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Oral Surgery Coding & Reimbursement Alert

ICD-10: Understand Grace Period To Ease into ICD-10 Implementation in Your Practice

Be ready to use ICD-10 or claims won't fly.

Amid the ocean of information CMS has released in the lead-up to ICD-10's official start date, many practices are struggling to stay afloat.

In July, CMS and the American Medical Association (AMA) released a piece of guidance that confused more than clarified for some people, because it seemed to say that CMS wouldn't deny claims with incorrect ICD-10 codes until 2016. Many had trouble deciphering the guidance and, with no clarification from payers, were left to their own devices to interpret the rule.

Good news: In September, CMS revised and reissued a set of FAQs that sheds a lot of light on its July guidance. Use this information straight from the feds to clear up your questions about the CMS and AMA communiqué.

Get Set For Using ICD-10 Codes From Day One

When CMS and the AMA jointly announced that it would process and not audit claims with valid ICD-10 codes, even if the particular ICD-10 code on a claim was technically incorrect, 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 October 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 for dates of service on or after Oct. 1, 2015. Claims systems won't be able to accept ICD-9 codes for those dates of service, so you must start using your ICD-10 codes for services on or after Oct. 1.

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 leukokeratosis nicotina palati, the appropriate code is K13.24. If, however, you mistakenly report K13.29 (Other disturbances of oral epithelium, including tongue), you're still coding within the same family of codes, and therefore, your contractor shouldn't deny the claim between Oct. 1, 2015 and Oct. 1, 2016. However, if you just report K13 (Other diseases of lip and oral mucosa), you might see a denial, because "in many instances, the code will require more than three characters in order to be valid," CMS says.

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

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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 Medicare administrative contractor (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 [national coverage determination] or LCD [local coverage determination] 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 to 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.

Does the 1-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."

And remember, there might still be a few payers only recognizing ICD-9 codes, such as worker's compensation organizations and auto insurances.

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 may very well 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.

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. However, CMS assured the Medicare community that the Ombudsman would be in place by Oct. 1, 2015.

Anyone who has participated in a CMS open door forum is familiar with the name **William Rogers, MD,** an emergency physician and surgeon who has also served as a medical officer with the agency for several years. That familiarity can help you going forward, now that Rogers has been named the ICD-10 ombudsman, CMS Administrator **Andy Slavitt** announced during a MLN provider call. q

Translation: The new position is filled and Rogers will be on board to answer your questions. You'll be able to reach Rogers with any ICD-10 issues at ICD10_ombudsman@cms.hhs.gov.

Resource: To read the rest of CMS's frequently-asked questions about ICD-10, visit http://go.cms.gov/1Iq1J8Y.

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