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Optometry Coding & Billing Alert

ICD-10: 5 FAQs Quell Confusion on CMS's Latest ICD-10 Announcement

The one- year grace period for ICD-10 claims applies to Medicare only.

If CMS's ICD-10 regulations have your head spinning, you're not alone.

When CMS announced on July 6 that it wouldn't deny claims with incorrect ICD-10 codes until 2016, many practices heaved a sigh of relief. But at the same time, other Part B providers had numerous questions about the decision, and how it will impact their ICD-10 diagnosis submissions.

Fortunately, CMS didn't leave practices hanging for too long, and on July 27, the agency released 13 FAQs about how the ICD-10 transition will happen in light of its latest proclamations on the subject. Read on to find out just what you'll need to know starting this October.

Clarification 1: Is ICD-10 Delayed for A Year?

When CMS and the AMA jointly announced that it would wait a year before denying claims with incorrect ICD-10 codes, some practices shrugged and said "See you next year, ICD-10"□but unfortunately, that's not going to work.

"The CMS/AMA Guidance does not mean there is a delay in implementation of the ICD-10 code set requirement for Medicare or any other organization," CMS said in its clarification. "Medicare claims with a date of service on or after Oct. 1, 2015 will be rejected if they do not contain a valid ICD-10 code."

Translation: You can't get away with just continuing to report ICD-9 codes once Oct. 1 hits. Claims systems won't be able to accept the current diagnosis coding system, so you must start using your ICD-10 codes in two short months.

Clarification 2: How Do We Determine If the Code Is in the Right 'Family?'

When CMS announced that it will pay claims as long as the ICD-10 code you report is from the correct "family of codes," some practices bristled at the description, noting that they didn't know what that meant. In essence, however, it just means you have to code within the appropriate category, the agency clarified.

"'Family of codes' is the same as the ICD-10 three-character category," CMS explained. "Codes within a category are clinically related and provide differences in capturing specific information on the type of condition."

Translation: If you're planning to report an anterior subcapsular polar age-related cataract of the right eye, the appropriate code is H25.031. If, however, you mistakenly report H25.9 (Unspecified age-related cataract), you're still coding within the same and therefore your contractor shouldn't deny the claim between Oct. 1, 2015 and Oct. 1, 2016. However, if you just report H25 (Age-related cataract), you might see a denial because "in many instances, the code will require more than three characters in order to be valid," CMS says.

Clarification 3: If We Get A Denial, Will We Know Whether the Reason Involved An Incorrect ICD-10 Code Family?

Naturally, you'll get denials for reasons other than an incorrect ICD-10 code family after Oct. 1—just as you get denials under ICD-9 for other reasons, the same will happen under ICD-10. Reasons can range from reporting the wrong CPT® code, billing Medicare as primary when it should be secondary, reporting a diagnosis that isn't covered for the service you provided, and many other reasons. Fortunately, your MAC will help you pinpoint the reason your claim was denied.

"Submitters will know that [the claim] was rejected because it was not a valid code vs. a denial for lack of specificity required for an NCD or LCD or other claim edit," CMS says. "Submitters should follow existing procedures for correcting and resubmitting rejected claims and issues related to denied claims."

Translation: Your appeals strategy will hinge on the reason your claim was denied, so be sure to check your remittance advice for the denial codes. If you find out that your claim is rejected due an invalid ICD-10 code, check through your ICD-10 coding options again to be sure that you selected a valid code under the new system.

Clarification 4: Does the One Year Grace Period Extend to Medicaid and Private Payers?

Because most practices don't exclusively see Medicare patients, it's important to clarify the fact that CMS's one-year grace period on ICD-10 claim denials is most likely not applicable to your other payers.

"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," CMS says. "This guidance does not apply to claims submitted for beneficiaries with Medicaid coverage, either primary or secondary." In addition, the agency explains, "Each commercial payer will have to determine whether it will offer similar audit flexibilities."

Translation: If you bill your Medicaid provider with the wrong ICD-10 code after Oct. 1, 2015—even if your code is in the right code "family"—you'll most likely face denials. As for private payers, you'll have to contact them on a case-by-case basis to find out if they will follow Medicare's lead on the grace period.

Clarification 5: When Can I Contact the Ombudsman?

In CMS's July 6 announcement, the agency said it would appoint an ICD-10 ombudsman to resolve issues and address concerns. Many practices are wondering when they'll have access to this department, because their concerns are already mounting.

This week, CMS assured the Medicare community that the Ombudsman "will be in place by Oct. 1, 2015."

Translation: Although it's possible that CMS might open up the Ombudsman's department before Oct. 1, the agency has at least confirmed that the new position will be filled and ready to take your calls by Oct. 1 at the latest.

Resource: To read the rest of CMS's frequently-asked questions about ICD-10, visit http://go.cms.gov/1lq1J8Y.