Chiropractic Coding & Compliance Alert

ICD-10 Update: Decoding the ICD-10 Flexibilities: What the Guidance Does and Does Not Cover

Look forward to disclaimers, status quo, and a new ombudsman.

ICD-10 is here, finally. As you settle down and adjust to the new system, here is some more official guidance CMS doled out for you in late September, in response to provider queries regarding the July 6 press release on concessions to help the providers in their seamless transition.

CMS Scores Big With Medicare Fee-for-Service Part B Physician Fee Schedule

First thing first: 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 including technical component (TC) only and global claims included in this same CMS/AMA guidance.

This guidance does not apply to claims submitted for beneficiaries with Medicaid coverage, either primary or secondary. Federal matching funding will not be available for provider payments that are not processed through a compliant MMIS and supported by valid, billable ICD-10 codes.

"Because we must follow CMS guidelines for our billing, this helps us," says **Elizabeth Earhart, CPC,** with Godshall Chiropractic in Millersville, PA. "My office does not participate with Medicaid, so we don't have to worry about it. As long as we use the codes within our scope, we will be fine for this transition and reimbursement."

Why only Medicare: The reason CMS focused on claims billed under the Part B physician fee schedule is because many physicians are in small practices that need additional flexibility to gain experience with the ICD-10 coding set. Claims billed under the Part B physician fee schedule are paid using CPT® codes and not ICD-10 codes. Other services, such as institutional services, are paid based on the ICD-10 codes.

For more information on the recent CMS press releases, refer to the article "CMS and AMA Promise to Forego ICD-10 Code Based Denials" in Chiropractic Coding and Compliance Alert, Volume 2, Number 8.

Heed the disclaimer: The recent guidance does not 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. 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. This reflects the fact that current automated claims processing edits are not being modified as a result of the guidance.

Get to know reasons for claim rejection: Submitters will get to know whether the claim was rejected because it was not a valid code or because of a lack of specificity required for a National Coverage Determination (NCD), Local Coverage Determination (LCD), or other claim edit. Submitters should follow existing procedures for correcting and resubmitting rejected claims and issues related to denied claims.

Established time limits to process claims: Section 1842(c)(2) of the Social Security Act requires Medicare contractors to make payment on not less than 95% of "clean claims" within 30 calendar days. If there are Medicare systems issues that interfere with claims processing, CMS and the MACs will disseminate information on how to access advance payments.

Accelerated payments for institutional providers (Part A): CMS regulations at 42 CFR Section 413.64(g) allows accelerated payments for Part A provider's not receiving periodic interim payments. This is applicable in the case of

delay in making payments or in "exceptional situations" when there is temporary delay form the provider's end in submitting bills. Note that an accelerated payment is a conditional partial payment, which requires repayment, and may be issued when the conditions described in CMS regulations at 42 CFR Section 413.64(g) are met and subject to contractor and CMS approval.

The Stakes That Stayed Status Quo

Although the Medicare review contractors will not deny claims based solely on the specificity of the ICD-10 diagnosis code so long it's a valid code from the right family of codes for a year; there are some stakes that you have to live up to, nevertheless.

Coding specificity required by NCDs: 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. Remember to check the NCDs and LCDs at http://www.cms.gov/medicare-coverage-database/.

"The impact will be minimal as long as we follow our guidelines and adhere to the LCDs," thinks Earhart.

Scope of audits: The Medicare fee-for-service audit and quality program flexibilities only pertain to post payment reviews. ICD-10 codes with the correct level of specificity will still be required for prepayment reviews and prior authorization requests.

What the guidance does not cover: The following aspects also are worth a glance:

- Each commercial payer will have to determine whether it will offer similar audit flexibilities. As of now, this flexibility extends only to services covered by Medicare.
- Medicare Advantage risk adjustment payment and audit criteria remain unchanged.
- Coding guidelines Medicare Advantage plans are unchanged.
- The Medicare review contractors only review Medicare fee-for-service claims. This Guidance does not apply to the Medicare Advantage plans.
- The Medicare fee-for-service audit and quality program flexibilities have not been expanded to other claim types. They only apply to physicians and other practitioners who bill under the Medicare Fee-for-Service Part B physician fee schedule.
- Medicare's processes regarding what elements are crossed over to supplemental payers (including commercial payers and State Medicaid Agencies) will be unchanged as a result of the flexibilities.
- Medicare fee-for-service audit and quality program flexibilities will not affect the Medicare crossover claims and the crossover process.

Consider the CMS 24-month Look-back Period

Providers have cast their doubt as to how will the CMS 24-month look-back period for Medicare fee-for-service audits affect the 12-month period of audit flexibility. Will the auditors review and deny claims from the October 2015-October 2016 period for ICD-10 code specificity after October 2016? According to CMS, contractors conducting medical review (such as Medicare Administrative Contractors/Recovery Auditors/Supplemental Medical Review Contractors) will not deny claims solely for the specificity of the ICD-10 code as long as there is no evidence of potential fraud. This is, however, not applicable to prepayment denials because of an NCD or LCD.

Remember the Policy on Dual Eligible Beneficiary

If a Medicare paid claim is crossed over to Medicaid for a dual-eligible beneficiary, will Medicaid be required to pay the claim? State Medicaid programs are required to process submitted claims that include ICD-10 codes for services furnished on or after Oct. 1 in a timely manner. If the claims processing verifies that the individual is eligible, the claimed service is covered, and that all administrative requirements for a Medicaid claim have been met, payment may be made, taking into account the amount payable by Medicare. Consistent with these processes, Medicaid may deny claims based

on system edits in an event when a diagnosis code is not valid.

ICD-10 ombudsman: The ICD-10 ombudsman is Dr. William Rogers. You can contact him for your doubts and questions by emailing ICD10_Ombudman@cms.hhs.gov. He will listen to issues affecting suppliers and providers alike, and will evaluate any specific issues that arise during implementation. Moreover, CMS's ICD-10 Coordination Center will also be actively monitoring to quickly identify and initiate resolution of issues that may arise as a result of the big transition.

Final takeaway: In the words of Earhart, "Many of the payers are saying they will follow CMS in not denying for incorrect coding as long as the ICD-10 code is within the scope of practice." She adds further, "I hope they would send us corrections so we know what to expect and adjust to what should be coded."