Medlearn Matters
Information for Medicare Providers

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Establishing New Requirements for ICD-9-CM Coding on Claims Submitted to Medicare Carriers - Increased Role for Physicians/Practitioners

Effective for dates of service on or after October 1, 2003, ICD-9-CM diagnosis codes must be included on all Medicare electronic and paper claims billed to Part B carriers, with the exception of ambulance claims. Providers and suppliers rely on physicians to provide a diagnosis code or narrative diagnostic statement on orders/referrals. This guidance serves as a reminder that physicians/practitioners must provide a diagnosis on all orders and referrals.

Background

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 on "all claims/encounters except claims for which there are no diagnoses (e.g., taxi claims)."

PM B-03-045 (CR2725) clarified 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, Audiologists, and Ambulatory Surgery Centers. Although the HIPAA requirements apply only to electronic claims, in order to maintain consistency in claims processing, CMS has mandated that these ICD-9-CM requirements will be applied to paper claims as well as electronic claims.

New Policy

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 will 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).

Carriers will no longer place invalid or valid diagnosis codes on any claim prior to sending the claim to the Common Working File and their coordination-of-benefits trading partners. Therefore, the diagnosis code must be entered on the claim by the submitter.

DMERC Suppliers

PM B-03-028 (CR2672) implemented requirements for submittal of a diagnosis for electronic claims processed by Durable Medical Equipment Regional Carriers (DMERC). PM B-03-045 (CR2725) expanded the requirements for submittal of the diagnosis required in PM B-03-028 to include paper claims and that invalid ICD-9-CM codes on claims will not be allowed. If there is an invalid ICD-9-CM code in the header or on the service line, the claim will be returned as unprocessable to the physician/practitioner/supplier.

Immunization Claims

For claims submitted by mass immunizers and any other entities billing for flu and pneumonia vaccinations, Medicare carriers will no longer be able to enter missing diagnosis codes on claims. The diagnosis code must be entered on the claim by the submitter.

2

Mammography Screening Claims

For claims submitted for screening mammography services, Medicare carriers will no longer be able to enter missing diagnosis codes on claims. The diagnosis code must be entered on the claim by the submitter. Claims for mammography services with no ICD-9-CM code will be returned as unprocessable by carriers.

HIPAA Requirements Affect Physicians/Practitioners 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/ referring physician/practitioner. In the absence of such coding information, the laboratory or other provider may determine the appropriate diagnostic code based on the ordering/referring physician/practitioner's narrative diagnostic statement or seek diagnostic information from the ordering/referring 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/practitioner-supplied diagnostic information supporting such code.

When providers/suppliers (except ambulance suppliers) submit a claim to a Medicare Part B carrier, they must assign an ICD-9-CM code to the service as follows:

(1) Coding When Diagnosis is Known

Assign an 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 a 4-digit code that further describes it, then the 3-digit code is not acceptable for claim

submission. If a 4-digit code has a 5-digit code that further describes it, then the 4-digit code is not acceptable for claim submission.

(2) Coding When Diagnosis is Unknown

Diagnoses documented as "probable," "suspected," "questionable," "rule-out," or "working diagnosis" should not be coded as though they exist. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit such as signs, symptoms, abnormal test results, exposure to communicable disease, or other reason for the visit. (See *ICD-9-CM Official Guidelines for Coding and Reporting*, page 49, available at http://www.cdc.gov/nchs/data/icd9/icdguide.pdf.)

Information for Laboratories

• Include the ICD-9-CM diagnosis code, as furnished by the physician/practitioner.

• If a diagnosis or narrative diagnosis is not submitted by the physician/practitioner, laboratories must request this information from the physician/practitioner who ordered the service.

Information for Ambulance Suppliers

• Since emergency medical technicians and paramedics do not have the necessary training to make a diagnosis, diagnosis is not available at the time of transport. It is the condition of the patient at the time of transport, rather than the patient's diagnosis, that determines whether transport and services are payable under the Medicare ambulance benefit.

3

• Carriers may request the trip sheet that documents the condition of the patient, including patient's chief complaints, at the time patient was loaded onto the ambulance in order to determine whether ambulance transport and services were medically necessary.

Timely and Accurate Claims Processing

With the exception of ambulance suppliers, physicians/practitioners submitting claims to Medicare Part B carriers must include a valid ICD-9-CM code in order to have their claims processed and paid as quickly as possible. Therefore, physicians/practitioners must ensure that all necessary information is included on orders/referrals. Failure to do so will result in processing delays and nonpayment of covered services.