CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-15 Medicaid Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2	**Date: October 10, 2014**

SUBJECT: Update to Pub.: 100-15, Chapter 09, to Provide Language-Only Changes for Updating ICD-10

I. SUMMARY OF CHANGES: This Change Request contains language-only changes for updating ICD-10 language in Pub 100-15, Chapter 9. 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	09/9020.4/ Third Party Files
R	09/9030/ Policy, Clinical, and Technical Quality Assurance Process

III. FUNDING:

IV. ATTACHMENTS:

Manual Instruction

MEDICAID PROGRAM INTEGRITY MANUAL

CHAPTER 9 – DATA ANALYSIS

9020.4 – THIRD PARTY FILES

(Rev.2, Issued: 10-10-14, Effective: **Upon Implementation of ICD -10 Implementation: Upon Implementation of ICD -10)**

A. Drugs Files

The National Drug Data files provide prices, descriptions, and collateral clinical information on drugs approved by the US Food and Drug Administration (FDA), plus commonly used over the counter drugs.

B. National Correct Coding Initiative (NCCI)

The NCCI was developed by the CMS to promote national correct coding methodologies and to control improper coding leading to inappropriate payment. The Correct Coding Edits table and the Mutually Exclusive Edits table include code pairs that should not be reported together for reasons explained in the Coding Policy Manual.

C. The Current Procedural Terminology (CPT)

The CPT code set includes the codes, descriptions, and guidelines intended to describe procedures and services performed by physicians and other health care providers and are maintained by the American Medical Association.

D. Healthcare Common Procedure Coding System (HCPCS)

The HCPCS is a standardized coding system used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies.

E. Diagnosis Related Group (DRG)

The DRG is a system used to classify hospital cases into one of approximately 500 groups expected to have similar hospital resource use. Developed for Medicare as part of the prospective payment system, DRGs are assigned based on ICD diagnoses, procedures, age, sex, discharge status, and the presence of complications or comorbidities.

F. International Classification of Diseases

The International Statistical Classification of Diseases and Related Health Problems (most commonly known by the abbreviation ICD) provides codes to classify diseases and a wide variety of signs, symptoms, abnormal findings, complaints, social circumstances and external causes of injury or disease.

ICD-9 diagnoses and procedures, and related codes, are used for:

- *inpatient discharges with discharge dates before the implementation of ICD-10, and*
- *outpatient services with date of service before the implementation of ICD-10.*

ICD-10 diagnoses and procedures, and related codes, are used for:

- *inpatient discharges on or after the implementation of ICD-10, and*
- *outpatient services with date of service on or after the implementation of ICD-10.*

Information and guidance regarding *ICD-10* is available on the CMS website. In addition, informational bulletins, as well as other communication resources are shared with the States.

9030 – POLICY, CLINICAL, AND TECHNICAL QUALITY ASSURANCE PROCESS

(Rev.2, Issued: 10-10-14, Effective: **Upon Implementation of ICD -10 Implementation: Upon Implementation of ICD -10)**

Quality assurance is an integrated, ongoing component of MIG and Review MIC activities. With the DFRD as the lead, quality assurance is performed by the DFRD and the DAA for general surveillance and review of reports submitted by Review MICs and is a tool for identifying potential abnormalities or anticipating potential problems in audits. The quality assurance process analyzes claim information and other related data to verify potential errors in an algorithm or with its results.

During the development of the algorithm, a sample is sent to the State for validation. If the State finds issues in the sample, the Review MIC contacts the DFRD for guidance. The DFRD reviews the concerns and makes recommendations so a valid algorithm and an accurate Algorithm Findings Report (AFR) will be produced. The quality assurance process includes in-depth policy, clinical, and technical analysis used to confirm the findings contained in the AFR. The policy review looks at all Federal and State factors that may affect algorithm findings, while the clinical review analyzes the logic utilized to identify the medical diagnosis, treatment, services contained in the AFR. The technical review validates the programs in the header section, reviews the logic in the SAS code, and validates the Review MIC programming requirements.

Policy review of the AFR considers:

- State specific payment and coverage policies;
- State waivers, where applicable;

- State laws;
- Federal laws;
- Medical Coding or Classification policies; and
- State sample report validation or invalidation.

Clinical review of the AFR considers:

- Language;
- Medical coding and classification guidelines relating to the diagnoses and procedures within algorithms and or models under review;
- State specific payment policies and guidelines;
- Federal policies;
- Clarity;
- References;
- Citations;
- Congruency of the concept with State policy and regulations;
- Limitations and exceptions;
- Data anomalies; and
- Those recommendations are correlated with findings.

Technical review of the AFR consists of:

- Confirmation of the appropriate use of data based on concept description;
- Confirmation that the data is clinically based on concept description;
- Confirmation the output is consistent with defined policy in the concept description;
- Confirmation that the validity of the result findings coincides with what is written in the limitations, exclusions, and recommendation descriptions; and
- Confirmation of the accuracy of key fields in relation to the concept description such as:
    - National Drug Codes (NDC);
    - Current Procedural Terminology (CPT) codes;
    - Health Care Common Procedural Coding Systems (HCPCS) Codes;
    - Current Dental Procedures (CDT) Codes;
    - ICD diagnoses and procedure codes;
    - Adjudication dates;
    - Medicaid Paid Amounts;
    - Adjustment codes; and
    - Algorithm review under review dates