TIPS FROM OUR CONSULTANT

By: Joy Newby, LPN, CPC, PCS
Newby Consulting

***ICD-10* Effective October 1, 2015**

Starting on October 1, Medicare claims with a date of service on or after October 1, 2015 will only be accepted if they contain a valid *ICD-10* code. The Medicare claims processing systems will not have the capability to accept *ICD-9* codes for **dates of service after September 30, 2015** or accept claims that contain both *ICD-9* and *ICD-10* codes.

There has been some misunderstanding about a recent announcement by the Centers for Medicare & Medicaid Services (CMS) discussing the temporary flexibility in the claims auditing and quality reporting during *ICD-10* implementation.

- ✓ For 12 months after *ICD-10* implementation, Medicare review contractors will not deny physician or other practitioner claims billed under the Part B physician fee schedule through either automated medical review or complex medical record review based solely on the specificity of the *ICD-10* diagnosis code as long as the physician/practitioner **used a code from the right family**. However, a valid *ICD-10* code will be required on all claims starting on October I, 2015.

- ✓ For all quality reporting completed for program year 2015, Medicare clinical quality data review contractors will not subject physicians or other Eligible Professionals (EP) to the Physician Quality Reporting System (PQRS), Value Based Modifier (VBM), or Meaningful Use (MU) penalties during primary source verification or auditing **related to the additional specificity** of the *ICD-10* diagnosis code, as long as the physician/EP used a code from the correct family of codes. Furthermore, an EP will not be subjected to a penalty if CMS experiences difficulty calculating the quality scores for PQRS, VBM, or MU due to the transition to *ICD-10* codes.

This announcement does not mean there is a delay in the implementation of *ICD-10*. What it does mean is that CMS is willing to continue to process claims that include unspecified codes from the correct family of codes.

"Family of codes" is the same as the *ICD-10* **three-character category**. Codes within a category are clinically related and provide differences in capturing specific information on the type of condition. For instance, category H25 (Age-related cataract) contains a number of specific codes that capture information on the type of cataract as well as information on the eye involved. Examples include: H25.031 (Anterior subcapsular polar age-related cataract, right eye), which has six characters; H25.22 (Age-related cataract, morgagnian type, left eye), which has five characters; and H25.9 (Unspecified age-related cataract), which has four characters. One must report a valid code and not a category number. In many instances, the code will require more than 3 characters in order to be valid.

Thus, even though a "family of codes" is a three-character category, the physician must report a valid code. For example, the "family of codes" for cellulitis and acute lymphangitis is L03 Cellulitis and acute lymphangitis. The temporary reprieve from having to report to the greatest extent known at the time of service means for dates of service 10/1/2015 through 9/30/2016, a physician could report L03.90 cellulitis unspecified in lieu of reporting a more specific code:

L03.011	Cellulitis of right finger
L03.012	Cellulitis of left finger
L03.031	Cellulitis of right toe
L03.032	Cellulitis of left toe
L03.111	Cellulitis of right axilla
L03.112	Cellulitis of left axilla
L03.113	Cellulitis of right upper limb
L03.114	Cellulitis of left upper limb
L03.115	Cellulitis of right lower limb
L03.116	Cellulitis of left lower limb

L03.211	Cellulitis of face Cellulitis of ear (H60.1-) Cellulitis of eyelid (H00.0-) Cellulitis of head (L03.81) Cellulitis of lacrimal apparatus (H04.3) Cellulitis of lip (K13.0) Cellulitis of mouth (K12.2) Cellulitis of nose (internal) (J34.0) Cellulitis of orbit (H05.0) Cellulitis of scalp (L03.81)
L03.221	Cellulitis of neck
L03.311	Cellulitis of abdominal wall
L03.312	Cellulitis of back [any part except buttock]
L03.313	Cellulitis of chest wall
L03.314	Cellulitis of groin
L03.315	Cellulitis of perineum
L03.316	Cellulitis of umbilicus
L03.317	Cellulitis of buttock
L03.811	Cellulitis of head [any part, except face]
L03.818	Cellulitis of other sites

In contrast, the claim must still include the *ICD-10* code that is supported by the documentation. For example, if the physician documents "lymphangitis" and does not specify it as acute, the coder should not select L03.91 which is the unspecified code for acute lymphangitis. The correct code for lymphangitis NOS (not otherwise specified) is I89.1

While this temporary reprieve from using the *ICD-10* code that represents the greatest extent known at the time of the encounter is tempting, physicians should consider whether it is wise to simply report unlisted codes for the first year of implementation. At some point, greater specificity will be required. NCI recommends that to the extent possible, physicians should use the more specific codes beginning with dates of service on or after October 1, 2015, so additional changes will not be necessary in the future.

CMS has made it very clear that there is no guarantee other payers will allow the use of unspecified codes (especially for primary diagnoses – reason for the encounter – which should be the first diagnostic statement in the assessment section of the progress note and listed as the first diagnosis on the claim). Physicians should verify with their major commercial payers to determine whether the unspecified codes from the same family of codes will be accepted on claims that include *ICD-10* codes.

Requests for Documentation Related to Orders

Physicians have been seeing an increase in requests for documentation of medical necessity when ordering durable medical equipment, prosthetics, and supplies (DMEPOS), laboratory and radiology services before the entity will complete the order. Although CMS does not require ordering physician/nonphysician providers to include the documentation with the order, some suppliers have taken the position that without the information, they will not complete the order.

When NCI began receiving complaints about the increased work related to an order, we contacted the Jurisdiction B DME Medicare Administrative Contractor. The D-MAC's representative explained that the supplier has the right to request the information with the order.

The majority of the requests appear to be coming from these suppliers because in Fiscal Year 2014, the Comprehensive Error Rate Testing (CERT) contractor reported a 53.1 percent improper payment rate for DME suppliers. The vast majority of the improper payments were due to the supplier not providing sufficient documentation to support the medical necessity for the DMEPOS items.

Examples of services leading to the improper payment rate related to insufficient documentation for specific services include, but are not limited to, the following:

DMEPOS Services	Insufficient Documentation
Oxygen Supplies/Equipment	94.3%
Glucose Monitor	85.0%
CPAP	94.1%
Enteral Nutrition	98.6%
Nebulizers & Related Drugs	96.2%
Hospital Beds/Accessories	96.2%

As this information is typically located in the physician/nonphysician provider's documentation in the patients' medical record, some suppliers have been requesting the documentation be submitted with the order. By having the information to begin with, the supplier can review the information to determine whether there is sufficient documentation to support the medical necessity especially when the item is subject to a Local Coverage Decision. Some suppliers are reviewing the information while others are simply filing the information in event the supplier is audited by any Medicare contractor.

According to §5.2 Chapter 5 of the *Medicare Program Integrity Manual*

For any DMEPOS item to be covered by Medicare, the patient's medical record must contain sufficient documentation of the patient's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable). The information should include the patient's diagnosis and other pertinent information including, but not limited to, duration of the patient's condition, clinical course (worsening or improvement), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with related items, etc.

If an item requires a Certificate of Medical Necessity (CMN), it is recommended that a copy of the completed CMN be kept in the patient's record. However, neither a physician's order nor a CMN nor a supplier prepared statement nor a physician attestation by itself provides sufficient documentation of medical necessity, even though it is signed by the treating physician. There must be clinical information in the patient's medical record that supports the medical necessity for the item and substantiates the answers on the CMN (if applicable) or information on a supplier prepared statement or physician attestation (if applicable).

The patient's medical record is not limited to the physician's office records. It may include hospital, nursing home, or home health agency (HHA) records and records from other professionals including, but not limited to, nurses, physical or occupational therapists, prosthetists, and orthotists.

The documentation in the patient's medical record does not have to be routinely sent to the supplier or to the DMERC or DMERC PSC. However, the DMERC or DMERC PSC may request this information in selected cases. If the DMERC or DMERC PSC does not receive the information when requested or if the information in the patient's medical record does not adequately support the medical necessity for the item, then on assigned claims the supplier is liable for the dollar amount involved unless a properly executed advance beneficiary notice (ABN) of possible denial has been obtained.

While not all of the insufficient documentation errors can be attributed to lack of physician documentation, the problem does appear to account for a significant portion. These problems stem from the physician providing insufficient documentation that does not meet the requirements to support the order and the medical necessity for the service (which could include evidence of a required face-to-face evaluation) and/or physicians failing to provide any documentation.

WPS POSTS INFORMATION ON ORDERING OXYGEN

As a member of the WPS (J-8 Part A/B Medicare Administrative Contractor for Indiana) Provider Outreach and Advisory Committee, we received the following information to be included in this article.

Physicians! Are You Ordering Oxygen For Your Patient?

Your medical record documentation determines whether your patient can receive the oxygen equipment and supplies you have prescribed and the amount of the patient's out of pocket expenses.

Your medical record documentation must show that other alternative treatments (e.g., medical and physical therapy directed at secretions, bronchospasm and infection) have been tried or considered and deemed clinically ineffective. The documentation must show the patient was seen within 30 days prior to the start of oxygen therapy. The medical record must show the medical condition necessitating the home use of oxygen therapy.

The medical record and/or prescription would indicate the oxygen flow rate (e.g., 2 liters per minute), the estimation of the frequency (10 minutes per hour), duration of use (12 hours per day) and duration of need (6 months). You must specify the type of oxygen delivery system to be used (i.e. portable/stationary concentrator, compressed gas portable/stationary, liquid portable/stationary.)

Medicare can make payment for home oxygen supplies and equipment when the patient's medical record shows the patient has significant hypoxemia and meets medical documentation, test results, and health conditions as specified in §240.2, Chapter 1, Part 4 of the Medicare National Coverage Determinations Manual http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf

You must complete and sign Form CMS-484 (Certificate of Medical Necessity (CMN): Oxygen.) https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms484.pdf. However, the CMN itself is not considered part of the medical record. All information included in the CMN must be supported by the contemporaneous medical record. You can find instructions on completing this form in the Chapter 5 of the Medicare Program Integrity Manual at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c05.pdf.

The Comprehensive Error Rate Testing (CERT) contractor has identified multiple errors in the claims received for oxygen equipment and supplies. These errors include missing physician clinical records showing the patient's condition and the continued need for oxygen, missing signed and dated order from the physician when changing the oxygen liter flow rate, missing copy of the oxygen saturation testing, and missing treating physician's re-evaluation for recertification CMN.

Help your patients and the Medicare program by verifying you have the medical record documentation to support the order and supply of oxygen for your patients. This allows Medicare to pay claims appropriately.