

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3081	Date: September 26, 2014
	Change Request 8692

Transmittal 3020, dated August 8, 2014, is being rescinded and replaced by Transmittal 3081, dated September 26, 2014, to delete the general rules for reporting diagnoses on claims in section 10.1. Providers have questioned if these bullets were providing different information than the Official ICD-9-CM and Official ICD-10-CM coding guidelines. This interpretation was not intended. Providers must refer to the Official ICD-9-CM and Official ICD-10-CM guidelines, which are a HIPAA standard, for these instructions. The location of the guidelines is shown in this section. All other information remains the same.

SUBJECT: Update to Pub. 100-04, Chapter 23 to Provide Language-Only Changes for Conversion to ICD-10

I. SUMMARY OF CHANGES: This Change Request (CR) contains language-only changes for updating ICD-10 language in Pub 100-04, Chapter 23. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

EFFECTIVE DATE: Upon Implementation of ICD-10

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: Upon Implementation of ICD-10

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-Only One Per Row.

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	23/10/ Reporting ICD Diagnosis and Procedure Codes
R	23/10.1/ General Rules for Diagnosis Codes
D	23/10.1.1/ Determining the Appropriate Primary ICD-9-CM Diagnosis Code for Diagnostic Tests Ordered Due to Signs and/or Symptoms
D	23/10.1.2/ Instructions to Determine the Reason for the Test
D	23/10.1.3/ Incidental Findings
D	23/10.1.4/ Unrelated Coexisting Conditions/Diagnoses
D	23/10.1.5/ Diagnostic Tests Ordered in the Absence of Signs and/or Symptoms
D	23/10.1.6/ Use of ICD-9-CM to the Greatest Degree of Accuracy and Completeness
D	23/10.1.7/ Coding Questions and Answers for Diagnostic Tests
R	23/10.2/ Inpatient Claim Diagnosis Reporting
N	23/10.3/ Outpatient Claim Diagnosis Reporting
N	23/10.4/ ICD Procedure Code
N	23/10.5/ Coding for Outpatient Services and Physician Offices
N	23/10.6/ Relationship of Diagnosis Codes and Date of Service

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

**Business Requirements
Manual Instruction**

Attachment - Business Requirements

Pub. 100-04	Transmittal: 3081	Date: September 26, 2014	Change Request: 8692
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I. GENERAL INFORMATION

- A. Background:** This Change Request (CR) contains language-only changes for updating ICD-10 language in Pub 100-04, Chapter 23.
- B. Policy:** There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility									
		A/B MAC			DMEPOS	Shared-System Maintainers				Other	
		A	B	H		F	M	V	C		
8692.1	All MACs shall be aware of the updated language for ICD-10 in Chapter 23 of Pub. 100 – 04.	X	X	X	X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility		
		A/B MAC	DME MAC	CEDI

		A	B	H H H		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information: N/A
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Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Not Applicable,

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager.

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Claims Processing Manual

Chapter 23 - Fee Schedule Administration and Coding Requirements

Table of Contents (Rev. 3081, Issued: 09-26-14)

10 - *Reporting ICD* Diagnosis and Procedure Codes

10.1 - General Rules for Diagnosis Codes

10.2 - Inpatient Claim Diagnosis Reporting

10.3 - Outpatient Claim Diagnosis Reporting

10.4 - ICD Procedure Code

10.5 - Coding for Outpatient Services and Physician Offices

10.6 - Relationship of Diagnosis Codes and Date of Service

10 - Reporting ICD Diagnosis and Procedure Codes

(Rev. 3081, Issued: 09-26-14, Effective: Upon Implementation of ICD -10, Implementation: Upon Implementation of ICD- 10)

Proper coding is necessary on Medicare claims because codes are generally used in determining coverage and payment amounts. *CMS accepts only HIPAA approved ICD-9-CM or ICD-10-CM/ICD-10-PCS codes, depending on the date of service. The official ICD-9-CM codes which were updated annually through October 1, 2013 are posted at*

<http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/codes.html>

The official annual updates and effective dates for any changes to ICD-10-CM and ICD-10-PCS codes are posted at <http://www.cms.gov/Medicare/Coding/ICD10/index.html>.

See the following sections (10.1 - 10.6) for additional instructions about coding ICD diagnoses for inpatient, outpatient, and other services.

10.1 - General Rules for Diagnosis Codes

(Rev. 3081, Issued: 09-26-14, Effective: Upon Implementation of ICD -10, Implementation: Upon Implementation of ICD- 10)

The Official ICD-9-CM Coding Guidelines can be found at

http://www.cdc.gov/nchs/icd/icd9cm_addenda_guidelines.htm

The Official ICD-10-CM and ICD-10-PCS Coding Guidelines can be found with the annual ICD-10-CM and ICD-10-PCS updates at <http://www.cms.gov/Medicare/Coding/ICD10/index.html>

The CMS understands that physicians may not always provide suppliers of DMEPOS with the most specific diagnosis code, and may provide only a narrative description. In those cases, suppliers may choose to utilize a variety of sources to determine the most specific diagnosis code to include on the individual line items of the claim. These sources may include, but are not limited to: coding books and resources, contact with physicians or other health professionals, documentation contained in the patient's medical record, or verbally from the patient's physician or other healthcare professional.

Beneficiaries are not required to submit *diagnosis* codes on beneficiary-submitted claims. Beneficiary-submitted claims are filed on Form CMS-1490S. For beneficiary-submitted claims, the carrier must develop the claim to determine a current and valid *diagnosis* code and may enter the code on the claim.

10.2 - Inpatient Claim Diagnosis Reporting

Rev. 3081, Issued: 09-26-14, Effective: Upon Implementation of ICD -10, Implementation: Upon Implementation of ICD- 10)

*On inpatient claims providers must report the principal diagnosis. The principal diagnosis is the condition established after study to be chiefly responsible for the admission. Even though another diagnosis may be more severe than the principal diagnosis, the principal diagnosis, as defined above, is entered. Entering any other diagnosis may result in incorrect assignment of a *Medicare Severity - Diagnosis Related Group (MS-DRG)* and an *incorrect* payment to a hospital under PPS. See Chapter 25, *Completing and Processing the Form CMS-1450 Data Set, for instructions about completing the claim.**

Other diagnoses codes are required on inpatient claims and are used in determining the appropriate MS-DRG. The provider reports the full codes for up to *twenty four* additional conditions if they coexisted at the time of admission or developed subsequently, and which had an effect upon the treatment or the length of stay.

The principal diagnosis should not under any circumstances be duplicated as an additional or secondary diagnosis. If the provider reports duplicate diagnoses they are eliminated in Medicare Code Editor (MCE) before GROUPER.

The Admitting Diagnosis Code is required for inpatient hospital claims subject to *contractor* review. The admitting diagnosis is the condition identified by the physician at the time of the patient's admission requiring hospitalization. For outpatient bills, the field defined as Patient's Reason for Visit is not required by Medicare but may be used by providers for nonscheduled visits for outpatient bills.

10.3 - Outpatient Claim Diagnosis Reporting

(Rev. 3081, Issued: 09-26-14, Effective: Upon Implementation of ICD -10, Implementation: Upon Implementation of ICD- 10)

For outpatient claims, providers report the full diagnosis code for the diagnosis shown to be chiefly responsible for the outpatient services. For instance, if a patient is seen on an outpatient basis for an evaluation of a symptom (e.g., cough) for which a definitive diagnosis is not made, the symptom is reported. If, during the course of the outpatient evaluation and treatment, a definitive diagnosis is made (e.g., acute bronchitis), the definitive diagnosis is reported. If the patient arrives at the hospital for examination or testing without a referring diagnosis and cannot provide a complaint, symptom, or diagnosis, the hospital reports the encounter code that most accurately reflects the reason for the encounter.

Examples include:

- Z00.00 Encounter for general adult medical examination without abnormal findings*
- Z00.01 Encounter for general adult medical examination with abnormal findings*
- Z01.10 Encounter for examination of ears and hearing without abnormal findings*
- Z01.118 Encounter for examination of ears and hearing with other abnormal findings*

For outpatient claims, providers report the full diagnosis codes for up to 24 other diagnoses that coexisted in addition to the diagnosis reported as the principal diagnosis. For instance, if the patient is referred to a hospital for evaluation of hypertension and the medical record also documents diabetes, diabetes is reported as another diagnosis.

Additional information and training is available on CMS Web site:

<http://www.cms.gov/Medicare/Coding/ICD10/index.html>

10.4 - ICD Procedure Codes

Rev. 3081, Issued: 09-26-14, Effective: Upon Implementation of ICD -10, Implementation: Upon Implementation of ICD- 10)

ICD procedure codes are required for inpatient hospital Part A claims only. Healthcare Common Procedure Code System (HCPCS) codes are used for reporting procedures on other claim types. Inpatient hospital claims require reporting the principal procedure if a significant procedure occurred during the hospitalization. For information of the selection of the principal procedure, see the Official ICD-10-PCS coding guidelines posted with the annual updates to ICD-10-PCS posted at <http://www.cms.gov/Medicare/Coding/ICD10/index.html>

*The principal procedure code and other procedure codes shown on the bill **must** be the full ICD-9-CM, Volume 3, or ICD-10-PCS procedure code, including all applicable digits, up to seven digits.*

Up to twenty four significant procedures other than the principal procedure may be reported.

10.5 - Coding for Outpatient Services and Physician Offices

Rev. 3081, Issued: 09-26-14, Effective: Upon Implementation of ICD -10, Implementation: Upon Implementation of ICD- 10)

The Official ICD-10-CM Coding Guidelines include a section for Outpatient Services (hospital-based and physician office). These guidelines can be found in the annual updates to ICD-10-CM posted at <http://www.cms.gov/Medicare/Coding/ICD10/index.html>

Contractors, physicians, hospitals, and other health care providers must comply with the Official ICD-10-CM Coding Guidelines.

10.6 - Relationship of Diagnosis Codes and Date of Service

(Rev. 3081, Issued: 09-26-14, Effective: Upon Implementation of ICD -10, Implementation: Upon Implementation of ICD- 10)

Diagnosis codes must be reported based on the date of service (including, when applicable, the date of discharge) on the claim and not the date the claim is prepared or received. Medicare contractors are required to edit claims on this basis, including providing for annual updates each October. Shared systems must maintain date parameters for diagnosis editing. Use of actual effective and end dates is required when new diagnosis codes are issued or current codes become obsolete with the annual updates.

The Health Insurance Portability and Accountability Act (HIPAA) requires that medical code sets must be date-of-service compliant. Since ICD diagnosis codes are a medical code set, effective for dates of service on and after October 1, 2004, CMS does not provide any grace period for providers to use in billing discontinued diagnosis codes on Medicare claims. The updated codes are published in the Federal Register each year as part of the Proposed Changes to the Hospital Inpatient Prospective Payment Systems in table 6 and effective each October 1.

Medicare contractors will return claims containing a discontinued diagnosis code as unprocessable. For dates of service beginning October 1, 2004, physicians, practitioners, and suppliers must use the current and valid diagnosis code that is then in effect for the date of service. After the updated codes are published in the Federal Register, CMS places the new, revised and discontinued codes on the ICD-9 or ICD-10 Web site as applicable.

<http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/codes.html>

or

<http://www.cms.gov/Medicare/Coding/ICD10/index.html> .

The CMS sends the updated codes to contractors on an annual basis via a recurring update notification instruction. This is normally released to contractors each June, and contains the new, revised, and discontinued diagnosis codes which are effective for dates of service on and after October 1st.