



## MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance and Workers' Compensation User Guide

### ICD-9 Requirements Frequently Asked Questions

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Welcome to the International Classification of Diseases, ninth revision (ICD-9) Requirements Frequently Asked Questions (FAQ) course.

## 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

- How are ICD-9 diagnosis codes added and removed?
- What ICD-9 diagnosis codes are submitted on ORM claims?
- What ICD-9 diagnosis codes are submitted when there is a TPOC Amount?
- How to obtain the ICD-9 diagnosis codes to submit?
- What to do when there are more than 19 ICD-9 diagnosis codes?
- What to do when an RRE cannot find an appropriate E -Code?
  - E-Code suggestions



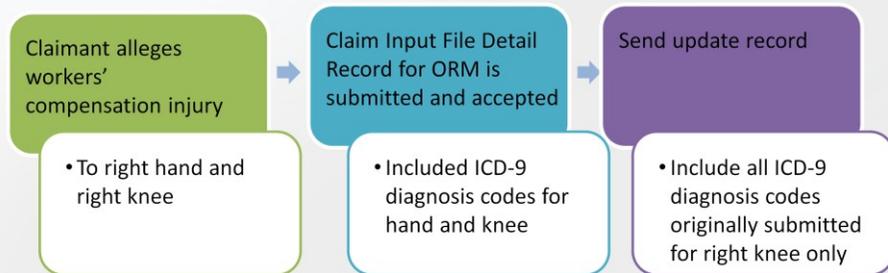
This module addresses FAQs regarding ICD-9 diagnosis code reporting for Section 111 and provides a list of E-codes which can be used in specific situations. The FAQs addressed in this course are: How are ICD-9 diagnosis codes added and removed? What ICD-9 diagnosis codes are submitted on Ongoing Responsibility for Medicals (ORM) claims? What ICD-9 diagnosis codes are to be submitted when there is a Total Payment Obligation to Claimant (TPOC) Amount? Where do we obtain the ICD-9 diagnosis codes to submit? What to do when there are more than 19 ICD-9 diagnosis codes. What to do when a Responsible Reporting Entity (RRE) cannot find an appropriate E-Code? What to do in a situation where a settlement, judgment, award or other payment releases medicals, but the type of alleged incident has no associated medical care and the Medicare beneficiary has not alleged a situation involving medical care?

## How are ICD-9 codes added and removed from existing records?

- RRE may add or remove ICD-9 diagnosis codes on subsequent update records
- Update records should include:
  - Previously submitted ICD-9 diagnosis codes that still apply to the claim report
  - 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 the RRE needs to submit.

## Example on How to Remove ICD-9 codes From an Existing Record

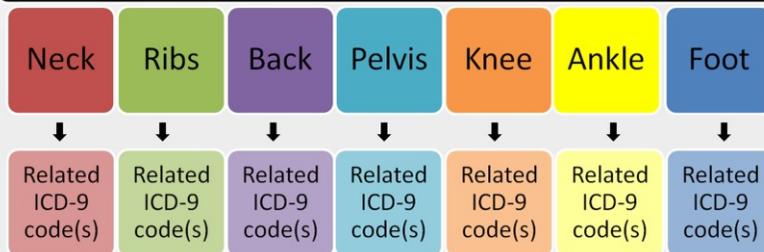


Let's assume an RRE assumes ORM for a claimant's alleged workers' compensation injuries to their right hand and right knee. The Claim Input File Detail Record is submitted and accepted. It included ICD-9 diagnosis codes for the hand and knee. In discovery, it is determined that the claimant sought treatment prior to the accident for their hand injury thus the hand injury was ordered to be removed as an accepted body part. An update record should be sent with all ICD-9 codes originally submitted for the right knee, but all originally submitted diagnosis codes for the hand should be excluded.

## What ICD-9 codes are submitted on ORM claims?

RRE submits ICD-9 codes for all alleged injuries and/or illnesses

### Example



Where ORM is assumed, RREs are to submit ICD-9 codes for all alleged injuries and/or illnesses for which the RRE has assumed ORM. For example, assume there was an auto accident where the beneficiary incurred injuries to his neck, ribs, back, pelvis, knee, ankle and foot. It is expected that the RRE will submit at least one ICD-9 code for each of the seven body parts that were injured.

What ICD-9 codes are to be submitted when there is a TPOC amount?

TPOC settlement,  
judgment, award or other  
payment amount

RRE to submit ICD-9 codes

- Describe all alleged injuries and/or illnesses

Where there is a TPOC settlement, judgment, award or other payment amount, the RRE is to submit ICD-9 codes that describe all of the alleged injuries and/or illnesses that were claimed and/or released, regardless of an admission of liability for any of the alleged injuries.

## Where do we obtain the ICD-9 codes to submit?

Hospital or medical claims received by RRE

OR

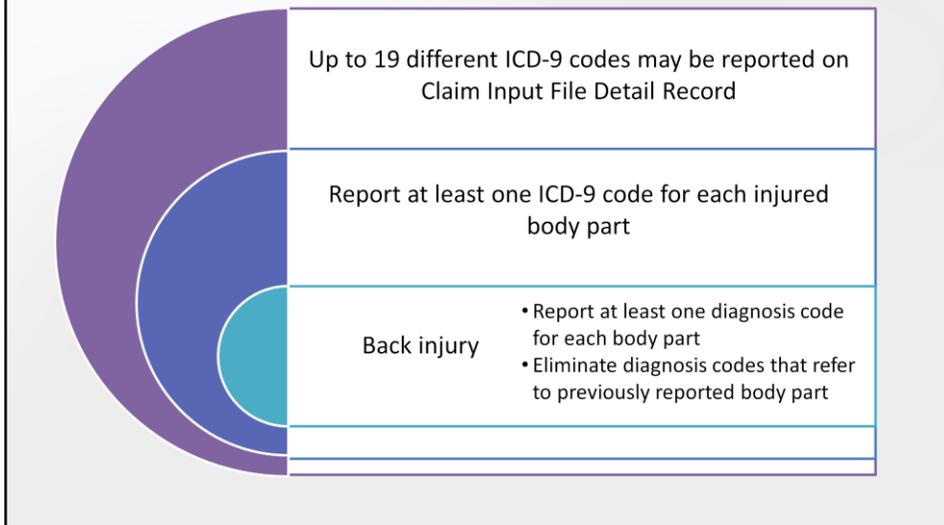
Derived by the RRE using

- Internal case reports
- Accident reports
- Medical records
- Physician consultation notes
- Operative reports
- Workers' Compensation Insurance Organization 's (WCIO) body part codes
- Translations from settlement agreements, etc.

RREs may start by examining any and all hospital and medical bills and claims received. Not all of the ICD-9 codes on the bills or claims may need to be submitted 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.

If bills or claims are not available, it may be necessary for the RRE to derive the ICD-9 Codes to submit. An RRE may derive ICD-9 codes through the review of other documentation including internal case reports, accident reports, medical records, physician consultation notes or operative reports. Workers' Compensation Insurance Organizations' (WCIO) body part codes may also be translated to ICD-9 diagnosis codes. RREs may even derive ICD-9 codes from a review of a settlement agreement.

## What do we report when we have more than 19 ICD-9 diagnosis codes?



There may be times when a beneficiary is severely injured and the RRE has more than 19 ICD-9 diagnosis codes to report. Since the Claim Input File Detail Record only has room for 19 ICD-9 diagnosis codes, it is important that an RRE reports at least one ICD-9 code for each injured body part.

In such a situation, it is likely that a number of the diagnosis codes relate to the same body part. For example, multiple diagnosis codes could be listed when a back injury occurs. When there are more than 19 diagnosis codes, be sure to report at least one diagnosis code for each body part that was injured. Eliminate diagnosis codes that refer to a previously reported body part.

## What do we do when an appropriate E Code cannot be located?

RREs may not find appropriate E Code to submit in Field 15 that matches Alleged cause of Injury, Incident, or Illness

Field 15 must still be populated

ICD-9 codes beginning in Field 19 become even more critical

Issues do not arise when E code in Field 15 is less specific as long as ICD-9 codes beginning in Field 19 are specific

Sometimes there will not be a good fit between an actual injury or illness and an E Code, i.e., the code required in Field 15, the Alleged Cause of Injury, Incident, or Illness. CMS understands that an exact match, or at times, even a 'close' match with an E Code may not be possible. When this occurs, an E Code must still be submitted in Field 15. The ICD-9 codes beginning in Field 19 then become even more critical and must accurately describe the illness, injury or incident claimed or being released by the settlement, judgment, award or for which ORM is assumed. The claims processing and recovery processes employed by CMS will not be negatively impacted when a less-specific E Code is submitted provided that appropriate ICD-9 diagnosis codes are included beginning in Field 19 of the Claim Input File Detail Record.

## E Code Suggestions

Alleged Cause	Possible E Codes
Asbestos Exposure	E0008 – External cause status NEC E0009 – External cause status NOS
Carpal Tunnel	E9273 – Cumulative trauma-repetitive motion
Hearing Loss	E9281 – Exposure to noise
Lifting	E0141 – Care-giving lifting E0160 – Digging, shovel, rake E0162 – Building & Construction

The table displayed reflects questions asked by RREs regarding what E Codes they should use in the listed situations. There may not be a single correct answer, thus for some alleged causes, we offer several possible E Codes.

If the Alleged Cause is Asbestos Exposure, possible E Codes to submit are E0008 or E0009, External cause status NEC and External cause status NOS respectively. For Carpal Tunnel, we suggest E9273, Cumulative trauma, repetitive motion. For Hearing Loss, E9281, Exposure to noise and for Lifting, E0141, Care-giving lifting, perhaps as might be suffered by someone working in a hospital, E0160 Digging, shovel or rake or E0162, Building and Construction.

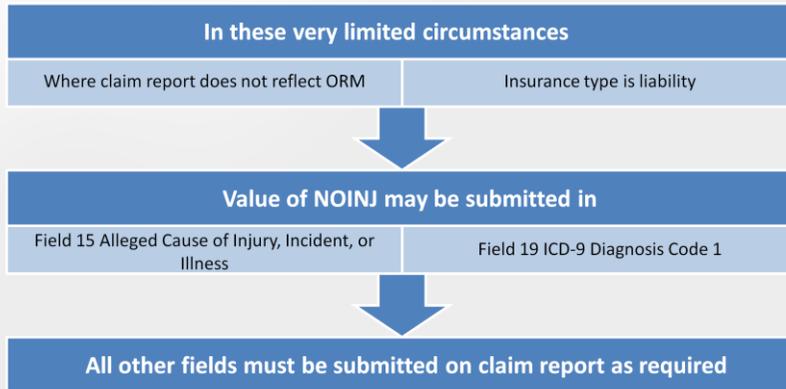
## E Code Suggestions

Alleged Cause	Possible E Codes
Acquiring HIV	E0008 – External cause status NEC E0009 – External cause status NOS
Failure to Diagnose	E8768 – Medical misadventure NEC E8769 – Medical misadventure NOS
Stress Induced Heart Attack	E0008 – External cause status NEC E0009 – External cause status NOS

If the alleged cause is acquiring HIV, we again suggest using code E0008 or E0009. If the alleged cause is failure to diagnose as in a medical malpractice case, E8768 or E8769, Medical misadventure NEC and NOS respectively may be appropriate. If the alleged cause is Stress that caused a heart attack, we would again suggest the use of E0008 or E0009.

Remember, when the E Code submitted in Field 15 does not allow Medicare to identify services received by the beneficiary that are related to the Alleged Injury, Incident, or Illness, the ICD-9 Codes submitted, beginning in Field 19, must allow for such identification.

What if there is a situation where a settlement, judgment, award or other payment releases medicals, but the type of alleged incident has no associated medical care and the Medicare beneficiary has not alleged a situation involving medical care?



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. There are certain, very limited liability situations where 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. In these very limited circumstances, when the claim report does not reflect ongoing responsibility for medicals (ORM) and the insurance type is liability, a value of "NOINJ" may be submitted in both Field 15 Alleged Cause of Injury, Incident, or Illness and Field 19 ICD-9 Diagnosis Code 1 ("NOINJ" must be put in both the alleged cause and first diagnosis field and all of the rest of the diagnosis fields must be blank). All other fields must be submitted on the claim report as required.



You have completed the ICD-9 Requirements Frequently Asked Questions CBT. Information in this presentation can be referenced by the Liability Insurance (Including Self-Insurance), No-Fault Insurance and Workers' Compensation User Guide's table of contents and any subsequent alerts. These documents are available for download at the following link:  
<http://www.cms.gov/mandatoryinsrep>.