Ohio Department of Medicaid

ICD-10 TIPS

ICD-10 Transition Information for Providers & Staff

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> Subject
The Ohio Department of Medicaid's (ODM) Understanding of the Centers for Medicare and Medicaid Services (CMS) and American Medical Association (AMA) Joint Announcement and Subsequent Guidance on ICD-10 Flexibilities

> Providers Types Impacted
All Providers Enrolled with Medicare and/or Ohio Medicaid

> Description
The transition to ICD-10 is required for everyone covered by the Health Insurance Portability and Accountability Act (HIPAA). Claims with a date of service or discharge on or after October 1, 2015 will only be accepted if they contain a valid ICD-10 code. The July 6, 2015 CMS/AMA joint announcement and subsequent guidance speaks to ICD-10 flexibility with Medicare claims. Medicare is offering flexibility in claims auditing and quality reporting processes. Medicare will not deny claims based solely on the specificity of the ICD-10 diagnosis code as long as the provider uses a valid ICD-10 code from the right 'family of codes.' While ODM only conducts a limited amount of claims editing and auditing with ICD, ODM will be validating that the ICD-10 codes submitted by providers are truly valid ICD-10 codes.

CMS recognizes that this is a significant transition to a larger set of diagnosis coding for use to the correct level of specificity on day one, October 1, 2015, so for the first 12 months CMS has instructed in Medicare Administrative Contractors (MACs) to not deny physician or other practitioner claims billed under the Part B physician fee schedule through their automated review or complex medical record review based solely on the specificity of the ICD-10 diagnosis code as long as the physician/practitioner uses a valid code from the right family of codes.

A 'family of codes' is the same as the ICD-10 diagnosis three-character category. Codes within a category are clinically related and provide differences in capturing specific information on the type of condition. For example, K50 (Crohn's disease) has codes within the category that require varying numbers of characters to be valid. The ICD-10 diagnosis codebook clearly provides information on valid codes within this, and other categories. And if in doubt, providers can check the list of valid 2016 ICD-10 diagnosis codes to determine if all characters have been selected and reported. A 'family of codes' is the same as the ICD-10 diagnosis three-character category. Codes within a category are clinically related and provide differences in capturing specific information on the type of condition. Providers are encouraged to check the list of valid 2016 ICD-10 diagnosis codes to determine if all characters have been selected and reported.

Examples of valid codes within category K50 include:

K50.00 Crohn's disease of small intestine without complications
K50.012 Crohn's disease of small intestine with intestinal obstruction
K50.90 Crohn's disease, unspecified, without complications

To include the Crohn's disease diagnosis on the claim, a valid code must be selected. If the paid claim were to be selected later for audit, the CMS Guidance makes it clear that the claim would not be denied because the wrong code was included, so long as the code was in the same family. In other words, if the selected code is within the K50 family, then the audit flexibility applies.

Please note ICD-10 procedure codes will not replace the Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) procedure code sets. ICD-10 procedure codes will only be used to report hospital inpatient procedures. CPT and HCPCS procedures codes will continue to be used to report services and procedures in outpatient and professional settings. For example, when billing ODM for pregnancy related services, providers bill the appropriate CPT code(s) specified in Ohio Administrative Code rule 5160-4-10 with the modifier "TH" to indicate that obstetrical, prenatal or post-partum services, were provided. In addition, providers bill the appropriate ICD-9 diagnosis code to indicate that the diagnosis is for antepartum care (e.g., V22, V23, or V28). After ICD-10 is implemented on October 1, 2015, providers will continue to bill CPT codes as specified above, but will indicate that the diagnosis is for antepartum care using the appropriate ICD-10 code(s).

A complete list of valid 2016 ICD-10 diagnosis and procedure codes along with the July 6, 2015 CMS/AMA joint announcement and subsequent guidance is posted at CMS's ICD-10 website (https://www.cms.gov/Medicare/Coding/ICD10/index.html?redirect=/ICD10).

> Managed Care Considerations

This *ICD-10 TIPS* applies to **ONLY fee-for-service billing**. If you are enrolled with a managed care plan, please contact the plan directly for their billing requirements.