ICD-10 Implementation Strategies and Planning
National Provider Call
Moderator: Leah Nguyen
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Podcast 3 of 4: NCVHS Meeting Update and
Medicare FFS Claims Processing, Billing, and Reporting Guidelines

Leah Nguyen: Welcome to the third of four podcasts from the National Provider Call on ICD-10 Implementation Strategies and Planning. This educational call was hosted by the CMS Provider Communications Group within the Center for Medicare on Thursday, November 17, 2011.

In this third podcast, Donna Picket from the Centers for Disease Control and Prevention gives an update on the National Committee on Vital Health Statistics Meeting on Provider and Vendor Readiness. Following this presentation, Sarah Shirey-Losso and Antoinette Johnson from the Center for Medicare, Provider Billing Group give a joint presentation on Medicare Fee-For-Service Claims Processing, Billing and Reporting Guidelines for ICD-10.

National Committee on Vital and Health Statistics (NCVHS) Meeting on Provider and Vendor Readiness

Leah Nguyen: We are also pleased to have with us today Donna Pickett, Medical Systems Administrator, Classifications and Public Health Data Standards, at the Centers for Disease Control and Prevention, with an update on the National Committee on Vital and Health Statistics (NCVHS) meetings on provider and vendor readiness.

Donna Pickett: Thank you. For those of you who are not familiar with the National Committee on Vital and Health Statistics, the NCVHS serves as an advisory body to the Department of Health and Human Services. It has a long history, roughly 60 years.

In 1996 the National Committee was restructured to meet expanded responsibilities under HIPAA. As part of those responsibilities, the National Committee has held hearings since 1996 on various aspects related to HIPAA standards, code sets, and transactions, including claims attachments, standards and operating rules, and other related issues. On June 17 this year, the National Committee held its second public hearing to review industry progress toward adoption of the updated version of the standards and code sets, namely, 5010 and ICD-10 code sets.

This hearing was attended by approximately 26 individuals representing a number of entities within the stakeholder industry: Federal agencies such as CMS and the Indian Health Service, health plans such as Blue Cross Blue Shield Association (the national association), AHIP, providers such as the American Medical Association and the American Hospital Association, as well as representatives from clearinghouses, vendors, other government entities, and State Medicaid agencies.

A number of cross-cutting observations and recommendations came out of the day-long discussions at this hearing. Slide 72 presents a high-level overview of some of these observations and recommendations.

Overall, testifiers expressed concern about both 5010 and ICD-10 industry readiness. One recommendation made was that Health and Human Services should use all communication vehicles to reiterate and emphasize that the

compliance dates are not changing, which you also heard earlier today from Pat Brooks and Elizabeth Reed.

It was also recommended that HHS should immediately make wide-scale announcements to industry stakeholders, association contacts, and others to more strongly encourage and foster testing between trading partners. This recommendation relates specifically to 5010, as its implementation date is January 2012.

On slide 73, I've listed a few ICD-10-specific observations from this hearing. The first, related to crosswalks and the general equivalence maps, is that there's an ongoing need, which will escalate, to educate people on the GEMs and crosswalking. You've just heard Nelly talk about those initiatives and the fact that excellent information has been provided at the ICD-9-CM Coordination and Maintenance Committee about the GEMs, and that information is still available on the CMS Web site.

Second, many testifiers indicated they would not be using GEMs or crosswalks, as they originally planned to do their conversion, but will natively start using the ICD-10 codes themselves, and not take the ICD-10 codes and translate them back to ICD-9-CM codes.

Another important issue that arose was that some testifiers expressed concern about the "explosion of proprietary and vendor provided crosswalks and GEMs," and its implications. It was suggested that additional discussion was needed to help the industry evaluate vendors and the quality of the products they are going to make available.

Slide 74 presents two additional key recommendations related to the GEMs and crosswalks. One is that HHS should work with associations to highlight the educational and resource information that is already available. We have already heard Nelly and Sue, representing AHA and AHIMA, describe the resources available from their organizations and on their Web sites. There is also a vast amount of information available on the CMS Web site.

Secondly, associations should solicit feedback from their constituents about the content and quality of available resources, so that modifications can be made to them during the 2011 and 2012 calendar years.

The NCVHS meeting also resulted in some observations and recommendations specific to ICD-10 (slide 75). Under "Resources," one of the observations was that there are uncertainties about the availability of an appropriate number of coders in the industry and their geographic location, making availability of trainers and coders a concern for some testifiers.

From this concern followed a recommendation that HHS collaborate with organizations such as AHIMA to assess the current levels of coders in the industry and the number of coders needed by 2013, identify potential gaps, and invest in expanding educational opportunities and resources to increase workforce capacity.

As shown on slide 76, it was also recommended that, per ACA provision, the National Committee hold additional hearings, either in late 2011 or early 2012, on potential areas where standardization will benefit the industry as a whole. These areas include adoption of HIPAA standards by entities who are not covered under HIPAA, such as workers compensation, auto insurance, and property and casualty. It is recommended that HHS encourage stakeholders in these entities to implement the transaction standards and code sets adopted under HIPAA not only to improve standardization, but also to bring the benefits that accrue under HIPAA to other users of the data, including those who are using coded data for their programs, such as workers compensation.

Slide 77 mentions how entities not covered under HIPAA are impacted by the transition to the new code set. Public health is not a covered entity. However, public health entities such as the CDC receive coded data (currently in ICD-9-CM) from providers, or use ICD-9-CM in their surveillance programs to code information captured from State and local governments and elsewhere. Thus, public health professionals also are concerned about the transition to the ICD-10 code sets.

CDC recognized these issues early on, so we formed a workgroup earlier this year to address them. Currently the workgroup includes approximately 21 members from across the agency. Approximately 90 programs within CDC will be affected by the transition to the new code sets, because they either code using ICD-9-CM or take in coded data from CDC partners and other programs.

Slide 79 lists the programs we've identified thus far. We will continue to do outreach to make sure we have identified any other programs that may be impacted by this transition. Part of the transition workgroup's goal is to disseminate information about the transition to ICD-10 code sets and to provide resources and tools to assist with that transition.

Within a month we will be conducting an agency-wide needs assessment survey to identify program needs, gaps, and other issues. This assessment will also draw from the experiences of programs within CDC that have already undertaken their implementation planning and have done their own needs assessment. We will look into partnering with agencies outside of CDC that have also begun these activities so we can gather lessons learned. The goal of this activity is to collect and share best practices and best solutions.

As you might understand, CDC and some other Federal agencies not directly involved in reimbursement issues have slightly different tools that don't necessarily touch on coverage determination or reimbursement issues. However, the codes are key to the functioning of many of the 90 programs I mentioned.

Slide 80 lists other steps the CDC has taken or will take related to the ICD-10 transition. We've already conducted webinars about preparation for the transition to the ICD-10 code sets. We are doing outreach to external partners, because they too will be affected, even though they are not HIPAA-covered entities but they too use code sets. We will also be doing outreach to vendors to see what aspects of their experience in preparing for hospital and health care transitions we can apply to the public health sector.

Slide 81 mentions three Web sites for those of you who are interested in additional information. The first one further describes the deliberations of the National Committee on Vital and Health Statistics, presenting all official NCVHS documents including meeting transcripts and presentations. This site also includes PowerPoint presentations given by testifiers at the committee meeting.

The CDC Web site contains the ICD-10-CM files and related materials, including the diagnosis general equivalence maps. If you access the diagnosis GEMs on the CDC page, you will also see links to the CMS page for PCS and other related materials. In fact, as Pat mentioned, we link to each other's Web sites for transparency and ease of access to the files.

The ICD-9-CM Coordination and Maintenance Committee Web site is also listed here. Information on diagnosis codes and the codes being proposed for ICD-10-CM is available on this site, as well as the full proposals and summaries and audio of the meeting proceedings.

With that, I will turn the microphone back to Leah.

Medicare Fee-for-Service Claims Processing, Billing, and Reporting Guidelines for ICD-10

Leah Nguyen: Thank you, Donna. Our final presentation—on Medicare Fee-For-Service claims processing, billing, and reporting guidelines for ICD-10 will be given by Sarah Shirey-Losso, Hospital Team Lead, and Antoinette Johnson, Health Insurance Specialist, both from the Center for Medicare, Provider Billing Group.

Sarah Shirey-Losso: Thanks, Leah. Before I turn the call over to Antoinette Johnson to speak about specific Medicare Fee-For-Service claims, I want to give an update on some more general ICD-10 activities we've been working on under Medicare Fee-For-Service claims processing.

Beginning this past January, and continuing each quarter until implementation, we're accomplishing various systems activities in analysis,

coding, design, and implementation. We've been diligently working on converting about 200 hard-coded Medicare Part A and Part B Fee-For-Service edits, working with our clinicians, using GEMs, and analyzing those edits to make sure they work the way they were intended to work when we were using ICD-9. We're also converting various tables and continue to expand internal files and screens for our claims processors.

With that, I'll turn it over to Antoinette.

Antoinette Johnson: Thank you, Sarah. During this portion of the call I will be providing a brief overview of the claims processing, billing, and reporting guidelines for ICD-10. As you all are aware, on October 1, 2013, all Medicare claims submissions with diagnoses and hospital inpatient procedure coding will change from ICD-9 to ICD-10.

This means all entities covered by HIPAA must make the transition, including any systems changes, throughout the entire health care industry. As stated earlier, all entities covered under HIPAA are therefore required to use ICD-10 code sets and standard transactions adopted under HIPAA for dates of service on and after October 1, 2013.

Slide 84 highlights the key components of CMS change request CR 7492, transmittal 950, issued August 19, 2011, which provided guidance on reporting diagnosis codes, claims submissions, and date span requirements for ICD-10 for Medicare Fee-For-Service claims. The change request outlines technical business requirements for our Medicare contractors as to how to code their systems in preparation for the implementation of ICD-10. For your convenience, on this slide we have provided a link to MLN Matters article 7492 for more detailed information.

Slide 85 outlines general reporting of ICD-10 codes. Providers and suppliers are still required to report all characters of a valid ICD-10 code on a claim. ICD-10 diagnoses codes have different rules regarding specificity, and providers and suppliers are required to submit the most specific diagnosis codes based on the information available at the time. In addition, regarding

procedure coding, ICD-10-PCS codes will only be used by inpatient hospital claims, as is currently the case with ICD-9 procedure codes.

Slide 86 provides details of submitting diagnosis codes on claims upon implementation of ICD-10. Some of the key points are:

- ICD-9 codes are no longer accepted on claims with dates of service October 1, 2013 and later.
- ICD-10 codes will not be recognized or accepted on claims before October 1, 2013.
- Claims cannot contain both ICD-9 codes and ICD-10 codes.
- If claims containing diagnosis codes are submitted incorrectly, institutional claims will be returned to the provider, and professional and supplier claims will be returned as unprocessable. Providers at that time may correct their claims with the appropriate ICD-9 or ICD-10 diagnosis code and resubmit.

Lastly, slide 87 provides guidance on claims for services that span the implementation date of October 1, 2013. In some cases, depending on the policies associated with those services, there cannot be a break in service with time—for instance, anesthesia services—although the new ICD-10 code set must be used effective October 1, 2013.

In our published guidance, we have direction on how to submit claims for inpatients as well as outpatients. For outpatient claims, we asked that you split the claim and use the "from" date. For inpatient claims, we asked that providers use the "through" date or the discharge date if services span the October 1 implementation date. Again, the provider article includes a detailed table that gives claims submission requirements by facility type, provider, and supplier, including special claims processing circumstances.

This concludes my portion of the presentation on Change Request 7492.

Leah Nguyen: Thank you for listening to this ICD-10 National Provider Call educational podcast. The information in this podcast was correct as of the date it was recorded. This podcast is not a legal document. Official Medicare program

legal guidance is contained in the relevant statutes, regulations, and rulings.

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