Special Instructions for the International Classification of Diseases, Clinical Modification 10th Edition (ICD-10-CM) Coding on Home Health Episodes that Span October 1, 2014

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, 2014 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.
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](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 2014 and ends in October 2014. 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, 2014. 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, 2014 with OASIS Completion Dates Before October 1, 2014

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, 2014 and the M0090 date is also before October 1, 2014, 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 2014, 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 2014, 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, 2014, so these claims will have claim “Through” dates of October 1, 2014 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 does not mean that all episodes must be re-coded under ICD-10-CM. CMS intends to avoid any extra burden that could result from requiring HHAs to code these episodes under both the ICD-9-CM and ICD-10-CM systems. To avoid that, we advise HHAs to use the General Equivalence Mappings (GEMs) or other convenient translation tables to derive ICD-10-CM codes for use on claims for episodes that span October 1, 2014. 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.

This may result in some inconsistency between the HIPPS code on the claim and the ICD-10-CM codes. 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.

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, 2014 but the episode ends in October 2014 (see table below).

**Episodes Starting Before October 1, 2014 with OASIS Completion Dates in October 2014**

There may be cases where the episode start of care date is before October 1, 2014 and, due to the 5 day completion window, the M0090 date is in October 2014. For example, an initial episode with a start of care date of September 28, 2014 could have an M0090 date of October 2, 2014. 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, 2014. 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.

As with the previous category of episodes that span October 1, CMS does not require these cases to be coded in both systems. We again advise that HHAs use the GEMs or other convenient translation tables to derive ICD-9-CM codes for use on the RAPs for episodes. 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 simply 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 2014**

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, 2014 could have an M0090 date of September 28, 2014. 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, 2014. HHAs will use the GEMs or other convenient translation tables to derive ICD-10-CM codes for use on these RAPs and claims.

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:

<table>
<thead>
<tr>
<th>Type of OASIS Assessment</th>
<th>RAP “From/ Through” Dates</th>
<th>OASIS M0090 Date/OASIS Version</th>
<th>Claim “Through” Date</th>
<th>Diagnosis Coding Used on OASIS</th>
<th>Diagnosis Coding Used on RAP</th>
<th>Diagnosis Coding Used on Claim</th>
</tr>
</thead>
</table>

To access the GEMs, you may go to http://www.cms.gov/Medicare/Coding/ICD10/2014-ICD-10-CM-CM-and-GEMs.html on the CMS website.

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, 2014, as announced in final rule CMS-0040-F issued on August 24, 2012. This final rule is available at http://www.cms.gov/Medicare/Coding/ICD10/Statute_Regulations.html on CMS website.

If you have any questions, please contact your MAC at their toll-free number, which is available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

CPT only copyright 2013 American Medical Association.