
CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 126

Date: MARCH 26, 2004

CHANGE REQUEST 2857

I. SUMMARY OF CHANGES: This change request is a manualization that clarifies ICD-9 coding for beneficiary claims.

MANUALIZATION - EFFECTIVE DATE: Not Applicable

***IMPLEMENTATION DATE: Not Applicable**

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS:

(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	23/10/ ICD-9-CM Diagnosis and Procedure Codes

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

X	Business Requirements
X	Manual Instruction
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Medicare contractors only**

Attachment - Business Requirements

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SUBJECT: Manualization Clarification of ICD-9 Coding

I. GENERAL INFORMATION

A. Background: In order to meet the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act (HIPAA), Medicare is requiring the submission of a current and valid ICD-9 code on claims. The CMS has issued two instructions regarding the submission of ICD-9 codes through Program Memorandums (PMs) B-03-028 and B-03-045.

B. Policy: Medicare beneficiaries are not covered entities under HIPAA. Therefore, Medicare is not requiring beneficiaries to submit ICD-9 codes on beneficiary-submitted claims. Beneficiary-submitted claims are filed on Form CMS-1490S. Although business requirement 1.4 in Transmittal B-03-045, Change Request 2725, states that carriers must not enter a diagnosis code on any claim type, this requirement is only meant to refer to systems generated ICD-9 codes. For beneficiary-submitted claims, the carrier must develop the claim to determine a current and valid ICD-9 code and may enter the code on the claim.

Medicare contractors must not systematically generate ICD-9 codes for claims they process.

C. Provider Education: None.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement

"Should" denotes an optional requirement

Requirement #	Requirements	Responsibility
2857.1	Carriers, durable medical equipment regional carriers (DMERCs) and standard systems maintainers (SSMs) must not require beneficiaries to submit an ICD-9 code on beneficiary-submitted claims on Form CMS-1490S.	Carrier/DMERC/SSMs
2857.2	If a beneficiary-submitted claim is filed without a current and valid ICD-9 code, then carriers and DMERCs must determine the appropriate ICD-9 code. Carriers and DMERCs may use the narrative description, if there is one, to determine the appropriate code, and may use the highest level of unspecified code if necessary.	Carrier/DMERC

2857.3	Carriers and DMERCs must not systematically generate ICD-9 codes for claims they process.	Carrier/DMERC/SSMs
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III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: October 1, 2003 Implementation Date: October 1, 2003 Pre-Implementation Contact(s): Appropriate regional office Post-Implementation Contact(s): Appropriate regional office	These instructions shall be implemented within your current operating budget.
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10 - ICD-9-CM Diagnosis and Procedure Codes

(Rev. 126, 03-26-04)

B3-4020.2 Item 21, A3-3604, PM-01-144, CMS Medlearn Web site for diagnosis codes, A3-3632, HO-230.8, B3-15021.1, B-03-028

ICD-9-CM and its “Official ICD-9-CM Guidelines for Coding and Reporting” have been selected as the approved coding set for entities covered under the Health Insurance Portability and Accountability Act (HIPAA) for reporting diagnoses and inpatient procedures. This requires the use of ICD-9-CM and its official coding and reporting guidelines by most health plans (including Medicare) by October 16, 2002. The Administrative Simplification Act of 2001, however, permits plans and providers to apply for an extension until October 16, 2003.

The “Official ICD-9-CM Guidelines for Coding and Reporting” provides guidance on coding. The “ICD-9-CM Coding Guidelines for Outpatient Services,” which is part of the “Official ICD-9-CM Guidelines for Coding and Reporting,” provides guidance on diagnosis coding specific to outpatient facilities and physician offices.

Proper coding is necessary on Medicare claims because codes are generally used to assist in determining coverage and payment amounts.

A - ICD-9-CM Diagnosis Codes

The CMS accepts only ICD-9-CM diagnostic and procedural codes that use definitions contained in DHHS Publication No. (PHS) 89-1260 or CMS approved errata and supplements to this publication. The CMS approves only changes issued by the Federal ICD-9-CM Coordination and Maintenance Committee. Diagnosis codes must be full ICD-9-CM diagnoses codes, including all five digits where applicable

Diagnosis coding changes for Volume 1 and 2 are approved annually by a Federal committee. The changes take effect each year October 1. Volume 3 is revised annually by CMS. Updates include:

- Addition of new codes;
- Deletion of old codes; and
- Revisions to descriptions of codes.

Rules for reporting diagnosis codes on the claim are:

- Use the ICD-9-CM code that describes the patient’s diagnosis, symptom, complaint, condition or problem. Do not code suspected diagnosis.
- Use the ICD-9-CM code that is chiefly responsible for the item or service provided.

- Assign codes to the highest level of specificity. Use the fourth and fifth digits where applicable.
- Code a chronic condition as often as applicable to the patient's treatment.
- Code all documented conditions that coexist at the time of the visit that require or affect patient care or treatment. (Do not code conditions that no longer exist.)

Claims submitted to the carrier on Form CMS-1500 or its electronic equivalent must have a diagnosis code to identify the patient's diagnosis/condition (item 21). All physician and nonphysician specialties (e.g., PA, NP, CNS, CRNA) must use an ICD-9-CM code number and code to the highest level of specificity. Up to four codes may be submitted in priority order (primary, secondary condition). An independent laboratory is required to enter a diagnosis only for limited coverage procedures.

All narrative diagnoses for nonphysician specialties must be submitted on an attachment.

Inpatient claims submitted to the intermediary on Form CMS-1450 or its electronic equivalent must have a principal diagnosis. For inpatient claims, the provider reports the principal diagnosis in FL 67. The principal diagnosis is the condition established after study to be chiefly responsible for the admission. Even though another diagnosis may be more severe than the principal diagnosis, the principal diagnosis, as defined above, is entered. Entering any other diagnosis may result in incorrect assignment of a DRG and an overpayment to a hospital under PPS.

The physician should code the ICD-9-CM code that provides the highest degree of accuracy and completeness. 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.

For electronically submitted DMEPOS claims, a valid diagnosis code, which most fully explains the patient's diagnosis, is required. The CMS understands that physicians may not always provide suppliers of DMEPOS with the most specific diagnosis code, and may provide only a narrative description. In those cases, suppliers may choose to utilize a variety of sources to determine the most specific diagnosis code to include on the individual line items of the claim. These sources may include, but are not limited to: coding books and resources, contact with physicians or other health professionals, documentation contained in the patient's medical record, or verbally from the patient's physician or other healthcare professional.

Beneficiaries are not required to submit ICD-9 codes on beneficiary-submitted claims. Beneficiary-submitted claims are filed on Form CMS-1490S. For beneficiary-submitted claims, the carrier must develop the claim to determine a current and valid ICD-9 code and may enter the code on the claim.

For outpatient claims, providers report the full ICD-9-CM code for the diagnosis shown to be chiefly responsible for the outpatient services in FL 67. For instance, if a patient is seen on an outpatient basis for an evaluation of a symptom (e.g., cough) for which a definitive diagnosis is not made, the symptom is reported (786.2). If, during the course of the outpatient evaluation and treatment, a definitive diagnosis is made (e.g., acute bronchitis), the definitive diagnosis is reported (466.0). If the patient arrives at the hospital for examination or testing without a referring diagnosis and cannot provide a complaint, symptom, or diagnosis, the hospital reports an ICD-9-CM code for “Persons Without Reported Diagnosis Encountered During Examination and Investigation of Individuals and Populations” (V70-V82). Examples include:

- Routine general medical examination (V70.0);
- General medical examination without any working diagnosis or complaint, patient not sure if the examination is a routine checkup (V70.9); or
- Examination of ears and hearing (V72.1).

Other diagnoses codes are required on inpatient claims and are used in determining the appropriate Diagnosis Related Group (DRG). The provider reports the full ICD-9-CM codes for up to eight additional conditions if they coexisted at the time of admission or developed subsequently, and which had an effect upon the treatment or the length of stay.

The principal diagnosis should not under any circumstances be duplicated as an additional or secondary diagnosis. If it is duplicated, intermediaries should eliminate it before GROUPER. Proper installation of the Medicare Code Editor (MCE) identifies situations where the principal diagnosis is duplicated.

For outpatient claims, providers report the full ICD-9-CM codes for up to eight other diagnoses that coexisted in addition to the diagnosis reported as the principal diagnosis. For instance, if the patient is referred to a hospital for evaluation of hypertension and the medical record also documents diabetes, diabetes is reported as an other diagnosis.

Form Locator 76 on the Form CMS-1450 is defined as Admitting Diagnosis/Patient’s Reason for Visit is required for inpatient hospital claims subject to PRO review. The admitting diagnosis is the condition identified by the physician at the time of the patient’s admission requiring hospitalization. For outpatient bills, the field is defined as Patient’s Reason for Visit and is not required by Medicare but may be used by providers for nonscheduled visits for outpatient bills.

Additional information and training is available in Medlearn on CMS Web site:

<http://cms.hhs.gov/medlearn/cbt%5Ficd9.asp>

B - ICD-9-CM Procedure Codes

ICD-9-CM procedure codes are required for inpatient hospital Part A claims only. Healthcare Common Procedure Code System (HCPCS) codes are used for reporting procedures on other claim types. Inpatient hospital claims require reporting the principal

procedure if a significant procedure occurred during the hospitalization. The principal procedure is the procedure performed for definitive treatment rather than for diagnostic or exploratory purposes, or which was necessary to take care of a complication. It is also the procedure most closely related to the principal diagnosis. The provider enters the ICD-9-CM code for the inpatient principal procedure on the Form CMS-1450 FL 80 titled Principal Procedure Code and Date. This includes incision, excision, amputation, introduction, repair, destructions, endoscopy, suture, and manipulation.

The principal procedure code shown on the bill **must** be the full ICD-9-CM, Volume 3, procedure code, including all 4-digit codes where applicable.

Other procedure codes are reported using the full ICD-9-CM, Volume 3, procedure codes, including all four digits where applicable. Up to five significant procedures other than the principal procedure may be reported.

ICD-9-CM diagnosis and procedure codes are available on CMS Web site:
<http://cms.hhs.gov/paymentsystems/icd9/>