Frequently Asked Questions Related to the July 6, 2015 CMS/AMA Joint Announcement and Guidance Regarding ICD-10 Flexibilities (Revised 9/14/2015)

SCAN Health Plan Answers to Questions about CMS Guidance and MA Plans

A joint statement was issued July 6, 2015 by Centers for Medicare and & Medicaid (CMS) and the American Medical Association (AMA) stating that "CMS is releasing additional guidance that will allow flexibility in the claims auditing and quality reporting process as the medical community gains experience using the new ICD-10 code set."[1] CMS has recognized that inadvertent coding errors or system glitches during the transition may occur which may result in audits, claims denials, and penalties under various Medicare reporting programs.

CMS issued further guidance expanding their policy adoption of correct level of code specificity[2 & 3] and select questions and answers from those CMS guidance's are included in this communication for the purpose of highlighting SCAN's plan to follow CMS guidance.

Q1: What claim types are covered under the CMS coding flexibility guidance?

A1: Only services paid under the Medicare Fee-for-Service Part B physician fee schedule are covered by the CMS/AMA coding flexibility guidance. SCAN expects that providers will code to the correct level of specificity for all other claim types.

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

A2: SCAN will follow CMS guidelines which states,

> "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 (and only for Medicare Fee-for-Service Part B claims), if a valid ICD- 10 code from the right family (see question 2 below) is submitted, Medicare will process and not audit valid ICD-10 codes unless such codes fall into the circumstances described in CMS .pdf "Clarifying Questions and Answers Related to July 6, 2015 CMS AMA Joint Announcement" Questions 6 & 7".[3]

[1] http://www.cms.gov/Medicare/Coding/ICD10/Downloads/AMA-CMS-press-release-letterhead-07-05-15.pdf
[2] http://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD-10-guidance.pdf
[3] https://www.cms.gov/Medicare/Coding/ICD10/Clarifying-Questions-and-Answers-Related-to-the-July-6-2015-CMS-AMA-Joint-Announcement.pdf

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 month 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.[3]

Q3: What is meant by a family of codes? (Revised 7/31/15) [3]

A3: Per CMS' guidance, a "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.

As an example, 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.[3]

Q4: Does this policy apply to claims and encounters processed by Medicare Advantage (MA) plans? Specifically, will non-specific codes in the same family also risk adjust?

A4: No. This policy does not apply to Medicare Advantage Contractors related to Risk Adjustment. While claims and encounters will not be automatically denied/rejected due to lack of code specificity, all medical policies, and the risk adjustment model will continue to apply. Only diagnosis codes in the Risk Adjustment Model (ICD10 version, available at http://www.hccuniversity.com/documents/hcc/tools/UpdatedICD-10HCCandRxHCCMappings.zip) will apply for risk adjustment.

Q5: Does this policy mean that an ICD-10 diagnosis code within a family will be accepted in all cases?

A5: No. When a Local or National Medicare Coverage policy exists, the submitted diagnosis code must be included in that policy to be accepted. All of these policies can be found, in accordance with CMS policy, using the following links:

NCD

- National

LCD

- California A
- California B (north)
- California B (south)
- Arizona A
- Arizona B
- DME

Questions on SCAN Health Plan Answers to Questions about CMS Guidance and MA Plans can be email to ICD-10@scanhealthplan.com.