Healthcare IT News

ICD-10: CMS won't deny claims for first year

The Centers for Medicare & Medicaid Services has agreed to adopt four AMA proposals regarding the code set conversion

July 6, 2015 – Healthcare IT News – In a surprise concession, the Centers for Medicare & Medicaid Services announced Monday that it would work with the American Medical Association on four steps designed to ease the transition to ICD-10.

Despite longtime disagreements on the topic, CMS will now adopt suggestions made by none other than the AMA with regard to the code set conversion. Those changes concern:

1. Claims denials. "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," CMS officials wrote in a guidance document.

2. Quality reporting and other penalties. "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," CMS explained. "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."

3. Payment disruptions. "If Medicare contractors are unable to process claims as a result of problems with ICD-10, CMS will authorize advance payments to physicians," AMA president Steven Stack, MD, noted in a viewpoint piece on the group's website.

4. Navigating transition problems. CMS intends to create a communication center of sorts, including an ICD-10 Ombudsman, "to help receive and triage physician and provider issues." The center will also "identify and initiate" resolution of issues caused by the new code sets, officials added.

"These provisions are a culmination of vigorous efforts to convince the agency of the need for a transition period to avoid financial disruptions during this time of tremendous change," wrote Stack.

While AMA played a pivotal role in bringing about these CMS concessions, it was not the only party calling for a smoother conversion to the new code set. Some members of the U.S. Congress have publicly suggested a dual-coding conversion period wherein CMS would accept and process claims in both ICD-9 and ICD-10. Instead of dual coding, CMS indicated that "a valid ICD-10 code will be required on all claims starting Oct. 1, 2015."

So as things stand today, providers have to use ICD-10 come October – but CMS will be more flexible about denials and payments than it has previously suggested it would be.

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