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ICD-10 Transition News: CMS Weighs in on Coding for Claims Spanning Oct. 1

Prepare for HIPPS code inconsistencies.

The ICD-10 implementation deadline is less than two months away, so it's time to start taking a closer look at how you'll submit claims during the transition.

The problem: Requests for Anticipated Payment for episodes that begin before Oct. 1 must contain ICD-9 codes, the **Centers for Medicare & Medicaid Services** reviews in MLN Matters article SE 1410. But claims with a "through" date Oct. 1 or later must contain HIPPS codes based on ICD-10 codes.

The solution: CMS will "allow HHAs to use the payment group code derived from ICD-9-CM codes on claims which span 10/1, but require those claims to be submitted using ICD-10-CM codes," CMS instructs. "This means that HHAs do not have to re-group the episode based on the ICD-10-CM codes."

However, "this could result in some inconsistency between the HIPPS code and the ICD-10-CM codes on the claim," CMS acknowledges. "CMS will alert medical reviewers at our MACs to ensure that the ICD-10-CM codes on these claims are not used in making determinations." In other words, "the coding used to support the payment of the HIPPS code will be the ICD-9-CM codes that were used on the RAP and which are stored in the OASIS system," CMS says.

See more details about claims spanning Oct. 1 in the article at
www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1410.pdf

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