DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Medicare
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ICD-10-CM/PCS BILLING AND PAYMENT
FREQUENTLY ASKED QUESTIONS

Please note: The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).

This publication provides the following information on the International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS):
- ❖ Frequently Asked Questions; and
- ❖ Resources.

FREQUENTLY ASKED QUESTIONS

Will International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) codes be accepted on claims with FROM dates of service or dates of discharge/THROUGH dates on or after October 1, 2015?

No. ICD-9-CM codes will no longer be accepted on both electronic and paper claims with FROM dates of service (on professional and supplier claims) or dates of discharge/THROUGH dates (on institutional claims) on or after October 1, 2015.

What will happen to institutional, professional, and supplier claims that contain ICD-9-CM codes for services on or after October 1, 2015?

Claims that contain ICD-9-CM codes for services on or after October 1, 2015, will be handled as follows:
- ❖ Direct data entry institutional claims – Returned to provider (RTP);
- ❖ Paper professional and supplier claims – Returned as unprocessable; and
- ❖ Electronic institutional, professional, and supplier claims – Rejected.

Billers whose paper or electronic claims are returned or rejected for an invalid diagnosis code may correct and resubmit those claims. You will receive a letter of explanation or a Remittance Advice that provides information about claim errors. After the claim has been corrected, you must resubmit it as a new claim within the timely filing period. Claims that have been returned as unprocessable may not be appealed.

You may appeal initial claim determinations, including denials, if you are dissatisfied with the claim determination and file a timely appeal request that contains the necessary information needed to process the request.

If a denial is due to a minor error or omission you made in filing a claim, you may request a reopening to correct such clerical errors. A reopening is separate and distinct from the appeals process. After the claim has been corrected, you must resubmit it within the timely filing period.

Can a claim contain both ICD-9-CM and ICD-10-CM/PCS codes?

No. A claim cannot contain both ICD-9-CM and ICD-10-CM/PCS codes. Medicare will RTP/return as unprocessable all claims billed with both ICD-9-CM and ICD-10-CM/PCS diagnosis and procedure codes on the same claim. For more information about split claims billing, refer to the following MLN Matters® articles:
- ❖ "Medicare Fee-For-Service (FFS) Claims Processing Guidance for Implementing International Classification of Diseases, 10th Edition (ICD-10) – A Re-Issue of MM7492" located at http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/SE1408.pdf on the Centers for Medicare & Medicaid Services (CMS) website; and
- ❖ "Institutional Services Split Claims Billing Instructions for Medicare Fee-For-Service (FFS) Claims that Span the International Classification of Diseases, 10th Edition (ICD-10) Implementation Date" located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1325.pdf on the CMS website.

Will providers be able to use ICD-10-CM/PCS codes on claims prior to the October 1, 2015, implementation date?

No. Providers may only use ICD-10-CM/PCS codes for services furnished on or after October 1, 2015. Claims that contain ICD-10-CM/PCS codes for services furnished prior to October 1, 2015, will be returned as unprocessable. You must submit claims for services furnished prior to October 1, 2015, with the appropriate ICD-9-CM code. For more information, refer to the MLN Matters® articles referenced above.

How should claims be handled when they are split for an outpatient encounter spanning the October 1, 2015, ICD-10 implementation date?

You must separately bill claims for services furnished prior to October 1, 2015, from claims for services furnished on or after October 1, 2015. When claims are split for an encounter spanning the ICD-10 implementation date, you must maintain all charges with the same Line Item Date of Service (LIDOS) on the correct corresponding claim for the encounter. You must not split single item services whose timeframes cross over midnight on September 30, 2015, into two separate charges. Instead, you must place the single item service in the claim based upon the LIDOS as follows:
- ❖ Emergency room (ER) encounters – Date the patient enters the ER; and
- ❖ Observation encounters – Date observation care begins.

For more information, refer to the MLN Matters® articles referenced above.

If there is no service for the encounter with a LIDOS on the split claim, should I send an October 2015 claim to Medicare for payment?

No. If there is no service for the encounter with a LIDOS on the split claim with an October 2015 date, you should not send an October 2015 claim to Medicare for payment. No payment is allowed on any of the charges because all charges are packaged. You must maintain a log of these charges for cost reporting purposes. For more information, refer to the split claims billing MLN Matters® article referenced on the previous page.

Will my payment under ICD-10 be the same as the payment I currently receive under ICD-9?

Hospitals – A fiscal year 2015 study conducted on the impact of converting Medicare Severity Diagnosis-Related Groups (MS-DRGs) to ICD-10 found that moving from an ICD-9-CM-based system to an ICD-10 MS-DRG replicated system resulted in a statistically zero impact on payment. Ninety-nine percent of the records did not shift to another MS-DRG when using an ICD-10 MS-DRG system. For the 1 percent of records that shifted, 41 percent were to a higher weighted MS-DRG and 66 percent were to a lower weighted MS-DRG. The net impact across all MS-DRGs was a reduction by 4/10000 or minus 4 cents per $100, which is statistically zero impact. For more information about this study, refer to "Converting MS-DRGs to ICD-10-CM and ICD-10-PCS – Updated 03/03/15 With New 2015 Impact Article" located in the Downloads section at http://www.cms.gov/Medicare/Coding/ICD10/ICD-10-MS-DRG-Conversion-Project.html on the CMS website.

Professional and supplier claims – Payment is based on the Healthcare Common Procedure Coding System (HCPCS) code and under ICD-10-CM, payment will also be based on the HCPCS code. A claim could be denied if the diagnosis does not warrant payment for the procedure. You should consult the appropriate payment policy, National Coverage Determination (NCD), or Local Coverage Determination (LCD) pertaining to the service you wish to bill to determine whether there are any changes to diagnosis code reporting requirements. You should also consult the 2015 payment rules and the forthcoming 2016 payment rules for ICD-10-CM impacts.

Will the NCD/LCD conversion be completed in time for the ICD-10 October 1, 2015, implementation date?

CMS has completed modifications to its claims processing systems to report the appropriate NCD/LCD captured during claims processing based on their association with either ICD-9-CM or ICD-10-CM/PCS diagnosis codes, the claim line service date, and the ICD-10-CM/PCS diagnosis code effective date. For information about NCD conversions, visit http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html on the CMS website.

When will the LCDs be converted and available in the Medicare Coverage Database (MCD)?

All ICD-10-CM/PCS LCDs were converted and published in April 2014. All associated ICD-10-CM/PCS articles were published in the MCD in September 2014.

When ICD-10-CM codes replace ICD-9-CM codes on October 1, 2015, will it impact how I report Current Procedural Terminology (CPT) and HCPCS codes?

No. When ICD-10-CM codes replace ICD-9-CM codes on October 1, 2015, it will not impact how you report CPT and HCPCS codes, including CPT/HCPCS modifiers for physician services. While ICD-10-CM codes have expanded detail, including specification of laterality for some conditions, you should continue to follow CPT and CMS guidance when you report CPT/HCPCS modifiers for laterality.

I have Certificates of Medical Necessity (CMNs) for patients that contain ICD-9 diagnosis codes. Do I need to submit new CMNs with ICD-10 codes for claims submitted after the transition to ICD-10?

CMS is not requiring suppliers to submit updated CMNs for claims submitted on or after the ICD-10 implementation date of October 1, 2015; however, these claims must contain a valid ICD-10 diagnosis code. CMNs created after the transition to ICD-10 must use ICD-10 codes. Suppliers should ensure that the diagnosis code(s) billed on the claim are supported by documentation in the medical record.

After ICD-10 implementation, how should pharmacies handle prescriptions with ICD-9 codes that were written prior to the implementation date?

When filling prescriptions that were written prior to the ICD-10 implementation date of October 1, 2015, pharmacies have the option to use the ICD-10-CM reimbursement mappings located at http://www.cms.gov/Medicare/Coding/ICD10/2015-ICD-10-CM-and-GEMs.html and the ICD-10-PCS reimbursement mappings located at http://www.cms.gov/Medicare/Coding/ICD10/2015-ICD-10-PCS-and-GEMs.html on the CMS website to translate ICD-9 codes into ICD-10. New prescriptions written after the transition to ICD-10 must use ICD-10 codes.

How should I submit claims with Home Health (HH) episodes that span the ICD-10 implementation date?

Medicare requires the use of ICD-10 codes on HH claims and Requests for Anticipated Payment (RAPs) with a THROUGH date on or after October 1, 2015. Since HH claims are submitted for a 60-day payment episode, there may be cases where an episode spans October 1. In these cases, the RAP for an episode will be submitted using ICD-9 codes and the corresponding claim will be submitted using ICD-10 codes. For more information about coding HH episodes that span the ICD-10 implementation date, refer to the MLN Matters® article titled "Special Instructions for the International Classification of Diseases, Clinical Modification 10th Edition (ICD-10-CM) Coding on Home Health Episodes that Span October 1, 2015" located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1410.pdf on the CMS website. Medicare does not require ICD-10 coding of these episodes in advance of the ICD-10 implementation date. Home Health Agencies should determine whether identifying the ICD-10 codes in advance will benefit them.

If patients have recurring appointments for physical therapy, occupational therapy, or speech-language pathology services that will continue after ICD-10 implementation, will new orders with ICD-10 codes be required?

In cases where physician or qualified non-physician practitioner orders are applicable to rehabilitation services furnished under CMS programs, CMS is not requiring updated orders to continue rehabilitation services after ICD-10 implementation on October 1, 2015; however, these claims must contain a valid ICD-10 diagnosis code. Physicians will need to provide the appropriate ICD-10 code to the therapist for these claims. Orders created after the transition to ICD-10 must use ICD-10 codes.

Will CMS allow for dual processing of ICD-9 and ICD-10 codes (accept and process both ICD-9 and ICD-10 codes for dates of service on and after October 1, 2015)?

No, CMS will not allow for dual processing of ICD-9 and ICD-10 codes after ICD-10 implementation on October 1, 2015. Many providers and payers, including Medicare, have already coded their systems to only allow ICD-10 codes beginning October 1, 2015. The scope of systems changes and testing needed to allow for dual processing would require significant resources and could not be accomplished by the October 1, 2015, implementation date. Should CMS allow for dual processing, it would force all entities with which we share data, including our trading partners, to also allow for dual processing. In addition, having a mix of ICD-9 and ICD-10 codes in the same year would have major ramifications for CMS quality, demonstration, and risk adjustment programs.

RESOURCES

The chart below provides ICD-10-CM/PCS resource information.

For More Information About…	Resource
ICD-10-CM/PCS	http://www.cms.gov/Medicare/Coding/ICD10/index.html on the CMS website
ICD-10-CM/PCS Information for Medicare Fee-For-Service Providers	http://www.cms.gov/Medicare/Coding/ICD10/Medicare-Fee-For-Service-Provider-Resources.html on the CMS website
ICD-10-CM/PCS Provider Resources	http://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html on the CMS website
ICD-10-CM/PCS Statute and Regulations	http://www.cms.gov/Medicare/Coding/ICD10/Statute_Regulations.html on the CMS website
All Available Medicare Learning Network® (MLN) Products	"MLN Catalog" located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNCatalog.pdf on the CMS website or scan the Quick Response (QR) code on the right
Provider-Specific Medicare Information	MLN publication titled "MLN Guided Pathways: Provider Specific Medicare Resources" booklet located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Provider_Specific_Booklet.pdf on the CMS website
Medicare Information for Patients	http://www.medicare.gov on the CMS website

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