

6 things you need to know about the ICD-10 transition

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The Centers for Medicare & Medicaid Services (CMS) is making the transition to the ICD-10 code set more flexible, but there are several clarifying points physicians should know.

The flexibilities the AMA secured with CMS address claims processing and denials, quality reporting penalties, payment disruptions and navigating transition problems. Mainly, physicians should be aware that for the first year ICD-10 is in place, Medicare Part B claims will generally not be denied solely based on the specificity of the diagnosis codes as long as they are from the appropriate family of ICD-10 codes.

To answer questions about the code change, CMS issued a question-and-answer document. *AMA Wire*® has pulled together some of the highlights. The agency plans to issue further guidance specifically for physicians in the coming weeks.

- **ICD-10 will not be delayed.** The deadline to switch to ICD-10 remains Oct. 1, although CMS has agreed to flexibilities for Medicare Part B claims that should help make that transition smoother.
- **Medicare claims with a date of service on or after Oct. 1 will be rejected if they do not contain a valid ICD-10 code.** ICD-10-CM is composed of codes with between three and seven characters. Codes with three characters act as the heading of a category of codes and can either be further subdivided to provide greater specificity (which would add characters) or stand alone. For example, C81—Hodgkin’s lymphoma—cannot stand alone and is not a valid code. But it can be further subdivided into C81.00 (nodular lymphocyte predominant Hodgkin lymphoma, unspecified site), C81.03 (nodular lymphocyte predominant Hodgkin lymphoma, intra-abdominal lymph nodes) or a few other options. In this example, using any one of the valid codes for Hodgkin’s lymphoma would **not** be cause for a rejected claim or an audit under the recently announced flexibilities for Medicare Part B claims. A complete list of valid codes and code titles is on the CMS website and listed in tabular order, the same order in the ICD-10-CM codebook.

A “family of codes” is the ICD-10 three-character category. Codes within a category are clinically related and provide differences in capturing specific information on the type of condition. For example, category H25—age-related cataract—contains a number of specific codes that captures information about the type of cataract and information on the eye involved. With few exceptions (described in more detail below), Medicare Part B claims will not be denied or subject to an audit solely based on the specificity of the diagnosis codes as long as they are from the appropriate family of ICD-10 codes.

Certain claims fall outside of the coding flexibility. In certain circumstances, a claim may be denied because the ICD-10 code is not consistent with an applicable policy, such as Local Coverage Determinations or National Coverage Determinations. Check CMS’ document for more information.

These flexibilities do not extend to prior authorization requests. The flexibilities only pertain to claims processing and post-payment reviews. ICD-10 codes with the correct level of specificity will be required for prepayment reviews and prior authorization.

CMS’ changes do not affect Medicaid or commercial payers. The official guidance only applies to Medicare fee-for-service claims from claims by physicians and other practitioners that are billed under the Medicare Fee-For-Service Part B physician fee schedule. It does not apply to claims submitted for beneficiaries with Medicaid coverage. Check CMS’ document for more information. The AMA continues to seek similar commitments from major commercial firms.

More ways to prepare

Although physicians now have the yearlong transition period, you should still make sure your practice is as prepared as possible ahead of Oct. 1.

CMS will host a call for physicians preparing for ICD-10 from 2:30 to 4 p.m. Eastern time Aug. 27. Experts will discuss coding guidance and tips, answers to coding questions, information about claims that span before and after the implementation date, and resources. Register online.

Additional important resources that can help you get ready over the next three months include:

- | A special series at *AMA Wire*® examines what you need to do each month to prepare for the transition, whether you’re an ICD-10 expert or just getting started.

- | Additional ICD-10 content at *AMA Wire* provides important insights for what you need to know about the new code set.

- | The AMA’s ICD-10 Web page offers important information and resources on implementation planning, from cross-walking between ICD-9 and ICD-10 to testing your readiness.

- | CMS also is offering free assistance, including its “Road to 10” website aimed specifically at smaller physician practices. This collection includes primers for clinical documentation, clinical scenarios and other specialty-specific resources to help with implementation. Read



more about the agency's resource offerings.