



Welcome to the International Classification of Diseases, Ninth Revision (ICD-9) Diagnosis Code Requirements Part I course.

Note: This module applies to Responsible Reporting Entities (RREs) that will be submitting Section 111 claim information via an electronic file submission as well as those RREs that will be submitting this information via direct data entry (DDE).

Disclaimer

While all information in this document is believed to be correct at the time of writing, this Computer Based Training (CBT) is for educational purposes only and does not constitute official Centers for Medicare & Medicaid Services (CMS) instructions for the MMSEA Section 111 implementation. All affected entities are responsible for following the instructions found at the following site:

<http://www.cms.gov/mandatoryinsrep>.

Course Overview

- ICD-9 defined
- Importance of ICD-9 diagnosis codes
 - Explains what these codes are used for
- ICD-9 diagnosis code reporting requirements for Section 111
 - How to derive an ICD-9 diagnosis code
- See ICD-9 Requirements Part II
 - Obtaining valid ICD-9 diagnosis codes
 - ICD-10 Overview



ICD-9 Requirements Part I defines ICD-9, explains the importance of ICD-9 diagnosis codes for Section 111 reporting, describes what these codes are used for, clarifies the ICD-9 diagnosis code reporting and explains how to derive an ICD-9 diagnosis code.

ICD-9 Requirements Part II explains where a Responsible Reporting Entity (RRE) can obtain valid ICD-9 diagnosis codes and ends with an overview on ICD-10.

Note: Liability insurance (including self-insurance), no-fault insurance and workers' compensation are sometimes collectively referred to as "non-group health plan" or "NGHP". The term NGHP will be used in this CBT for ease of reference.

What is an ICD-9?

Acronym used in the medical field

- Stands for International Classification of Diseases, ninth revision
- ICD is designed to promote international comparability in the collection, processing, classification and presentation of mortality statistics

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What are ICD-9 Diagnosis Codes Used For?

- Help Medicare claims paying offices process Medicare claims
- Example
 - Beneficiary suffers a broken collar bone in automobile accident
 - RRE assumes ORM for broken collar bone and submits record with ICD-9 diagnosis code 81000 (fractured clavicle NOS-closed)
 - Medicare claims office will reject any related claim if it has not first been processed by the RRE
 - Failure to provide accurate or appropriate diagnosis codes may result in Medicare paying primary on claims that are the responsibility of the RRE

ICD-9 diagnosis codes submitted by RREs on Section 111 Claim Input Files are used by Medicare claims paying offices to help process Medicare claims.

For example, if an RRE assumes Ongoing Responsibility for Medicals (ORM), this means that the RRE should pay first on any claim with a service related to the condition(s) for which the RRE assumed ORM. Let us say an RRE assumes ORM for a broken collar bone a beneficiary suffered in an automobile accident. The RRE may report ICD-9 diagnosis code 81000 (fractured clavicle NOS-closed). Later, if a hospital or medical claim is sent to a Medicare claims paying office for services related to the broken collar bone, the Medicare claims office will reject the claim if it was not first processed by the RRE.

If an RRE does not report accurate or all appropriate diagnosis codes related to the condition(s) for which ORM was accepted, Medicare may mistakenly pay primary on claim(s) for which the RRE has assumed primary payment responsibility.

What are ICD-9 Diagnosis Codes Used For?

- Help Medicare Secondary Payer Recovery Contractor (MSPRC)
- Example
 - Beneficiary suffers neck and ankle sprains in 2009
 - Settlement reached in 2010 with \$10,000 TPOC
 - RRE submits claim record with ICD-9 diagnosis codes 8470 (sprain of neck) and 84500 (sprain of ankle)
 - Exact match on submitted ICD-9 diagnosis codes is not required
 - Recovery will be pursued on claims related to the injuries



ICD-9 diagnosis codes submitted by RREs are also used by the Medicare Secondary Payer Recovery Contractor (MSPRC). Assume a beneficiary suffered neck and ankle sprains in 2009. The beneficiary pursued a claim for damages and settlement was reached in 2010 with a \$10,000 Total Payment Obligation to Claimant (TPOC) being made to the beneficiary.

The RRE submits a Section 111 claim record and reports ICD-9 diagnosis codes 8470, sprain of neck and 84500, sprain of ankle. The MSPRC will use this information to search Medicare claims history during the relevant time frame. The MSPRC will identify any claims paid primary by Medicare that relate to the neck and ankle sprains. An exact match on the submitted ICD-9 diagnosis codes (8470 & 84500) is not required. If Medicare has made primary payment on claims related to the injuries, recovery of the Medicare benefits paid will be pursued from the beneficiary.

Reporting ICD-9 Diagnosis Codes

All add and update records must include ICD-9-CM diagnosis codes considered valid for Section 111 reporting in the:

- Alleged Cause of Injury, Incident, or Illness or E-Code in Field 15 **AND**
- At least the first of the ICD-9 diagnosis code fields beginning in Field 19

RREs must provide as many ICD-9 diagnosis codes as possible to adequately describe the TPOC and/or ORM reported

All add and update records on Claim Input Files and DDE submissions must include ICD-9-CM diagnosis codes considered valid for Section 111 reporting in the Detail Record Alleged Cause of Injury, Incident or Illness or E-Code (Field 15) and in at least the first of the ICD-9 diagnosis codes 1-19 beginning in Field 19. Although only one valid ICD-9 diagnosis code will be required, RREs must provide as many as possible to adequately describe the TPOC and/or ORM reported.

Reporting ICD-9 Diagnosis Codes

There may not always be an E-Code that matches the circumstance for the Alleged Cause of Injury, Incident or Illness

When there is not a good E-Code match, the ICD-9 codes become even more critical

If there is no available E-Code, it is suggested that one of the following codes be submitted

- E0008 – External cause status NEC
- E0009 – External cause status NOS

CMS recognizes that there will not always be an E-Code that matches the circumstance for the Alleged Cause of Injury, Incident or Illness. When this occurs, a code for Field 15, the Alleged Cause of Injury, Incident or Illness must still be submitted. When there is not a good E-Code match, the ICD-9 code(s) reported starting in Field 19 become(s) even more critical and must accurately describe the injury, incident or illness being claimed or released or for which ORM is assumed.

If an RRE searches **all** available E-Codes and determines that none fit the actual Alleged Cause of Injury, Incident or Illness, it is suggested that one of the following codes be submitted: E0008 – External cause status NEC or E0009 – External cause status NOS.

Reporting ICD-9 Diagnosis Codes

- RREs may add or remove ICD-9 diagnosis codes on subsequent update records after the initial add record has been submitted and accepted
- Update records should include
 - Previously submitted ICD-9 diagnosis codes that still apply
 - New codes the RRE needs to submit

An RRE may add or remove ICD-9 diagnosis codes on subsequent update records after the initial add record has been submitted and accepted. Update records should include the previously submitted ICD-9 diagnosis codes that still apply to the claim report along with any new codes that the RRE needs to submit.

Selecting ICD-9 Diagnosis Codes

- Medical claim records may include diagnosis codes that are unrelated to the illness or injury
- Only submit ICD-9 diagnosis codes that describe the alleged injuries or illnesses that were claimed and/or released or for which ORM was assumed
- Unrelated ICD-9 diagnosis codes should not be submitted

Sometimes, the medical claim records may include diagnosis codes that are unrelated to the illness or injury. For Section 111 reporting, an RRE must submit ICD-9 codes that describe the alleged injuries or illnesses that were claimed and/or released or for which ORM was assumed. If a particular ICD-9 code does not meet this requirement, it should not be submitted.

Selecting ICD-9 Diagnosis Codes

Medicare beneficiary is injured in an auto accident, suffers a laceration to the nose

- No-fault Insurer assumes ORM
- Beneficiary also treated for poison ivy and a longstanding heart condition
- Medical bill from No-fault Insurer included ICD-9 diagnosis codes
 - 873.20 Open wound of nose
 - 692.6 Dermatitis due to poison ivy
 - 414.01 Arteriosclerotic heart disease [ASHD]
- Submit ICD-9 diagnosis code 873.20 as 87320 on the Claim Input File Detail Record

For example, assume a Medicare beneficiary is injured in an auto accident and his No-fault Insurer accepts ORM for injuries that are the result of the accident. The beneficiary suffered a laceration to his nose in the accident. While receiving care for the nose laceration in the emergency room, the beneficiary was also treated for poison ivy and a long standing heart condition, neither of which were related to the auto accident. The No-fault Insurer did not assume ORM for either of those conditions.

When the Claim Input File Detail Record is submitted by the No-fault Insurer, it should only contain ICD-9 code 873.20 for the nose injury. The record should not include ICD-9 codes 692.6 for poison ivy nor 414.01 for the heart disease. Remember, when submitting the ICD-9 diagnosis code 873.20, it should be submitted as 87320 (without the decimal point).

Selecting ICD-9 Diagnosis Codes

- Requires some level of knowledge of ICD coding to correctly select code(s) being claimed or released
- Critical that codes match the injury allegations, so there is no discrepancy as to which services are related
- Example
 - Beneficiary died as a result of an automobile accident
 - If RRE submits ICD-9 code 7982 (Death within 24 hours of symptoms), Medicare cannot identify which bills are related to the accident
 - If RRE submits ICD-9 code 80161 (Fracture of base of skull), bills can be more easily identified

Section 111 reporting may at times require the RRE to derive ICD-9 diagnosis codes from information on file. Some level of knowledge of ICD coding will assist in correctly selecting the ICD-9 code(s) being claimed or released. It is critical that the ICD-9 codes reported to CMS match the injury allegations, so there is no discrepancy as to which services are related.

To illustrate, assume a Medicare beneficiary died as the result of an automobile accident. If the RRE only supplied ICD-9 code 7982 (Death within 24 hours of symptoms) Medicare may not be able to identify which hospital and medical claims received were related to the accident. However, if the RRE supplied ICD-9 code 80161 (Fracture of base of skull), identification of related hospital and medical claims can be accomplished.

Selecting ICD-9 Diagnosis Codes

Find ICD-9 codes, related to the claim report, on the medical claim records from the injured party

Not all codes may need to be reported

- Do not report unrelated Diagnosis Codes
- Do not report codes that are not valid for Section 111

Although a general ICD-9 code may exist for doctor/hospital visit, always report specific, more descriptive ICD-9 code(s)

- Lead to more accurate coordination of benefits, including facilitating accurate claims payment and/or the determination of recovery amounts

RREs can find ICD-9 codes, related to the claim report, on the medical claim records they receive from the injured party. RREs do not necessarily need to report all of the diagnosis codes appearing on a claimant's actual medical forms or invoices because some codes may not be related and some codes selected by doctors or hospitals may not even appear on the list of codes that are currently accepted by CMS for Section 111 reporting purposes.

Although a general ICD-9 code may exist for a doctor or hospital visit independent of a specified injury, illness or diagnosis, RREs should always report specific, more descriptive ICD-9 code(s) that describe the illness or injury, not just those that describe services rendered. This will lead to more accurate coordination of benefits, including facilitating accurate claims payment and/or the determination of recovery amounts, where applicable.

Selecting ICD-9 Diagnosis Codes

Set up a systems process to translate text descriptions into valid ICD-9 codes

Instruct claims handlers to independently choose a valid ICD-9 code from the code lists provided by CMS

Search Internet for information regarding ICD-9 codes

- Downloadable search lists
- Free software to assist with deriving codes

RREs may choose to set up a systems process to translate text descriptions of illnesses or injuries into valid ICD-9 codes. They may instruct claims handlers to independently choose a valid ICD-9 code(s) from the code lists provided by CMS based on information on the claim and/or in their files. RREs and reporting agents may also find it helpful to search the Internet where many sources of information regarding ICD-9 diagnosis codes may be found including downloadable search lists and free software to assist with deriving codes applicable to specific injuries.

ICD-9 Diagnosis Code Use of 'NOINJ' Value

- Some very limited liability situations where a settlement, judgment, award or other payment releases medicals or has the effect of releasing medicals, but
 - Type of alleged incident typically has no associated medical care, and
 - Medicare beneficiary/injured party has not alleged a situation involving medical care or a physical or mental injury
- Examples of this situation are
 - Claim for loss of consortium
 - Errors or omissions liability insurance claim
 - Directors and officers liability insurance claim
 - Claim resulting from a wrongful action related to employment status action is alleged

In some very limited liability situations a settlement, judgment, award or other payment releases medicals or has the effect of releasing medicals but the type of alleged incident typically has no associated medical care and the Medicare beneficiary/injured party has not alleged a situation involving medical care or a physical or mental injury. This is frequently the situation with a claim for loss of consortium, an errors or omissions liability insurance claim, a directors and officers liability insurance claim, or a claim resulting from a wrongful action related to employment status action is alleged. Current Section 111 reporting requires the RRE to report in these circumstances.

ICD-9 Diagnosis Code Use of 'NOINJ' Value

- In these very limited circumstances when the claim report does not reflect ORM and the insurance type is liability
 - Submit the “no injury” code NOINJ in both Field 15 and Field 19

When the NOINJ value is used	
Field	Required Value
Alleged Cause of Injury, Incident, or Illness (Field 15)	NOINJ
ICD-9 Diagnosis Code 1 (Field 19)	NOINJ
ORM Indicator (Field 98)	N
Plan Insurance Type (Field 71)	L
All remaining ICD-9 Diagnosis Codes 2-19 (Fields 21-55)	Fill with spaces
All other remaining fields on claim report	As required

- Note: CMS will closely monitor the use of the 'NOINJ' value

In these very limited circumstances when the claim report does **not** reflect ORM and the insurance type is liability, submit the “no injury” code “NOINJ” in the Alleged Cause of Injury, Incident, or Illness (Field 15) and the ICD-9 Diagnosis Code 1 (Field 19). When the “NOINJ” value is used, it must be submitted in both Field 15 and Field 19. Additionally, the following fields must be submitted as described, otherwise the record will reject with the applicable error code: ORM Indicator (Field 98) must be N; Plan Insurance Type (Field 71) must be L; all remaining ICD-9 Diagnosis Codes 2-19 (Fields 21-55) must be filled with spaces; and all other remaining fields must be submitted on the claim report as required. If these conditions are not met, the record will be rejected with the CI25 error code.

Note: CMS will closely monitor the use of the NOINJ default value to ensure it is used appropriately. RREs using this code erroneously are at risk of non-compliance with Section 111 reporting requirements.

ICD-9 Diagnosis Code Data Editing

- Data submitted in the ICD-9 diagnosis code fields on add or update transactions will be fully edited according to the field descriptions
- Any submitted ICD-9 diagnosis code must
 - Be a valid code
 - Be left justified and any remaining unused bytes filled with spaces to the right
 - Include any leading and trailing zeros only if they appear that way on the list of valid ICD-9 diagnosis codes
 - Not include the decimal
 - Field 15: E-Code E917.9 should be submitted as E9179
 - Field 19: ICD-9 code 038.42 should be submitted as 03842
- Note: ICD-9 Diagnosis Code edits are not applied to delete transactions

Whenever data is submitted in any of the ICD-9 diagnosis code fields (i.e., the Alleged Cause of Injury, Incident, or Illness (Field 15) and/or the diagnosis code fields (beginning in Field 19) on an add or update transaction, the data will be fully edited according to the field descriptions provided in the record layout regardless of when this data is submitted. Any submitted ICD-9 diagnosis code must: be a valid code; be left justified and any remaining unused bytes filled with spaces to the right; include any leading and trailing zeros only if they appear that way on the list of valid ICD-9 diagnosis codes. Do not add leading or trailing zeroes just to fill the 5 positions of the field on the file layout; and do not include the decimal. For example, in Field 15, E-Code E917.9 should be submitted as E9179. In Field 19, ICD-9 diagnosis code 038.42 should be submitted as 03842.

Note: ICD-9 diagnosis code edits are not applied to delete transactions.

ICD-9 Diagnosis Code Data Editing

- Medicare beneficiary
 - Injured in automobile accident
 - Suffers fractured ankle
- RRE must submit ICD-9 E-Code and correct ICD-9 diagnosis code on Claim Input File Detail Record
 - Field 15 = E8120 (motor vehicle traffic accident)
 - Field 19 = 82400 (fracture of ankle)
- When ICD-9 E-Code/diagnosis codes not entered correctly, Claim Input File Detail Record will fail



Let us say a Medicare beneficiary is injured in an automobile accident and has suffered a fracture to his ankle. The RRE must submit both the ICD-9 E-Code and correct ICD-9 diagnosis code on the Claim Input File Detail Record as follows: submit the value E8120 (motor vehicle traffic accident) in Field 15 and submit the value 82400 (fracture of ankle, i.e., ICD-9 Code 824.00) in Field 19.

When the ICD-9 E-Code and/or ICD-9 diagnosis codes are not entered correctly, the Claim Input File Detail Record will fail with the applicable error code (i.e., CI03 and/or CI05-CI25).

ICD-9 Diagnosis Code Data Editing

- ICD-9 diagnosis codes are three, four or five positions in length
 - No partial codes may be submitted
- If the ICD-9 code is less than five positions
 - Do not add leading or trailing zeros
 - Fill extra position(s) with spaces
 - Example ICD-9 8472 (lumbar sprain)
 - Valid entry: 8472 (last position of this field entered as a space)
 - Invalid entry: 08472 or 84720 (leading/trailing zero entered)

ICD-9 diagnosis codes are three, four or five positions in length. No partial codes may be submitted. In other words, you may not submit only the first 3 digits of a 4-digit code. Additionally, if you are submitting an ICD-9 code that is only three or four positions in length, do not add leading or trailing zeros. When the ICD-9 code to be submitted is less than five positions, the extra position or positions should be filled with spaces. For example, if you are submitting ICD-9 code 8472 for lumbar sprain, this code should be entered as a 4 position ICD-9 code. The last position of this field should be filled with a space. If this same code is entered with a leading or trailing zero e.g., 08472 or 84720, the ICD-9 code becomes invalid.

ICD-9 Diagnosis Code Data Editing

- ICD-9 diagnosis codes that are four or five positions in length may not be truncated.
- Example: ICD-9 codes 3898 and 38901 are both valid
 - Submitting either code as 389 makes the ICD-9 code invalid

ICD-9 diagnosis codes that are four or five positions in length may not be shortened. For example, ICD-9 Codes 3898 and 38901 are both valid codes. However, if either of these codes is submitted as 389, the ICD-9 code becomes invalid.

Validating ICD-9 Diagnosis Codes

1. All submitted diagnosis codes must be valid
 - Must exactly match first 5 positions of any ICD-9 Diagnosis Code of any of the DX files currently used to validate codes
 - Cannot be a V-Code (begin with the letter “V”)
2. Any submitted code cannot be on list of excluded codes
3. Diagnosis code submitted in Field 15
 - MUST be an E-Code (begin with the letter “E”)
4. Any diagnosis code submitted in Fields 19-55
 - Cannot be an E-Code

In order to prevent a Claim Input File Detail Record from rejecting for issues related to ICD-9 diagnosis codes, RREs should ensure the following: 1) All ICD-9 diagnosis codes in Field 15 and in Fields 19-55 must be valid (i.e., each submitted code must exactly match the first 5 positions on any entry (line) of any of the DX files currently being used by the Coordination of Benefits Contractor (COBC) to validate ICD-9 diagnosis codes and cannot be a V code); 2) Any submitted code cannot be on the list of excluded codes listed in Appendix I of the NGHP User Guide; 3) The diagnosis code submitted in Field 15 must be an E-Code; and 4) Any diagnosis code submitted in Fields 19-55 cannot be an E-Code.

ICD-9 Data Editing Example

Example 1

- Field 19 = 20078 (valid)
- Field 21 = 20079 (invalid)

- Claim will reject with a
CI06 (Invalid ICD-9
Diagnosis Code 2)

Example 2

- Field 15 = E8000 (valid)
- Field 19 = E8001 (only
valid in Field 15)

- Claim will reject with a
CI05 (Invalid ICD-9
Diagnosis Code 1)

- Detail Records that reject for invalid diagnosis codes will have to be corrected and resubmitted

Suppose a Claim Input File Detail Record has ICD-9 diagnosis code 20078 (a valid code) submitted in Field 19 and ICD-9 diagnosis code 20079 (an invalid code) submitted in Field 21. The Claim Input File Detail Record will reject even though one diagnosis code was valid. This Claim Response File Detail Record will be returned with a CI06 (Invalid ICD-9 Diagnosis Code 2).

Suppose another Claim Input File Detail Record has ICD-9 diagnosis code E8000 (a valid code) submitted in Field 15 and ICD-9 diagnosis code E8001 submitted in Field 19. Although E8001 is a valid code, "E-Codes" are only considered valid when submitted in Field 15. "E-Codes" are not permitted in Fields 19-55. This Claim Input File Detail Record will reject. The Claim Response File Detail Record will be returned with a CI05 (Invalid ICD-9 Diagnosis Code 1). Detail Records that reject for invalid diagnosis codes will have to be corrected and resubmitted.



You have completed the ICD-9 Requirements Part I course. Information in this course can be referenced by using the NGHP User Guide's table of contents. This document is available for download at the following link:
<http://www.cms.gov/mandatoryinsrep>.