Program Memorandum Carriers

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal B-03-045 **Date: JUNE 6, 2003**

CHANGE REQUEST 2725

SUBJECT: ICD-9-CM Coding Requirements for Claims Submitted to Medicare Carriers

I. GENERAL INFORMATION

A. Background:

This Program Memorandum (PM) implements a new policy to require an ICD-9-CM diagnosis code on all paper and electronic claims billed to carriers with the exception of ambulance claims (specialty type 59).

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), a final rule published in the **Federal Register** on August 17, 2000 established new standards, requirements, and implementation specifications for health plans, health care clearing houses, and health care providers who transmit any health information in an electronic form. The applicable electronic format for transmitting Medicare claims information is the ASC X12N 837. The implementation specifications define the new requirements for these formats. The ASC X12N 837 Professional Implementation Guide (version 4010A.1) requires a diagnosis(es) on "all claims/encounters except claims for which there are no diagnoses (e.g., taxi claims)."

This PM clarifies that based upon the implementation specifications for HIPAA, an ICD-9-CM code is not required for all ambulance supplier claims, but is required for all other professional claims e.g., physicians, non-physician practitioners, independent clinical diagnostic laboratories, occupational and physical therapists, independent diagnostic testing facilities, audiologist, and ASCs. Although the HIPAA requirements do not apply to paper claims, you are to implement the ICD-9-CM requirement for paper claims as well as all electronic claims, regardless of the version of the electronic claim format.

Emergency medical technicians (EMTs) and paramedics use a trip sheet to document the condition of the beneficiary, including the patient's chief complaints, at the time that the beneficiary is loaded onto the ambulance. This documentation may later be requested by the intermediary/carrier during medical review of the claim for use in determining whether the ambulance transport and services provided were medically necessary.

However, EMTs and paramedics do not have the training necessary to make a diagnosis. Thus, no diagnosis is available at the time of transport. Moreover, it is the condition of the beneficiary at the time of transport, rather than the beneficiary's diagnosis, that determines whether the transport and services provided are payable under the Medicare ambulance benefit.

B. Policy:

A diagnosis code must be included on all Medicare claims (electronic and paper) submitted to Part B carriers, except those claims submitted by ambulance suppliers. Professional suppliers of service include: physicians, non-physician practitioners, independent clinical diagnostic laboratories, occupational and physical therapists, independent diagnostic testing facilities, audiologist, and ASCs.

The claim should contain the ICD-9-CM code that provides the highest degree of accuracy and completeness. In the past, there has been some confusion about the meaning of "highest degree of specificity," and in "reporting the correct number of digits". In the context of ICD-9-CM coding, the "highest degree of specificity" refers to assigning the most precise ICD-9-CM code that most fully explains the narrative description of the symptom or diagnosis. Concerning level of specificity, ICD-9-CM codes contain either 3, 4, or 5-digits. If a 3-digit code has 4-digit codes which further describe it, then the 3-digit code is not acceptable for claim submission. If a 4-digit code has 5-digit codes which further describe it, then the 4-digit code is not acceptable for claim submission.

C. Implementation:

Editing of Claims Submitted to Carriers for the Presence of a Diagnosis Code

Effective for dates of service on or after October 1, 2003, all paper and electronic claims submitted to carriers must contain a valid diagnosis code with the exception of claims submitted by ambulance suppliers (specialty type 59). Carriers must return as unprocessable, paper and electronic claims that do not contain a valid diagnosis code with the exception of claims submitted by ambulance suppliers (specialty type 59).

Program Memorandum B-03-028, Change Request 2672, implemented requirements for submittal of a diagnosis for electronic claims processed by durable medical equipment regional carriers. This PM expands the requirements for submittal of the diagnosis required in PM B-03-028 to include paper claims.

If any carriers are currently placing invalid or valid diagnosis codes on any claims prior to sending the claim to CWF and their coordination-of-benefits trading partners, they must discontinue this practice.

Carriers and CWF must not reject an ambulance claim on the basis that it does not contain a diagnosis code.

Physicians Reporting Diagnosis Codes When A Diagnostic Test Is Ordered

Section 4317 of the Balanced Budget Act of 1997 provides, with respect to diagnostic laboratory and certain other services, that "if the Secretary (or fiscal agent of the Secretary) requires the entity furnishing the services to provide diagnostic or other medical information to the entity, the physician or practitioner ordering the service shall provide that information to the entity at the time the service is ordered by the physician or practitioner." A laboratory or other provider must report on a claim for Medicare payment the diagnostic code(s) furnished by the ordering physician. In the absence of such coding information, the laboratory or other provider may determine the appropriate diagnostic code based on the ordering physician's narrative diagnostic statement or seek diagnostic information from the ordering physician/practitioner. However, a laboratory or other provider may not report on a claim for Medicare payment a diagnosis code in the absence of physician-supplied diagnostic information supporting such code.

Provider Education

Carriers must notify suppliers of these changes through your Web sites within two weeks of receipt and publish the information in your next regularly scheduled bulletin. In addition, if you have a listserv that targets the affected provider communities, you shall use it to notify subscribers that important information about "ICD-9-CM Coding Requirements" is available on your Web site. The CMS will publish a national provider education article shortly that addresses these guidelines.

II. BUSINESS REQUIREMENTS

Requirement #	Requirements	Responsibility
1.1	Carriers must return paper and electronic claims as unprocessable from all specialty types except "59" that does not have a diagnosis code(s) on the claim.	Carriers
1.2	Carriers may not return as unprocessable a paper or electronic claim for an ambulance service (specialty type 59) because the claim has no diagnosis code.	Carriers
1.3	CWF may not reject an ambulance service claim (specialty type 59) because the claim has no diagnosis code.	Common Working File
1.4	Carriers must not enter a diagnosis code (valid or invalid) on any claim type.	Carriers

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions

B. Design Considerations:

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces:

D. Contractor Financial Reporting/Workload Impact:

E. Dependencies:

F. Testing Considerations:

IV. ATTACHMENT(S)

Version: Implementation Date: October 1, 2003 Discard Date: October 1, 2004 Post-Implementation Contact: regional offices	Effective Date: October 1, 2003 Funding: These instructions should be implemented within your current operating budget. Pre-Implementation Contact: If you have any questions, contact your regional office.