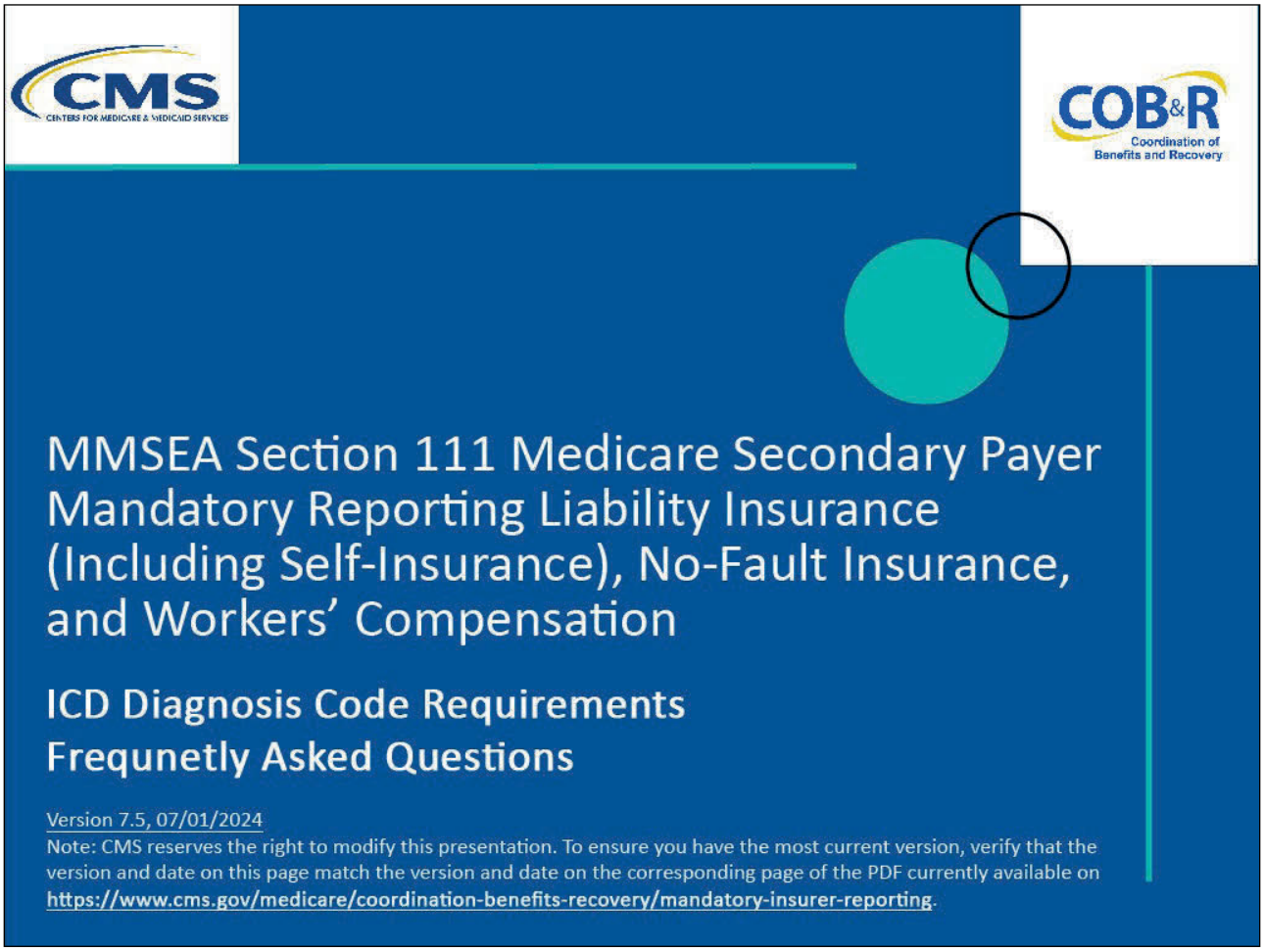
ICD Diagnosis Code Requirements Introduction - Frequently Asked Questions

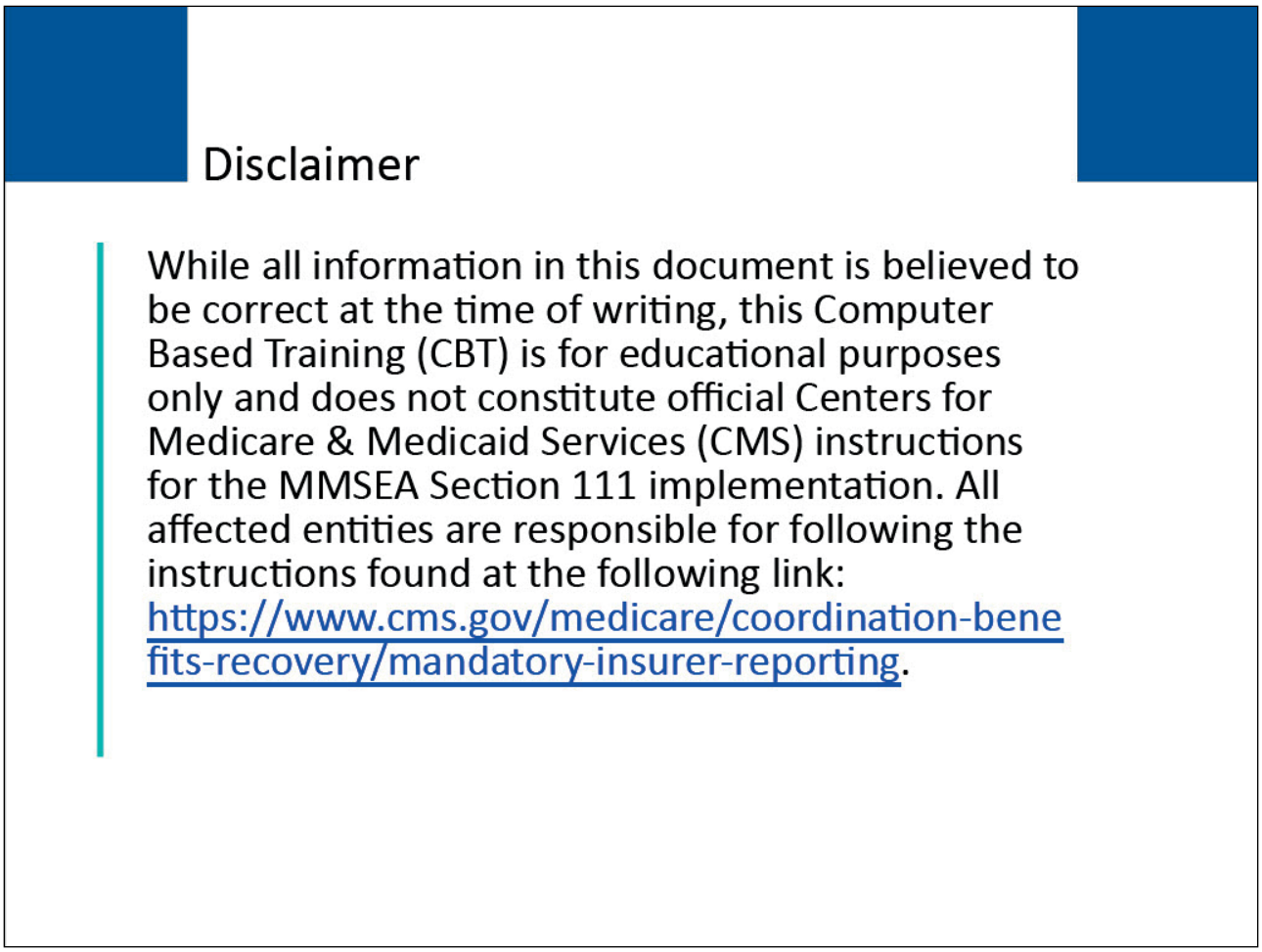
Slide 1 of 14 - ICD Diagnosis Code Requirements Introduction - Frequently Asked Questions



Slide notes

Welcome to the International Classification of Diseases (ICD) Diagnosis Code Requirements Frequently Asked Questions (FAQ) course.

Slide 2 of 14 - Disclaimer

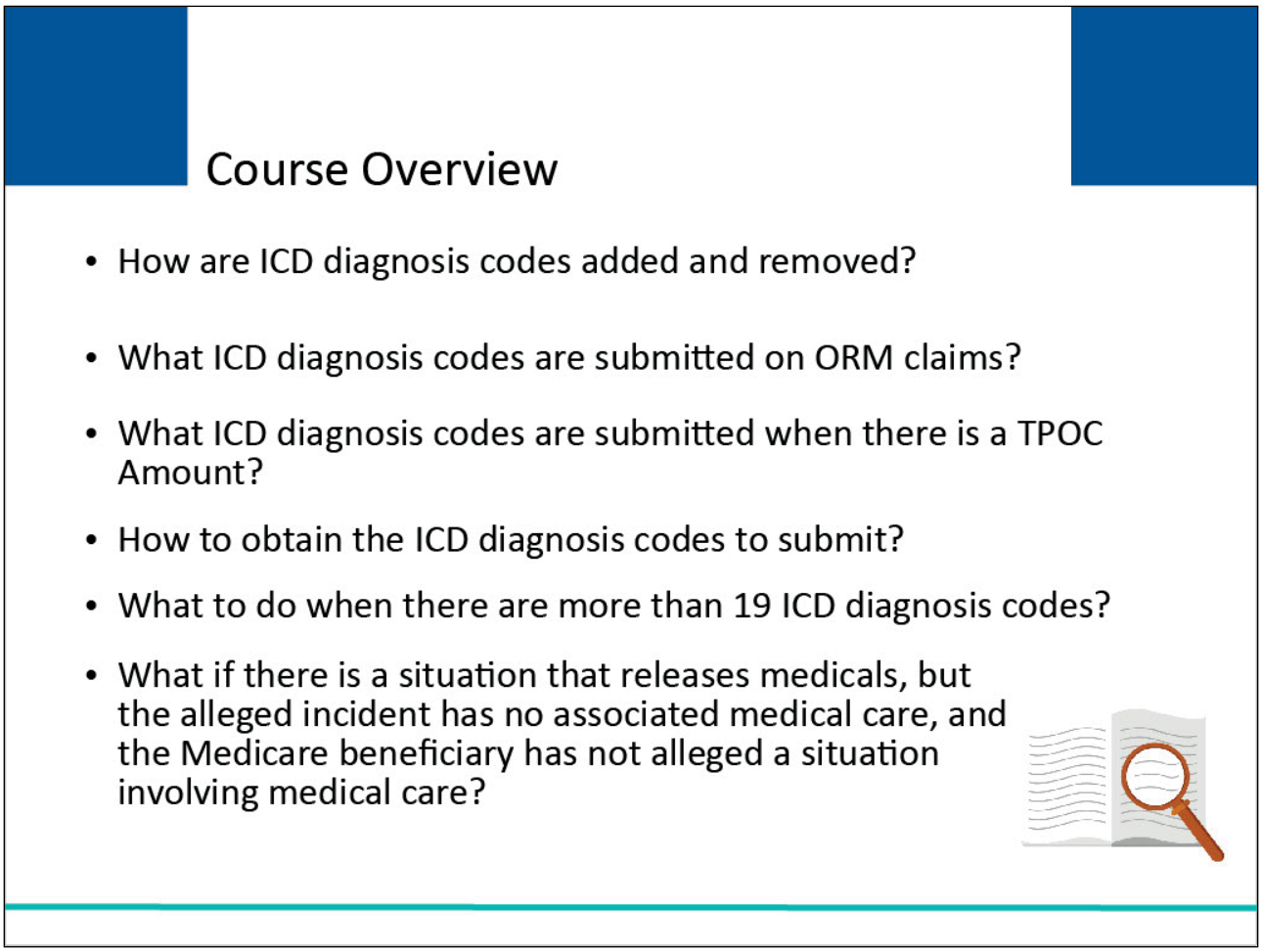


Slide notes

While all information in this document is believed to be correct at the time of writing, this Computer Based Training (CBT) is for educational purposes only and does not constitute official Centers for Medicare & Medicaid Services (CMS) instructions for the MMSEA Section 111 implementation.

All affected entities are responsible for following the instructions found at the following site: CMS NGHP Website.

Slide 3 of 14 - Course Overview



Slide notes

This module addresses FAQs regarding ICD diagnosis code reporting for Section 111. The FAQs addressed in this course are:

- How are ICD diagnosis codes added and removed?
- What ICD diagnosis codes are submitted on Ongoing Responsibility for Medicals (ORM) claims?
- What ICD diagnosis codes are to be submitted when there is a Total Payment Obligation to Claimant (TPOC) Amount?
- Where do we obtain the ICD diagnosis codes to submit?
- What to do when there are more than 19 ICD diagnosis codes?
- What if there is a situation where a settlement, judgment, award, or other payment releases medicals, but the type of alleged incident has no associated medical care, and the Medicare beneficiary has not alleged a situation involving medical care?

Slide 4 of 14 - PAID Act

PAID Act

The Medicare Secondary Payer (MSP) policy is designed to ensure that the Medicare Program does not pay for healthcare expenses for which another entity is legally responsible. To aid settling parties in determining this information, Congress has enacted the Provide Accurate Information Directly Act, also known as the PAID Act, requiring that CMS provide Non-Group Health Plans with a Medicare beneficairy's Part C and Part D enrollment information for the past 3 years.

This information will be provided both online and offline in the NGHP Query Response File. Additionally, CMS has requested that this solution also include the most recent Part A and Part B Entitlement dates.

Slide notes

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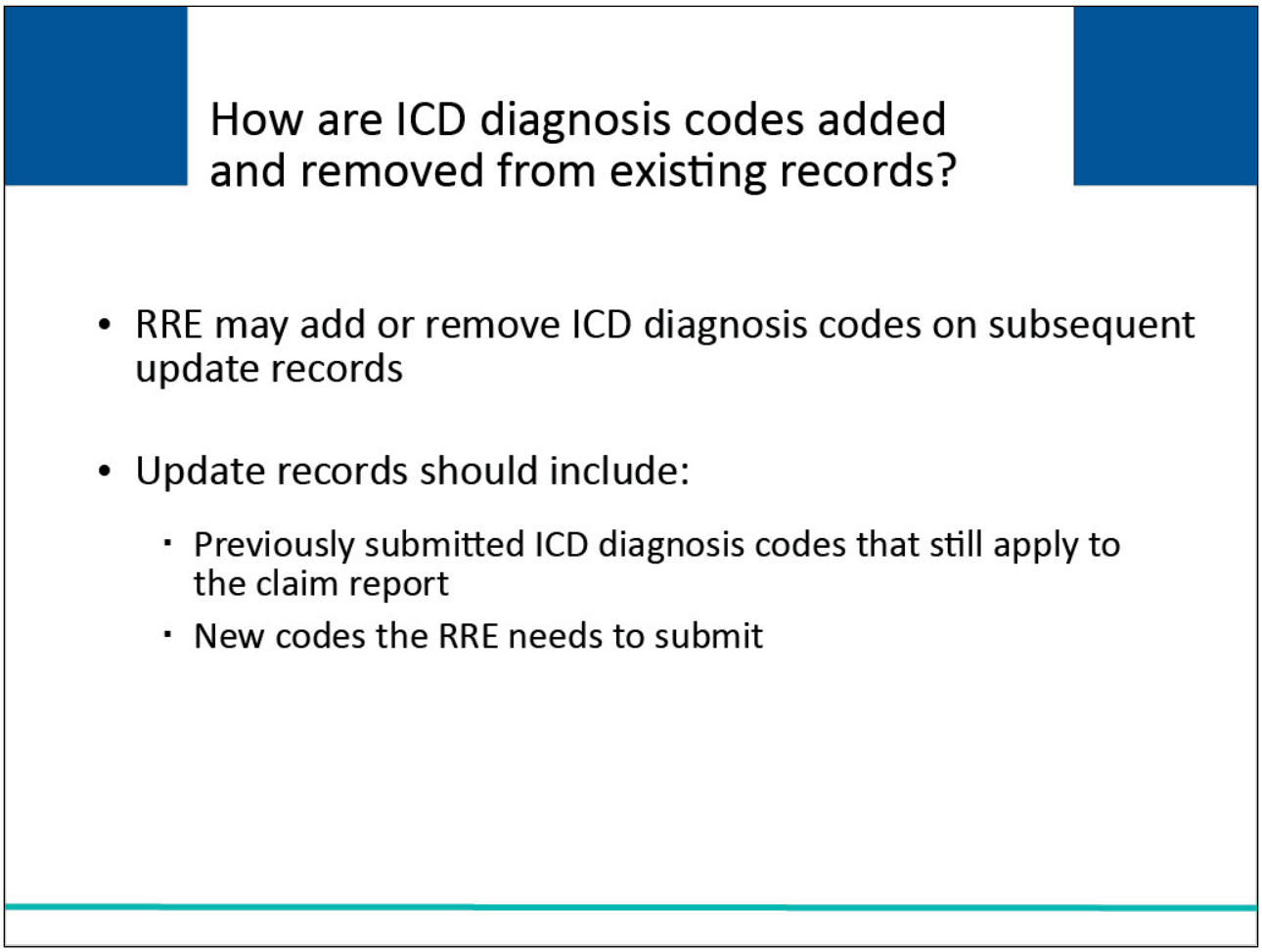
This information will be provided both online and offline in the NGHP Query Response File. Additionally, CMS has requested that this solution also include the most recent Part A and Part B Entitlement dates.

Note: To support the PAID Act, the Query Response File will be updated to include Contract Number, Contract Name, Plan Number, Coordination of Benefits (COB) Address, and Entitlement Dates for the last three years (up to 12 instances) of Part C and Part D coverage. The updates will also include the most recent Part A and Part B entitlement dates.

Slide 5 of 14 - How are ICD diagnosis codes added and removed from existing records?



Slide notes

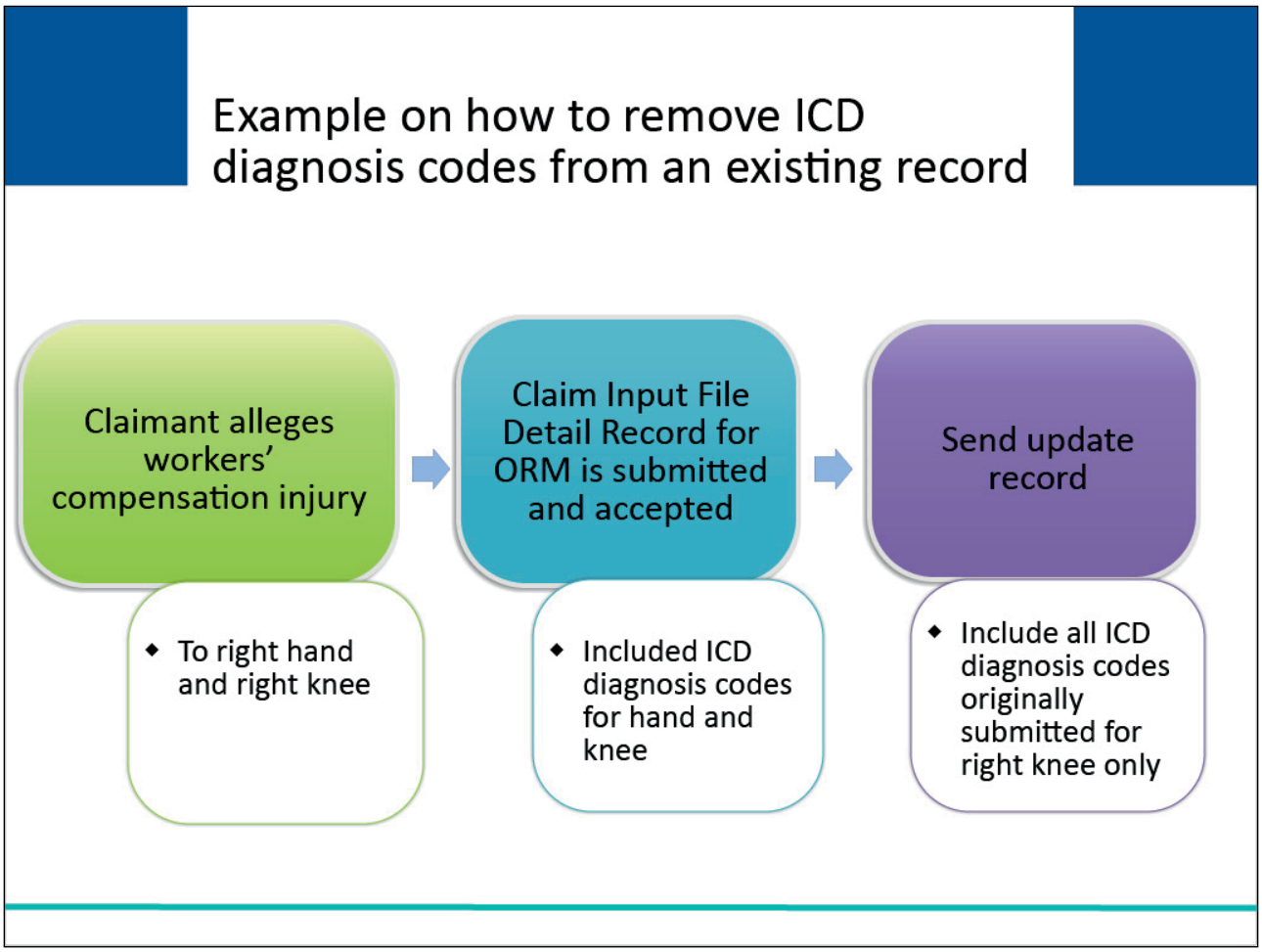
An RRE may add or remove ICD diagnosis codes on subsequent update records after the initial add record has been submitted and accepted.

Update records should include the previously submitted ICD diagnosis codes that still apply to the claim report along with any new codes the RRE needs to submit.

Note: As of 10/1/2015, ICD-10-CM diagnosis codes are required on all claim reports with CMS DOI of October 1, 2015, and subsequent.

However, the update record must include either all ICD-9 codes or all ICD-10 codes. If a combination of codes is submitted, the record will reject.

Slide 6 of 14 - Example on how to remove ICD diagnosis codes from an existing record



Slide notes

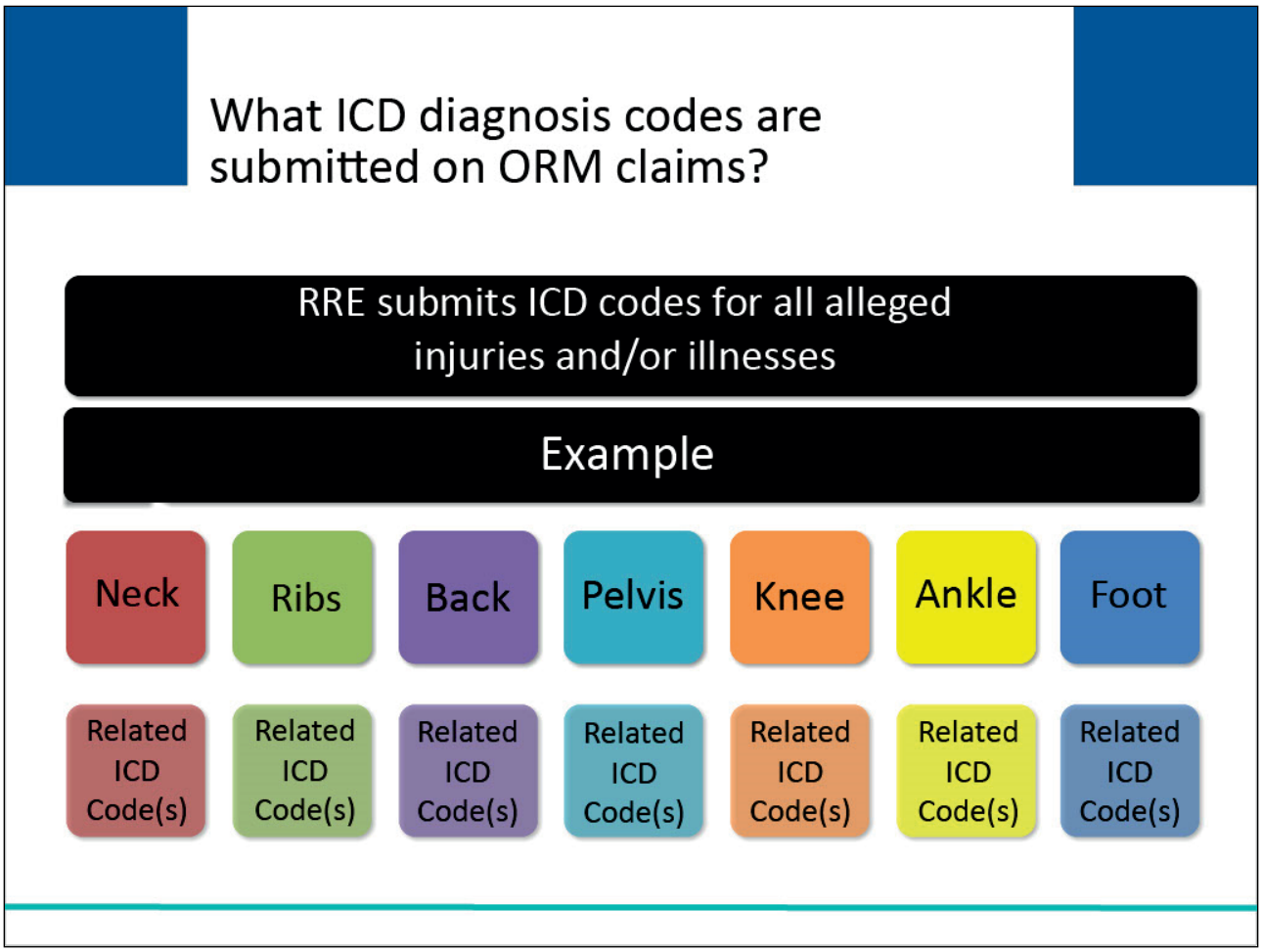
Let's assume an RRE assumes ORM for a claimant's alleged workers' compensation injuries to their right hand and right knee. The Claim Input File Detail Record is submitted and accepted.

It included ICD diagnosis codes for the hand and knee.

In discovery, it is determined that the claimant sought treatment prior to the accident for their hand injury thus the hand injury was ordered to be removed as an accepted body part.

An update record should be sent with all ICD diagnosis codes originally submitted for the right knee, but all originally submitted diagnosis codes for the hand should be excluded.

Slide 7 of 14 - What ICD diagnosis codes are submitted on ORM claims?



Slide notes

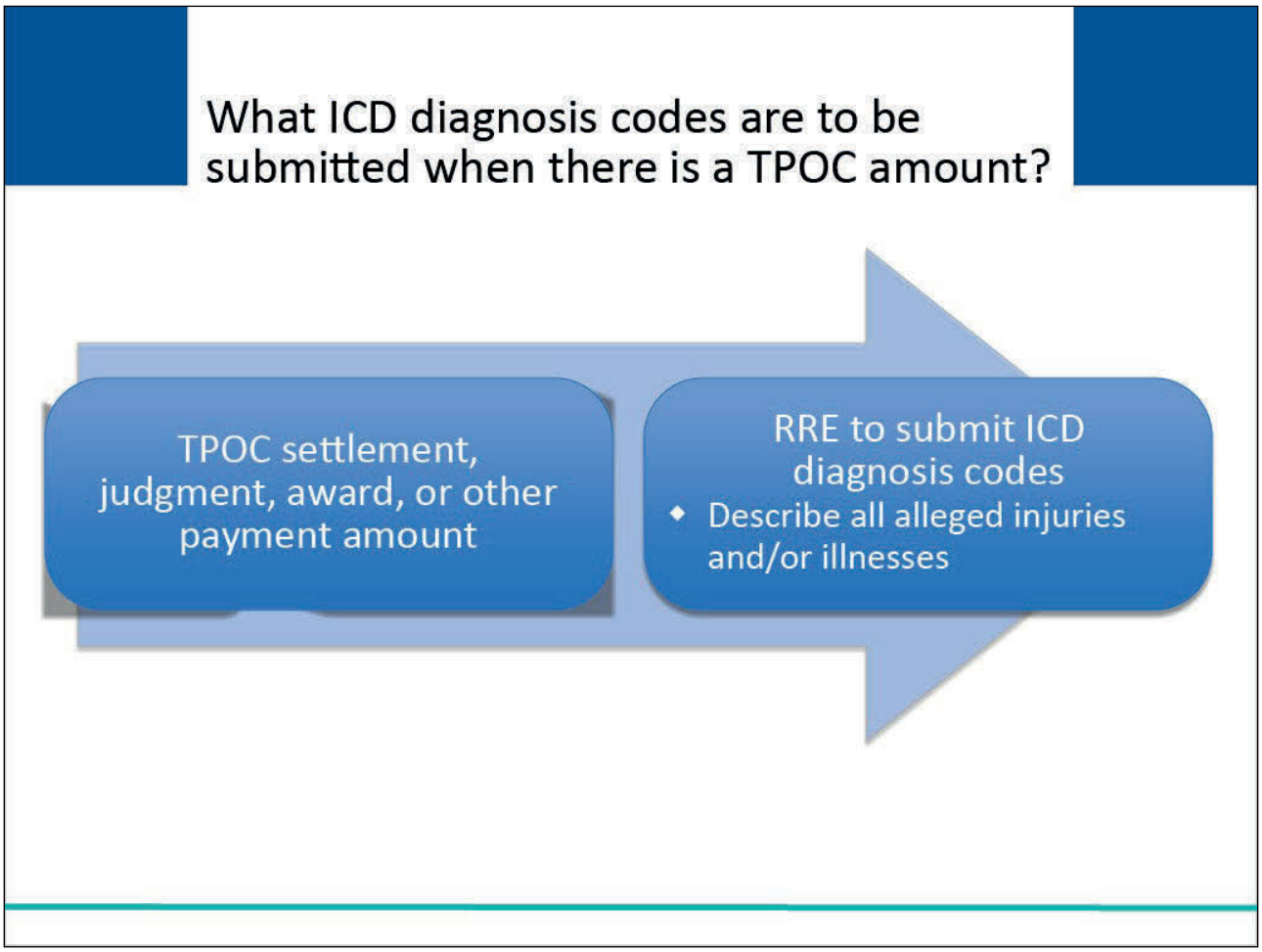
Where ORM is assumed, RREs are to submit ICD codes for all alleged injuries and/or illnesses for which the RRE has assumed ORM.

For example, assume there was an auto accident where the beneficiary incurred injuries to his neck, ribs, back, pelvis, knee, ankle, and foot.

It is expected that the RRE will submit at least one ICD code for each of the seven body parts that were injured.

Note: RREs can now enter a future Ongoing Responsibility for Medicals (ORM) Termination Date (Field 79) up to 75 years from the current date.

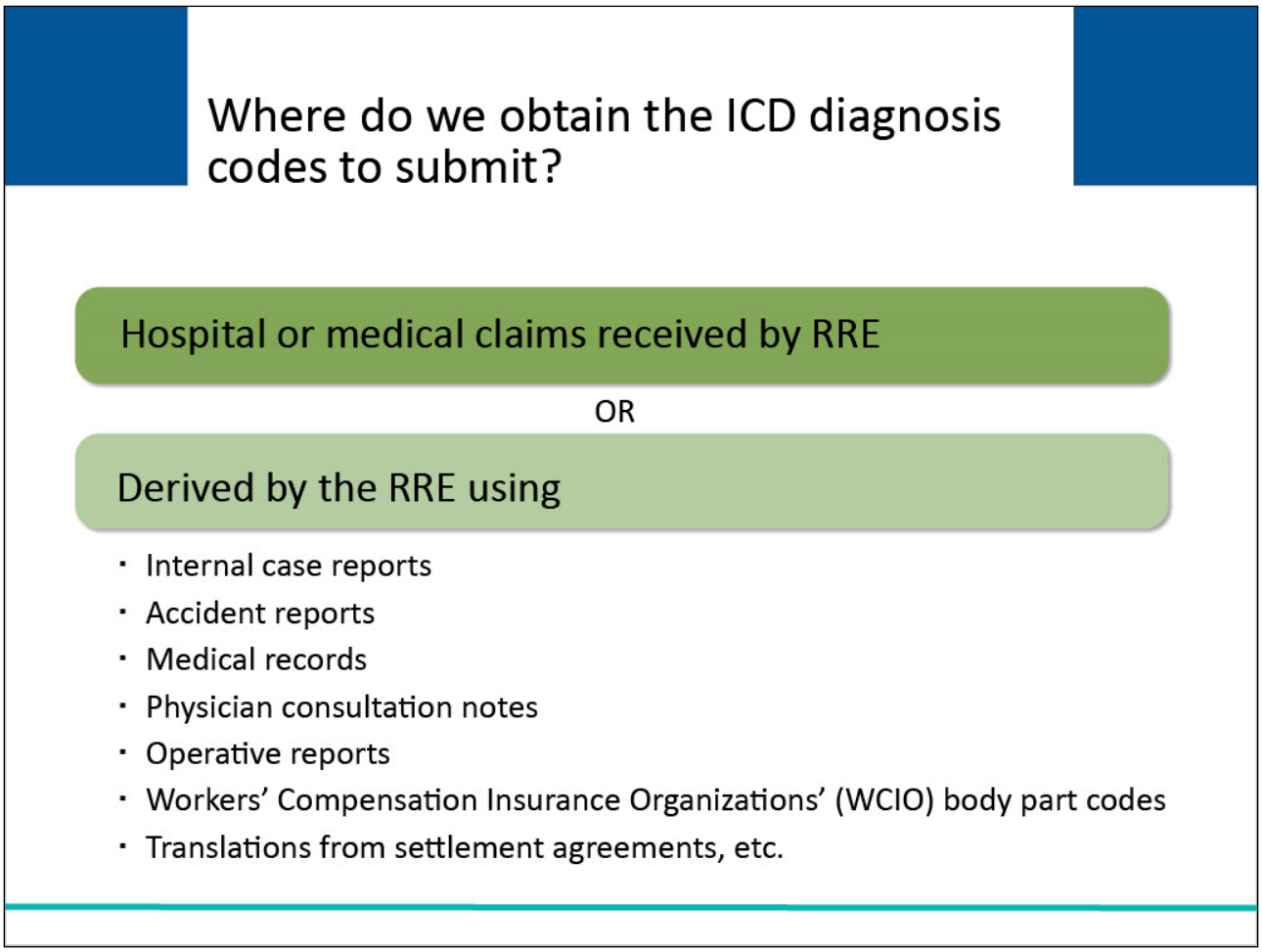
Slide 8 of 14 - What ICD diagnosis codes are to be submitted when there is a TPOC amount?



Slide notes

Where there is a TPOC settlement, judgment, award, or other payment amount, the RRE is to submit ICD diagnosis codes that describe all of the alleged injuries and/or illnesses that were claimed and/or released, regardless of an admission of liability for any of the alleged injuries.

Slide 9 of 14 - Where do we obtain the ICD diagnosis codes to submit?



Slide notes

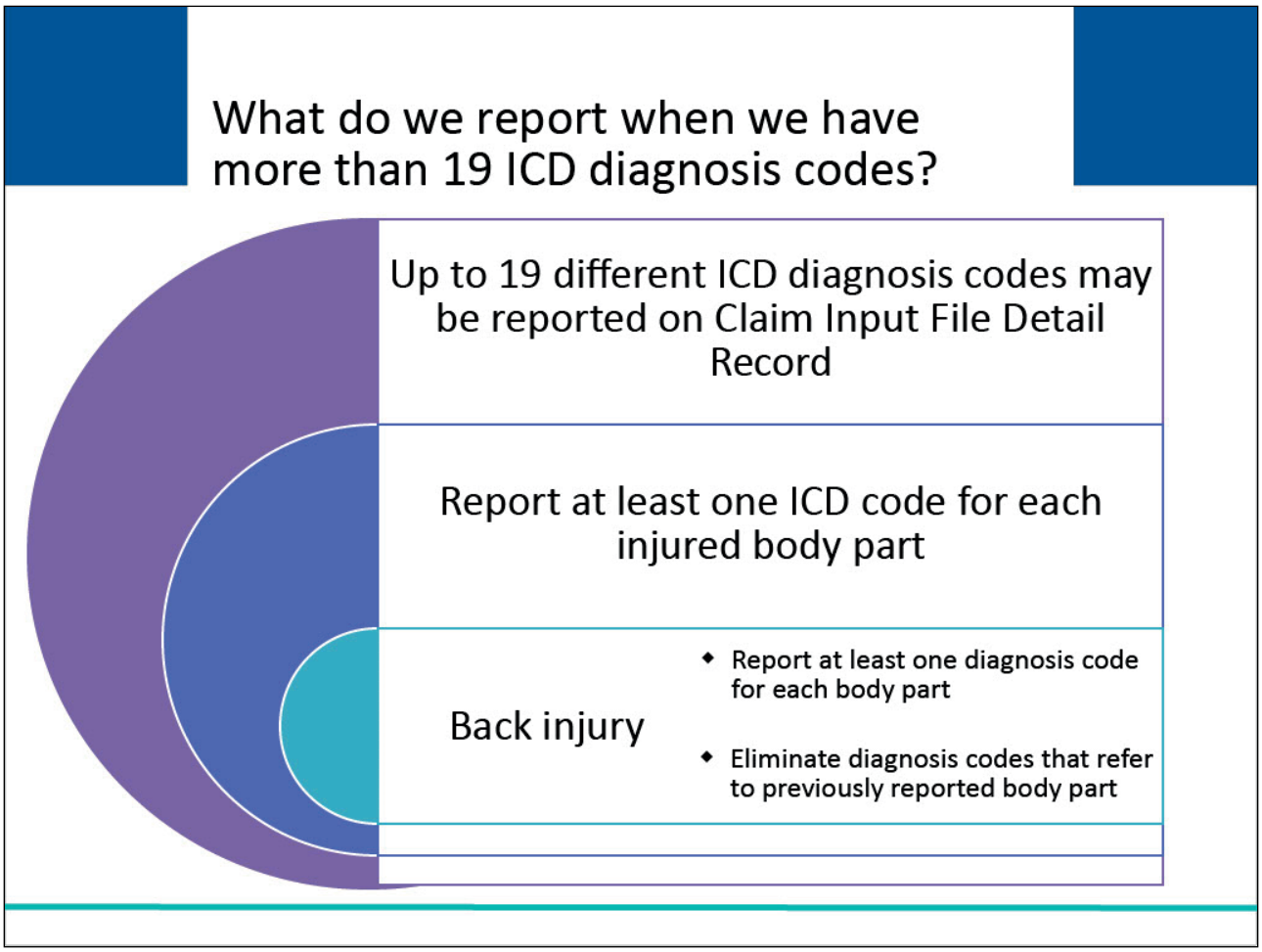
RREs may start by examining any and all hospital and medical bills and claims received. Not all of the ICD diagnosis codes on the bills or claims may need to be submitted because some codes may not be related, and some codes selected by doctors or hospitals may not even appear on the list of codes that are currently accepted by CMS for Section 111 reporting purposes.

If bills or claims are not available, it may be necessary for the RRE to derive the ICD diagnosis codes to submit.

An RRE may derive ICD diagnosis codes through the review of other documentation including internal case reports, accident reports, medical records, physician consultation notes, or operative reports.

Workers' Compensation Insurance Organizations' (WCIO) body part codes may also be translated to ICD diagnosis codes. RREs may even derive ICD diagnosis codes from a review of a settlement agreement.

Slide 10 of 14 - What do we report when we have more than 19 ICD diagnosis codes?



Slide notes

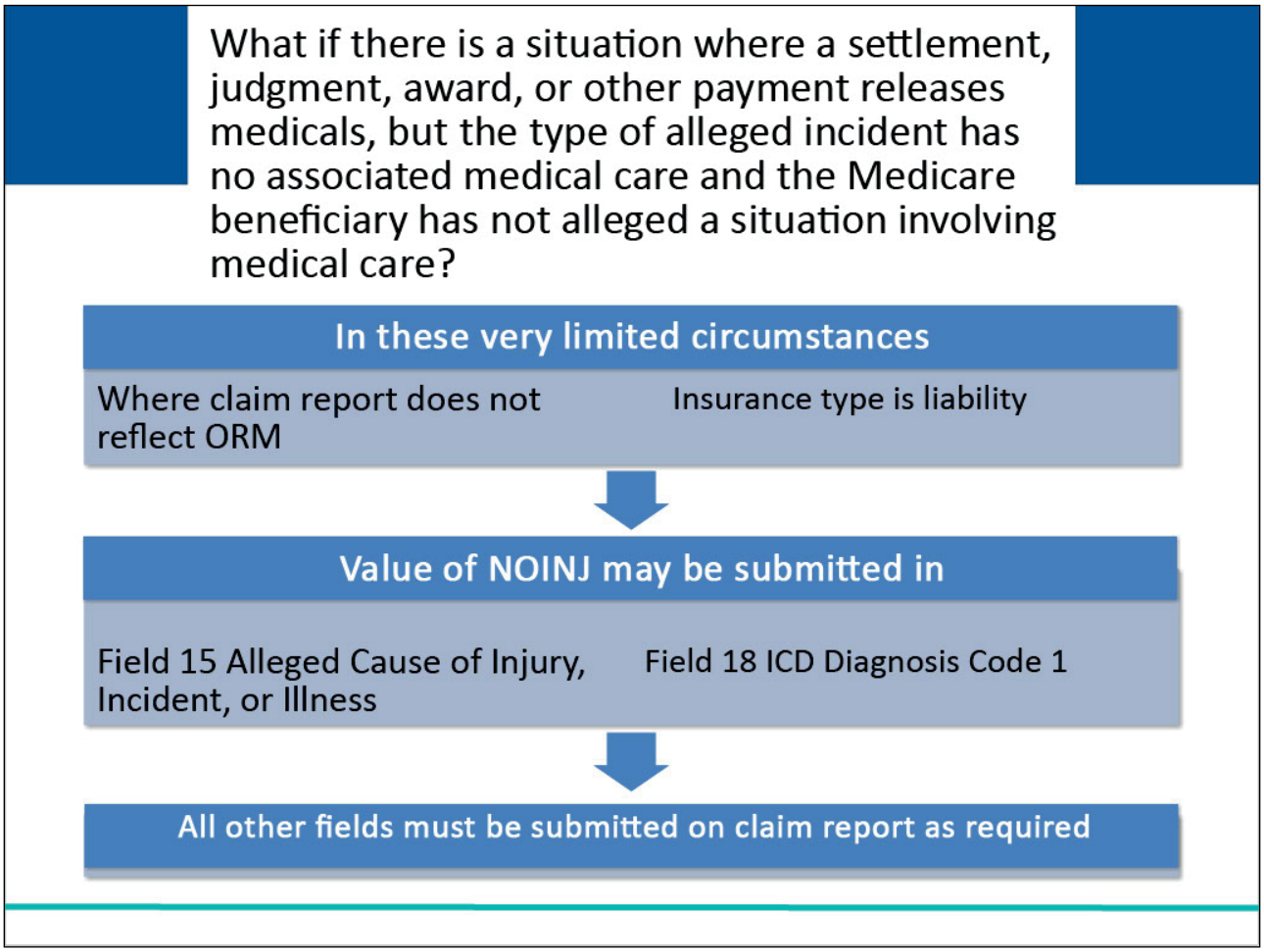
There may be times when a beneficiary is severely injured, and the RRE has more than 19 ICD diagnosis codes to report.

Since the Claim Input File Detail Record only has room for 19 ICD diagnosis codes, it is important that an RRE reports at least one ICD diagnosis code for each injured body part.

In such a situation, it is likely that a number of the diagnosis codes relate to the same body part. For example, multiple diagnosis codes could be listed when a back injury occurs.

When there are more than 19 diagnosis codes, be sure to report at least one diagnosis code for each body part that was injured. Eliminate diagnosis codes that refer to a previously reported body part.

Slide 11 of 14 - What if there is a situation where a settlement, judgment, award, or other payment releases medicals, but the type of alleged incident has no associated medical care and the Medicare beneficiary has not alleged a situation involving medical care?

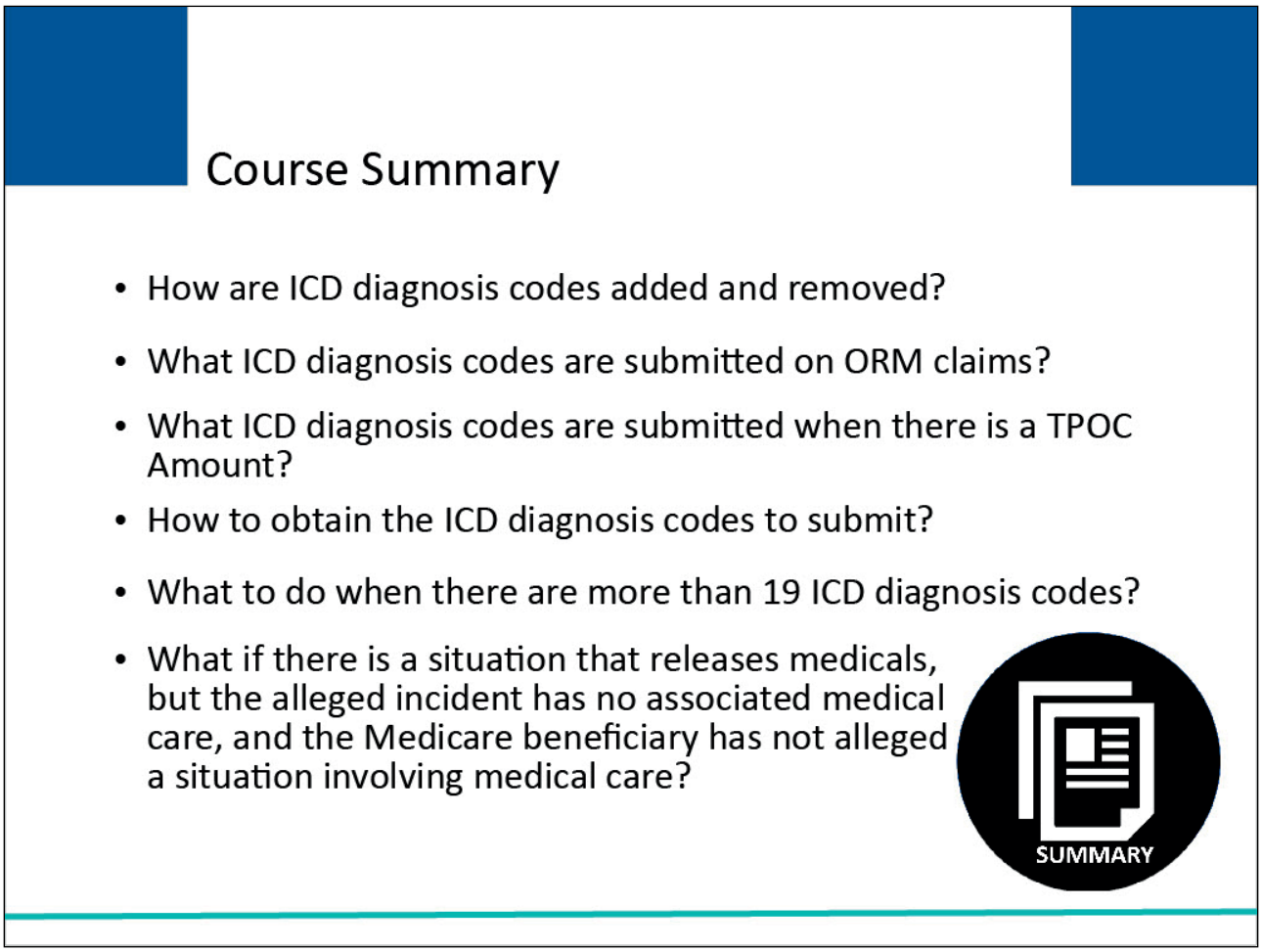


Slide notes

This is frequently the situation with a claim for loss of consortium, an errors or omissions liability insurance claim, a directors and officers liability insurance claim, or a claim resulting from a wrongful action related to employment status action is alleged. There are certain, very limited liability situations where a settlement, judgment, award, or other payment releases medicals or has the effect of releasing medicals, but the type of alleged incident typically has no associated medical care and the Medicare beneficiary/Injured Party has not alleged a situation involving medical care, or a physical or mental injury. In these very limited circumstances, when the claim report does not reflect ongoing responsibility for medicals (ORM) and the insurance type is liability, a value of “NOINJ” may be submitted in both Field 15, Alleged Cause of Injury, Incident, or Illness, and Field 18, ICD Diagnosis Code 1 (”NOINJ” must be put in the first diagnosis field and all of the rest of the diagnosis fields must be blank). All other fields must be submitted on the claim report as required.

In very rare instances, liability claims can now be reported as a non-injury claim or “NONINJ” (more information is available in (NGHP User Guide Chapter IV Section 6.2.5.2).

Slide 12 of 14 - Course Summary



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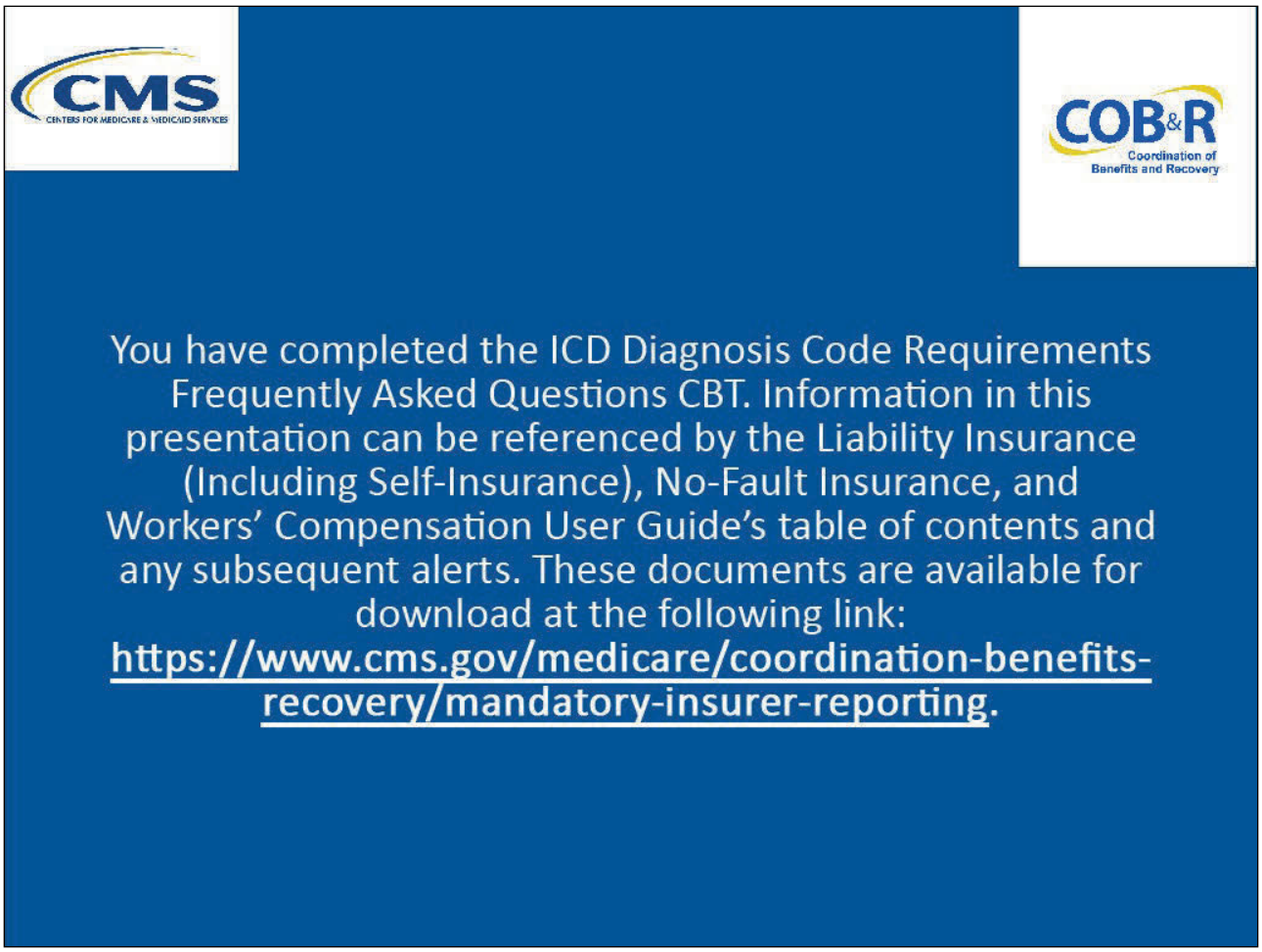
- What if there is a situation that releases medicals, but the alleged incident has no associated medical care, and the Medicare beneficiary has not alleged a situation involving medical care?

Slide 13 of 14 - Conclusion



Slide notes

You have completed the ICD Diagnosis Code Requirements Frequently Asked Questions CBT. Information in this presentation can be referenced by the Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation User Guide's table of contents and any subsequent alerts. These documents are available for download at the following link: CMS NGHP Website.

Slide 14 of 14 - NGHP Training Survey

Slide notes

If you have questions or feedback on this material, please go to the following NGHP Training Survey.