 date. This policy will also apply to codes submitted in connection to the Meaningful Use program and quality programs like the Physician Quality Reporting System.

In a subsequent release dated July 27, 2015, CMS provided additional information to clarify what it means by a family of codes and a valid code.

Family of Codes

The first three characters in an ICD-10-CM code represent a category. The ICD-10-CM code for ankylosing spondylitis of the lumbar region is M45.6. The ICD-10-CM category is M45. A family of codes is the same as the ICD-10 three-character category. However there are very few instances in which an ICD-10-CM code consists of only these first three characters.

Valid ICD-10-CM Codes

A valid ICD-10 code is composed of 3, 4, 5, 6, or 7 characters depending on the specificity of the diagnosis. To be valid, an ICD-10-CM code must be reported out to the full number of characters associated with the code for the condition. Reporting to the highest level of specificity was a concept under ICD-9-CM and is continued under ICD-10-CM.

A three-character code should be reported only if the diagnosis is not further subdivided. In the example above, a claim that reports only M45 would be rejected since M45 breaks down further to a 4th character:

M45.0	Ankylosing spondylitis of multiple sites in spine
M45.1	Ankylosing spondylitis of occipito-atlanto-axial region
M45.2	Ankylosing spondylitis of cervical region
M45.3	Ankylosing spondylitis of cervicothoracic region
M45.4	Ankylosing spondylitis of thoracic region
M45.5	Ankylosing spondylitis of thoracolumbar region
M45.6	Ankylosing spondylitis of lumbar region
M45.7	Ankylosing spondylitis of lumbosacral region
M45.8	Ankylosing spondylitis of sacral and sacrococcygeal region
M45.9	Ankylosing spondylitis of unspecified sites in spine

What this all means is that a claim that contains only M45 would be rejected as an invalid code and the practice would be able to resubmit it with a valid code. A claim for ankylosing spondylitis of the lumbar region that was reported with *any* valid code from the M45 family would hold up if audited.

A claim may be denied if the submitted ICD-10-CM code is not reported to the fullest level of specificity if coverage is dependent upon meeting the criteria established by a Local Coverage Determination (LCD) or a National Coverage Determination (NCD). The recent Guidance does not change the coding specificity required by LCDs and NCDs.

As always, all claim rejections and denials should be carefully reviewed. If the rejection or denial is due to an issue associated with ICD-10-CM coding, the claim may be corrected and resubmitted. But it should be noted that, as previous to the transition to ICD-10, a claim may be denied based on other reasons such as a National Correct Coding Initiative (NCCI) edit, failure to meet a payer's definition of medical necessity, or a procedure is deemed uncovered. Claims may still be reviewed or audited for reasons other the specificity of the ICD-10-CM code.

The move to ICD-10-CM brings significant changes to the provider community. While CMS and the Part B Medicare Administrative Contractors (MAC) have done considerable work to make the transition as smooth as possible, there still may be some "hiccups" along the way. CMS has planned for some potential "hiccups" by allowing physicians/practitioners to request an advance payment from their MAC if the MAC is unable to process a claim in a timely manner. The payment is a conditional partial payment and must be repaid. To receive an advance payment, the physician/practitioner is required to submit the request to his/her MAC.

CMS does not have the authority to make an advanced payment when a physician/practitioner is unable to submit a valid claim for services rendered.

To further assist providers in this transition to ICD-10-CM, CMS has established an ICD-10 Ombudsman who will work closely with representatives of CMS's regional offices to address providers' concerns. CMS has announced that William Rodgers, M.D. who directs CMS's Physicians Regulatory Issues Team (PRIT) will serve in this capacity. Questions should be sent to him at icd10_ombudsman@cms.hhs.gov.

The flexibilities in the CMS/AMA statement apply only to claims for professional services paid via the Medicare Fee-for Service Part B physician fee schedule. Commercial payers are not bound by the flexibility in coding as described in the Guidance. Each commercial payer can decide independently whether it will offer similar coding and auditing flexibility. As such, it is important for that ASA members continue to educate themselves about ICD-10-CM and work toward full transition.

ASA will continue to provide guidance and education to help our members successfully navigate this transition.