EDGE SERVER WEBINAR SERIES V

ICD-10 Implementation: EDGE Server Medical Claim Submission

October 6, 2015

Health Insurance Marketplace Program Training Series

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Agenda

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Session Guidelines

- This is a 90-minute webinar session.
- For questions regarding content and the DDC program, please contact your Financial Management (FM) Service Representative directly and copy the Centers for Medicare & Medicaid Services (CMS) Help Desk (CMS_FEPS@cms.hhs.gov).
- For questions regarding logistics and registration, please contact the Registrar at (800) 257-9520.

Intended Audience

- Amazon and On-Premise Server Issuers (Marketplace and Non-Marketplace)
- Third Party Administrators (TPAs) and Support Vendors

Purpose

The purpose of this External Data Gathering Environment (EDGE) server session is:

- To provide issuers and TPAs information about submission of International Classification of Diseases, Ninth Revision (ICD-9) and International Classification of Diseases, Tenth Revision (ICD-10) Diagnoses Codes on medical claims that have Statement Covers From dates before 9/30/15 and Statement Covers Through dates equal to or after 10/1/15.

ICD-9 / ICD-10 Diagnoses and EDGE Server Medical Claim Submission

ICD-9 / ICD-10 EDGE Server Claim Submission Overview

- The EDGE server reference tables will be updated on November 2, 2015.
  - CMS will update the Diagnosis Code table (DGNS_CD_TYPE) to include an Effective End Date of 9/30/2015 for all ICD-9 Diagnosis Codes (DGNS_QLFYR_CD=01).
  - CMS will update the Diagnosis Code table (DGNS_CD_TYPE) to include an Effective Start Date of 10/1/2015 for all ICD-10 Diagnosis Codes (DGNS_QLFYR_CD=02).
  - CMS will update the Hierarchical Condition Category (HCC) table (ENRL_DGNS_CD_TO_CC_CD_ASSOC) to include all mappings for both ICD-9 and ICD-10 Diagnosis Codes.

ICD-9 / ICD-10 EDGE Server Claim Submission Overview (continued)

- The EDGE server uses the Statement Covers Through date on a medical claim to verify if a Diagnosis Code is valid on that date in the Diagnosis Code reference table.
  - If the Statement Covers Through date on the claim is equal to or between the reference table Diagnosis Code Effective Start and End dates, the reference check is passed.
    - Issuers must submit ICD-9 Diagnosis Codes on claims with Statement Covers Through dates that are equal to or prior to 9/30/15.
    - Issuers must submit ICD-10 Diagnosis Codes on claims with Statement Covers Through dates that are equal to or later than 10/1/15.

ICD-9 / ICD-10 EDGE Server Claim Submission Overview (continued)

- CMS published guidance on how to handle specific types of claims where services begin prior to 10/1/15 and end after 10/1/15.
- The current EDGE server design will accept claims that follow the CMS published guidance with the exception of Durable Medical Equipment (DME) services.
- Issuers are reminded that the final data submission for the 2015 Risk Adjustment (RA) and Reinsurance (RI) Benefit Year is April 30, 2016. Issuers may submit claims, and Supplemental Diagnosis files, with ICD-9 and ICD-10 Diagnosis Codes until April 30, 2016.

Overview of CMS Published Guidance

- CMS published Medicare Learning Network (MLN) Matters Number SE1408: *Medicare Fee-For-Service (FFS) Claims Processing Guidance for Implementing International Classification of Diseases, Tenth Revision (ICD-10) – A Re-Issue of MM7492.*
- This publication included the following information:
  - ICD-9 Diagnosis Codes will no longer be accepted on claims (including electronic and paper) with from Dates of Service (on professional and supplier claims) or dates of discharge/through dates (on institutional claims) on or after October 1, 2015.
  - A claim cannot contain both ICD-9 Diagnosis Codes and ICD-10 Diagnosis Codes.

Overview of CMS Published Guidance (continued)

- CMS acknowledges there are circumstances where claims include services that began prior to 10/1/15 and ended after 10/1/15. CMS has instructed issuers on how to submit such claims.
- This presentation will review the CMS guidance and how claims are to be submitted to the EDGE server in accordance with that guidance.
    - This information will be included in the next version of the EDGE Server Business Rules (ESBR).

Inpatient Claims - Hospital

Inpatient Hospital

- CMS MLN Matters Guidance states:
  - If the hospital claim has a discharge and/or Statement Covers Through date on or after 10/1/15, then the entire claim is billed using ICD-10 Diagnosis Codes.
- EDGE Server Implementation:
  - Inpatient *hospital* claims that have a Statement Covers Through date on or after 10/1/15 must be submitted with ICD-10 Diagnosis Codes only.

Inpatient Hospital (continued)

- Inpatient *hospital* claims submitted to the EDGE server are defined as Bill Types 111 and 117.
- Interim bills that are converted from 112, 113 and/or 114 into a 111 or 117 Bill Type must be aggregated as currently outlined in the ESBR.
  - These aggregated bills must be submitted with ICD-10 Diagnosis Codes only.
- Issuers who feel they have diagnoses on interim bills (with dates prior to 10/1/15) that are not reported as ICD-10 diagnoses on the final bill have two (2) options for submitting ICD-9 Diagnosis Codes.

Inpatient Hospital (continued)

- ICD-9 Diagnosis Codes that appear on interim bills and are not present on the final bill may be submitted using one (1) of the below options:
  - **Option 1**: Issuers may use the published CMS General Equivalence Mappings (GEMs) to crosswalk and submit an ICD-9 Diagnosis Code as an ICD-10 Diagnosis Code on the final claim.
  - **Option 2:** Issuers may submit the ICD-9 Diagnosis Code on the Supplemental Diagnosis File Submission file when:
    - The ICD-9 Diagnosis Code is supported in the medical record.
    - The Date(s) of Service on the Supplemental Diagnosis file are before 10/1/15 and within the statement coverage periods on the final claims

Inpatient Claims - Other Facility

Inpatient Other Facility

- CMS MLN Matters Guidance:
  - Requires some facility claims, such as skilled nursing, to be split and others, such as swing beds, to be submitted in their entirety.
- EDGE Server Implementation:
  - Inpatient facility claims, other than hospital claims, that have a Statement Covers Through date on or after 10/1/15 may be split or submitted in their entirety.

Inpatient Other Facility (continued)

- Inpatient facility claims, other than hospital claims, are submitted to the EDGE server using Bill Types 121/127, 181/187, 211/217, 221/227, 281/287, 411/417, 651/657, 661/667, and 861/867.
- Interim bills associated with these Bill Types may either be submitted individually or may be aggregated, as currently outlined in the ESBR.

Inpatient Other Facility (continued)

- Issuers who submit Interim bills individually with Statement Covers From and Statement Covers Through dates earlier than 10/1/15 should submit ICD-9 Diagnosis Codes.
- Issuers who aggregated interim bills as one (1) final claim with a Statement Covers Through date on or after 10/1/15 should submit ICD-10 Diagnosis Codes.
  - Issuers who choose to aggregate claims may submit ICD-9 Diagnosis Codes using one (1) of the two (2) methods described for inpatient hospital claims (crosswalk ICD-9 Diagnosis Codes to ICD-10 Diagnosis Codes or submit the ICD-9 Diagnosis Codes on the Supplemental Diagnosis Submission file).

Outpatient Facility, Anesthesia, DME and Other Claims

Outpatient Facility Claims Bundled with Inpatient Claims

- CMS MLN Matters Guidance addresses outpatient services that are bundled with an inpatient service.
  - For bundled services, the inpatient hospital rule applies – only ICD-10 Diagnosis Codes are permitted if the Statement Covers From date is earlier than 10/1/15 and the Statement Covers Through date is equal to or later than 10/1/15.
- EDGE Server Implementation:
  - The ESBR does not address outpatient services that are bundled with an inpatient service. However, if issuers bundle such services, and the statement coverage dates cross 10/1/15, then only ICD-10 Diagnosis Codes will be accepted.

Outpatient Facility Claims Not Bundled with Inpatient Claims (continued)

- The ESBR allows for outpatient facility claims that are not bundled with inpatient claims to be submitted individually or aggregated.
    - Outpatient facility claims will follow the same rules of submission, as outlined for inpatient facility claims other than hospital claims.
        - Issuers may aggregate or split outpatient facility claims and submit either ICD-9 or ICD-10 Diagnosis Codes based on the statement coverage period.

Anesthesia

- CMS MLN Matter Guidance states:
  - Anesthesia procedures that begin on 9/30/15, but end on 10/1/15, are to be billed with ICD-9 Diagnosis Codes and use 9/30/15 as both the Statement Covers From date and Statements Covers Through date.
- EDGE Server Implementation:
  - Issuers should follow CMS guidance for anesthesia claims that begin on 9/30 and end on 10/1 and modify the Statement Covers Through date to 9/30/15 and submit ICD-9 Diagnosis Codes.

Durable Medical Equipment (DME)

- CMS MLN Matters Guidance states:
  - Diagnosis Codes associated with DME services will be based on the Statement Covers From date. Therefore, claims that begin earlier than 10/1/15 and have a Statement Covers Through date on or after 10/1/15 are submitted with an ICD-9 Diagnosis Code.
- EDGE Server Implementation:
  - DME claims submitted with an ICD-9 Diagnosis Code on claims that have a Statement Covers From date earlier than 10/1/15 and a Statement Covers Through date on or after 10/1/15 will be rejected.

Durable Medical Equipment (DME) (continued)

- DME claims that have a Statement Covers From date earlier than 10/1/15 and a Statement Covers Through date on or after 10/1/15 would include ICD-9 Diagnosis Codes; therefore, issuers must change the Statement Covers Through date to 9/30/15 in order for the claim to be accepted.
  - Only DME claims with a Statement Covers From and Statement Covers Through date on or after 10/1/15 should include ICD-10 Diagnosis Codes.

All Other Services

- Claims that include a Statement Covers From date earlier than 10/1/15 and a Statement Covers Through date equal to or later than 10/1/15 may only be submitted with ICD-10 Diagnosis Codes due to reference table verifications.
- Issuers who have specific scenarios that do not align with these requirements should contact their Financial Management (FM) Service Representative and the information will get escalated for review.

Medical Claim Submission Summary

- Diagnosis Codes are validated based on the Statement Covers Through date on a claim.
- Claims with Statement Covers Through dates of 10/1/15 or later must only include ICD-10 Diagnosis Codes.
- Issuers must continue to aggregate inpatient hospital interim bills that cover a full stay that begin prior to 10/1/15 and end on or after 10/1/15.

Medical Claim Submission Summary (continued)

- Issuers may split inpatient facility claims, in locations other than a hospital, and outpatient facility claims, and submit ICD-9 Diagnosis Codes for statement coverage periods that begin and end prior to 10/1/15 and ICD-10 Diagnosis Codes for statement coverage periods that begin and end on or after 10/1/15.
- Claims for anesthesia services that start on 9/30/15 and end on 10/1/15 must be modified to indicate a Statement Covers Through date of 9/30/15 and should only include ICD-9 Diagnosis Codes to be accepted.
- Claims for DME services that start prior to 9/30/15 and end on or after 10/1/15 must be modified to indicate a Statement Covers Through date of 9/30/15 and should only include ICD-9 Diagnosis Codes to be accepted.

Upcoming Webinars

Upcoming Webinars

- Upcoming webinar presentations will:
  - Highlight important business rules as they relate to a specific inbound file type.
  - Provide information on outbound files.
  - Explain data management and data retention requirements.
- CMS staff will be available at the end of each webinar presentation to answer questions on the material covered in each session.

Upcoming Webinars

Webinar	Scheduled Event Date
Open Q&A Session	**October 13, 2015**
Baseline Submission	**October 20, 2015**
Open Q&A Session	October 27, 2015
***Duplicate Claims and Mother/Baby Claims**	**November 3, 2015**

***Note – The Duplicate Claims and Mother/Baby Claims session previously scheduled for October 27, 2015 has been moved to November 3, 2015.**

Questions?

To submit questions by phone:

- ❑ Dial ‘14’ on your phone’s keypad
- ❑ Dial ‘13’ to exit the phone queue

Resources

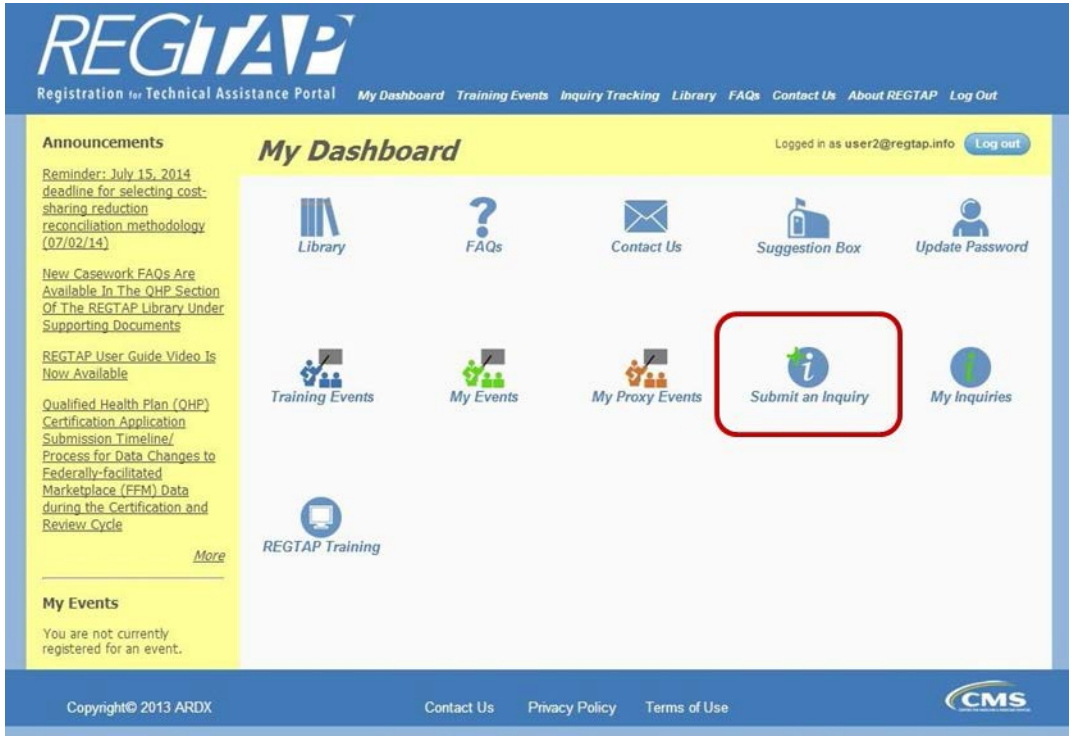
Resources

Resource	Link/Contact Information
Center for Consumer Information and Insurance Oversight (CCIIO)	http://cms.gov/cciio/
Registration for Technical Assistance Portal (REGTAP) • Registration • Inquiry Tracking and Management System (ITMS) • Resource Library • Frequently Asked Questions (FAQs)	https://www.REGTAP.info/
CMS Help Desk • Technical assistance with EDGE Registration, Provisioning and File Processing	CMS_FEPS@cms.hhs.gov 855-CMS-1515

Inquiry Tracking and Management System (ITMS)

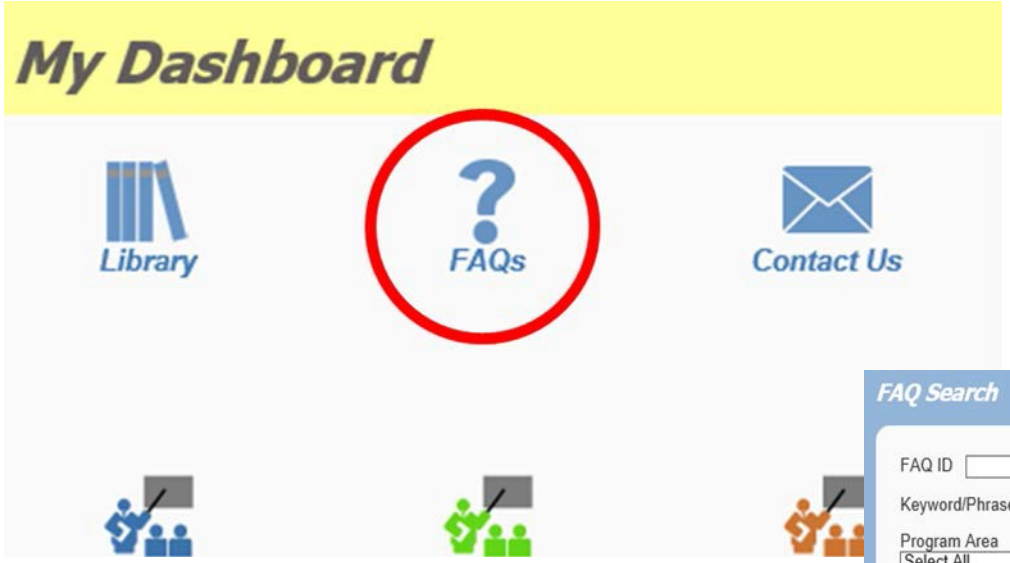
ITMS is available at https://www.REGTAP.info/

Users can submit questions after the webinar by selecting “Submit an Inquiry” from My Dashboard.



Note: Enter only one (1) question per submission.

FAQ Database on REGTAP



The FAQ Database allows users to search FAQs by FAQ ID, Keyword/Phrase, Program Area, Primary and Secondary categories, and Publish Date.

FAQ Database is available at https://www.REGTAP.info/

Closing Remarks