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Centers for Medicare & Medicaid Services



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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

Note: This article was revised on August 1, 2014, to show the new ICD-10 implementation date of October 1, 2015. All other information is unchanged.

Provider Types Affected

This MLN Matters® Article is intended for physicians, providers, suppliers, and other covered entities who submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries in home health (HH) care settings.

Provider Action Needed

This MLN Matters® Special Edition (SE) 1410 alerts providers that on October 1, 2015, all Medicare claims submissions of diagnosis codes will change from the International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) to the 10th Edition (ICD-10-CM). All entities covered by the Health Insurance Portability and Accountability Act (HIPAA) must make this transition requiring systems changes throughout the entire health care industry.

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Background

In 2011, the Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 7492, which provided information on reporting guidelines and claims submissions requirements for ICD-10-CM. Particularly, CR 7492 provided instructions regarding claims with service dates that span the ICD-10 effective date. Recently, CMS issued an updated article (SE1408) at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1408.pdf>, which provides special billing instructions for home health agencies (HHAs) to apply to HH claims where the episode begins in August or September 2015 and ends in October 2015. MLN Matters® Article SE1408 also provides details for coding other types of claims for services that span the ICD-10 implementation date of October 1, 2015. This article provides further details regarding HH claims for episodes that span the October 1 date.

Key Points of This Article

Three factors affect how ICD-10-CM must be used on these episodes for services that span the October 1 date:

1. The claim “From” date (episode start date);
2. The Outcome and Assessment Information Set (OASIS) assessment completion date (OASIS item M0090 date); and
3. The claim “Through” date.

Episodes Starting Before October 1, 2015, with OASIS Completion Dates Before October 1, 2015

In the case of initial HH episodes, the OASIS assessment must be completed within 5 days of the start of care. The assessment completion date (M0090 date) determines whether the HH Grouper software that determines the payment group for the episode will apply ICD-9-CM or ICD-10-CM codes to the episode. In the case where the episode start of care date is before October 1, 2015 and the M0090 date is also before October 1, 2015, ICD-9-CM codes will be used on the OASIS and to determine the payment group code (the Health Insurance Prospective Payment System (HIPPS) code).

For HH claims (type of bill 032x), ICD-10-CM reporting is required based on the claim “Through” date. On Requests for Anticipated Payment (RAPs), Medicare billing instructions require that the “From” and “Through” dates are the same. So if the episode begins in September 2015, the “From” and “Through” dates on the RAP would report the same date in September. These RAPs would report ICD-9-CM diagnosis codes using codes matching the OASIS assessment.

If the HH episode spans into October 2015, the corresponding final claim for the episode will be required to report ICD-10-CM codes. HH claims cannot be split into periods before and after October 1, 2015, so these claims will have claim “Through” dates of October 1,

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2015, or later. The HIPPS code on the final claim must match the HIPPS code that was reported on the RAP. The HIPPS code on the RAP was based on the ICD-9-CM codes matching the OASIS assessment.

CR 7492 stated that CMS will:

“Allow HHAs to use the payment group code derived from ICD-9-CM codes on claims which span 10/1, but require those claims to be submitted using ICD-10-CM codes.”

This means that HHAs do not have to re-group the episode based the ICD-10-CM codes. But this could result in some inconsistency between the HIPPS code and the ICD-10-CM codes on the claim. CMS will alert medical reviewers at our MACs to ensure that the ICD-10-CM codes on these claims are not used in making determinations. CMS will also alert researchers using CMS data files of this inconsistency. The coding used to support the payment of the HIPPS code will be the ICD-9-CM codes that were used on the RAP and which are stored in the OASIS system.

These same procedures will apply to resumption of care assessments (M0100 = 03) and to recertification (M0100 = 04) and follow-up (M0100 = 05) assessments when the episode start date and the M0090 date on those assessments are both before October 1, 2015 but the episode ends in October 2015 (see table below).

Episodes Starting Before October 1, 2015, with OASIS Completion Dates in October 2015

There may be cases where the episode start of care date is before October 1, 2015, and, due to the 5 day completion window, the M0090 date is in October 2015. For example, an initial episode with a start of care date of September 28, 2015, could have an M0090 date of October 2, 2015. In these cases, ICD-10-CM codes will be used on the OASIS and to determine the HIPPS code.

The RAP for this example would have “From” and “Through” dates of September 28, 2015. As a result, these RAPs would need to report ICD-9-CM diagnosis codes even though ICD-10-CM codes were used on the OASIS assessment.

Since RAPs are not subject to medical review and are replaced in Medicare claims history by the final claim, there is no need to account for adverse impacts in these situations. The ICD-9-CM codes are required in order for the RAP to be processed. The corresponding final claim for the episode will report ICD-10-CM codes matching the OASIS assessment.

Recertification Episodes Beginning in the First Days of October 2015

In the case of recertification episodes, the M0090 date can be up to 5 days earlier than the episode start date. So, a recertification episode starting on October 2, 2015, could have an M0090 date of September 28, 2015. ICD-9-CM codes are used on the OASIS assessment and will be used to determine the HIPPS code. But in this case, both the RAP and claim will require ICD-10-CM codes since the “Through” date on both will be after October 1, 2015.

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The coding used to support the payment of the HIPPS code will be the ICD-9-CM codes which are stored in the OASIS system. In these cases also, CMS will alert medical reviewers at our MACs and researchers using CMS data files to prevent adverse impacts.

The following table summarizes the above scenarios:

Type of OASIS Assessment	RAP "From/Through" Dates	OASIS M0090 Date/OASIS Version	Claim "Through" Date	Diagnosis Coding Used on OASIS	Diagnosis Coding Used on RAP	Diagnosis Coding Used on Claim
Start of Care/Resumption of Care	9/28/2015	9/30/2015 OASIS-C	11/26/2015	ICD-9-CM	ICD-9-CM	ICD-10-CM
Recertification	9/28/2015	9/25/2015 OASIS-C	11/26/2015	ICD-9-CM	ICD-9-CM	ICD-10-CM
Start of Care/Resumption of Care	9/28/2015	10/2/2015 OASIS-C1	11/26/2015	ICD-10-CM	ICD-9-CM	ICD-10-CM
Recertification	10/2/2015	9/28/2015 OASIS-C	11/30/2015	ICD-9-CM	ICD-10-CM	ICD-10-CM

Additional Information

To find additional information about ICD-10, visit <http://www.cms.gov/Medicare/Coding/ICD10/index.html> on the CMS website.

The ICD-10-related implementation date is now October 1, 2015.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html> under - How Does It Work.

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