August 2015

Sharing our response to CMS/AMA guidance about ICD-10

As you may know, on July 6, 2015, Centers for Medicare & Medicaid Services (CMS) and the American Medical Association (AMA) announced efforts to help providers prepare for ICD-10. They published guidance that will allow for flexibility in the claims auditing and quality reporting process. This will help as the medical community gets used to the new ICD-10 code set.

We categorized their guidance into the four areas described below. Please see our comments/explanation to each.

Claims denials

CMS guidance: "While diagnosis coding to the correct level of specificity is the goal for all claims, for 12 months after ICD-10 implementation, Medicare review contractors will not deny physician or other practitioner claims billed under the Part B physician fee schedule, through either automated medical review or complex medical record review based solely on the specificity of the ICD-10 diagnosis code, as long as the physician/practitioner used a valid code from the right family. However, a valid ICD-10 code will be required on all claims starting on October 1, 2015," as CMS stated in a guidance document.

Our response: Since the July 6, 2015 CMS/AMA joint announcement, we received many questions related to claim denials. The July 27, 2015 CMS document clarified some of these questions. To summarize the guidance:

- The ICD-10 compliance date hasn't changed. For dates of service of October 1, 2015 and after, you should use ICD-10 codes in all transactions where ICD coding is required.
- There isn't a "grace period" associated with this change. CMS won't allow the use of ICD-9 codes for dates of service after October 1, 2015.
- All policies that we apply during the claims payment process won't change, other than a conversion to the ICD-10 code set.
- The 12-month audit and quality flexibility pertains only to post-payment review programs. Medicare review contractors administer these programs. They relate to Part B physician claims only.

Quality reporting and other penalties

CMS guidance: "For all quality reporting completed for program year 2015, Medicare clinical quality data review contractors will not subject physicians or other Eligible Professionals (EP) to the Physician Quality Reporting System (PQRS), Value Based Modifier (VBM), or Meaningful Use 2 (MU) penalty during primary source verification or auditing related to the additional specificity of the ICD-10 diagnosis code, as long as the physician/EP used a code from the correct family of codes. Furthermore, an EP will not be subjected to a penalty if CMS experiences difficulty calculating the quality scores for PQRS, VBM, or MU due to the transition to ICD-10 codes."

Our response: The PQRS encourages individual EPs and group practices to report information on the quality of care to Medicare. PQRS gives participating EPs and group practices the chance to assess the quality of care they provide to patients. The participating EPs who successfully report data qualify for the PQRS incentive payment.

We process and issue PQRS incentive payments to non-contracted physicians based on the data included on the files CMS sends us. The ICD-10 transition should have no effect on this process. We'll keep following CMS guidance as we get more clarity about their statements and policies.

Payment disruptions

CMS guidance: "When the Part B Medicare Contractors are unable to process claims within established time limits because of administrative problems, such as contractor system malfunction or implementation problems, an advance payment may be available. An advance payment is a conditional partial payment, which requires repayment, and may be issued when the conditions described in CMS regulations at 42 CFR Section 421.214 are met."

Our response: While Medicare may be making advanced payments available if Part B Medicare contractors aren't able to process claims within established time limits due to administrative issues, we don't plan on taking such action. Based on results from our extensive provider testing, we're confident that this won't be necessary.

Help with the transition

CMS guidance: "CMS understands that moving to ICD-10 is bringing significant changes to the provider community. CMS will set up a communication and collaboration center for monitoring the implementation of ICD-10. This center will quickly identify and initiate resolution of issues that arise as a result of the transition to ICD-10. As part of the center, CMS will have an ICD-10 Ombudsman to help receive and triage physician and provider issues."

Our response: We've been preparing for the upgrade for many years and will be ready to support ICD-10 on the compliance date. If you find that you have a problem or concern after the change, call us at the phone numbers below.

We'll be closely monitoring claim metrics that will give us early insight to help us find any intake, claim or service issues. This will help us respond to you quickly and fix any issues. Of course, we'll keep following guidance from the Department of Health and Human Services and CMS. We'll also continue to work closely with providers and clearinghouses to share information. We plan to have all of our systems, vendor tools and business processes and policies ready for October 1, 2015.

Resources/how you can learn more

- We created several webinars to help you. These give an overview of our testing, including our approach, results and lessons learned. On the education site, type "collaborative" in the search box.

- You can also check our dedicated ICD-10 page. As we progress, we'll update our site with current information.

- Be sure to check out CMS' free help, which includes the "Road to 10." This is for smaller physician practices. The "Road to 10" has primers for clinical documentation, clinical scenarios

and other specialty-specific resources to help with implementation. CMS also released provider training videos that offer helpful tips.

We're here to help

If you have questions, just call us at:

- **1-800-624-0756** for HMO-based and Medicare Advantage plans
- **1-888-MDAetna (1-888-632-3862)** for all other plans

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