Program Memorandum Carriers

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

Transmittal B-03-028 **DATE: APRIL 18, 2003**

CHANGE REQUEST 2672

SUBJECT: Durable Medical Equipment Regional Carriers (DMERC) – ICD-9-CM Coding

Background

The Centers for Medicare & Medicaid Services (CMS) has issued several instructions on the implementation of the 2003 Update to the International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis codes. The ICD-9-CM diagnosis codes were adopted under the Health Insurance Portability and Accountability Act (HIPAA) as the medical code set to be used for reporting diagnosis in the HIPAA X12N 837 Health Care Claim Transaction. The X12N 837 (version 4010A1) requires a diagnosis on all claims unless there are no diagnoses (i.e., taxi claims). Since current CMS policy does not always require a diagnosis on the claim for certain services, this Program Memorandum (PM) provides additional guidance to DMERCs in implementing the HIPAA X12N 837 requirement for reporting diagnosis codes. Instructions that will address reporting the ICD-9-CM on other carrier claims will be forthcoming.

Policy

The physician should code 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.

For electronically submitted claims for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), a valid diagnosis code, which most fully explains the patient's diagnosis, is required. 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**. (Suppliers are precluded from including diagnostic information on a certificate of medical necessity per §1842(j)(2)(a) of the Social Security Act.) 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.

Listed below is specific information about claims submission:

a) All electronic claims submitted to the DMERC must contain a valid diagnosis code for each line item on the claim.

b) Electronic claims (assigned or unassigned) **without** an ICD-9-CM code(s) shall be returned as front end rejects to the supplier. These claims do not get in the front door.

c) For all claims with an ICD-9-CM code, a valid ICD-9-CM code (the code that provides the highest level of specificity for the date the service was provided) must be used.

d) Assigned claims with an **invalid** ICD-9-CM code shall be returned as unprocessable and unassigned claims shall be denied for incorrect coding. (**NOTE**: If DMERCs are currently developing these unassigned claims prior to denial, they may continue to do so.)

e) Paper claims require an ICD-9-CM code if specified (e.g., required by a local medical review policy (LMRP)). However, if an ICD-9-CM code is required, the code will go through the same accuracy edits as electronic claims.

The DMERCs shall not deny claims where the diagnosis code on a claim does not match the diagnosis on the order or a certificate of medical necessity (CMN), so long as: 1) There is sufficient evidence in the patient's medical record to justify the use of the diagnosis code, 2) The diagnosis on the claim justifies coverage for the item or service, and 3) The diagnosis code on the claim is valid and to the highest level of specificity.

In addition, DMERCs shall not require suppliers to obtain new orders or CMNs in those cases where ICD-9-CM codes were updated unless normal business practices would require a new order or CMN. For instance, suppliers are required to obtain new orders and/or CMNs when the patient's medical condition changes. If an ICD-9-CM code is updated, and the patient's medical condition has not changed, there is no requirement for the supplier to obtain a new order and/or CMN.

Provider Education:

Educate suppliers on the above instructions on your Web sites, next regularly scheduled bulletin, training sessions, and listservs.

The *effective date* for this PM is May 1, 2003.

The *implementation date* for this PM is May 1, 2003.

These instructions should be implemented within your current operating budget.

This PM may be discarded after April 1, 2004.

If you have any questions, contact your Regional Office.