Medicare Fee-For-Service Claims Processing Contingency Plan for ICD-10 Implementation

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INTRODUCTION

PURPOSE

This document provides contingency planning scenarios and response options for Medicare Fee-For-Service (FFS) claims processing related to International Classification of Diseases Version 10 (ICD-10) Implementation.

BACKGROUND

ICD codes are used to record the patient's state of health and institutional procedures. It is used in the U.S. for morbidity and mortality reporting as well as reimbursement. All other G7 countries have already adopted their respective versions of ICD-10. Physician specialty groups, hospitals, dentists and coders in the United States provided extensive input into the development of ICD-10-CM, as the Centers for Disease Control and Prevention responded to their requests for more precise codes to capture conditions they treat. The National Committee for Vital Health Statistics (NCVHS) first held hearings on the adoption of ICD-10 in 2002, and sponsored a RAND study on its merits.

After considerable public and industry input and based on a 2003 recommendation from NCVHS, the ICD-10 code set adoption was proposed in regulation in 2008, with a compliance date of October 1, 2011. HHS adopted ICD-10 in a final rule published in January, 2009 , and, based on thousands of stakeholder comments, adopted a compliance date of October 1, 2013, two years' later than the proposed 2011 date. In proposed and final rules in 2012, HHS moved the ICD-10 compliance date to October 1, 2014 to give the industry an additional year to work toward the transition. In April 2014, the Protecting Access to Medicare Act further delayed the compliance date. In response to this legislation, in July 2014, HHS issued a final rule delaying the implementation date to October 1, 2015.

SCOPE

This document provides contingency plans for five scenarios: (1) industry systems failures resulting in provider inability to submit any ICD-10 codes on Medicare FFS claims beginning October 1, 2015, (2) industry failure to submit correct ICD-10 codes on Medicare FFS claims beginning October 1, 2015, (3) CMS systems failure to accept and correctly process Medicare FFS claims containing ICD-10 codes beginning October 1, 2015, (4) delay in ICD-10 implementation, and (5) problems with the October 1, 2015, Medicare FFS systems release unrelated to ICD-10 but blamed externally on ICD-10 implementation.

ASSUMPTIONS

- ICD-10 implementation is scheduled for October 1, 2015 for Medicare FFS claims processing systems.
- CMS will be monitoring Medicare FFS claims reject rates related to ICD submission on a daily basis beginning October 1, 2015.
- CMS will monitor denial rates for unexpected changes in the event fluctuations could be linked to ICD-10 submission.

- Each day for a minimum of 30 days a decision will be made regarding whether or not a contingency plan must be invoked.
- If Medicare FFS claims are not being processed correctly due to any of the scenarios presented under SCOPE above the appropriate contingency plan option will be invoked.
- **Under no scenario would CMS be able to allow for dual processing**; that is, allowing both ICD-9 and ICD-10 codes to be submitted for dates of service October 1, 2015 and later is not possible. The FFS claims processing systems can accept only one or the other for the same date of service.
- CMS may need to work with the MACs and data centers to manage workload should large number of claims be held (either by CMS or by providers) or need reprocessing. MACs will report status of held and reprocessed claims as required by CMS.
- A coordinated approach to provider education and outreach will be developed jointly among CM, OEI, OC and OL.

Additional Reference Document: ICD-10 Day 1 Activities for the Medicare Fee-for-Service (FFS) Program. This document will contain specific monitoring metrics, timeframes for collection, source of information, and triggers for invoking the contingency plan.

CONTINGENCY OPTIONS

SCENARIO 1

Medicare FFS systems working as expected. Provider systems failures result in provider inability to submit any ICD-10 codes on Medicare FFS claims beginning October 1, 2015. ICD-10 continues to be required on all Medicare FFS claims.

CMS Actions: Educational blitz reminding submitters of options and tools available for ICD-10 readiness.

- Remind providers of the following options for submitting claims with ICD-10 codes should their systems not be capable:
  - Paper claims submission
    - Guidelines currently exist that allow providers to request an exception for mandatory electronic submission (IOM 100-4, chapter 24, section 90.3).
    - MACs do quarterly reviews enforcing that all paper filers fall into an ASCA waiver situation.
    - Include information about the payment floor being longer for paper claims versus for electronic claims so that providers understand they will not be paid as quickly as they might expect
    - Medicare Administrative Contractors (MACs) receive reports on all providers who go from electronic to paper submission. Currently MACs call these providers to help them resume electronic billing. Potential MAC budgetary impact if volumes of paper billers and MAC interactions with them increases significantly.
    - Paper claims stock is made available to providers from certain commercial online retailers (including the Government Printing Office) and office

    supply stores. CMS may wish to encourage retailers to have stock on hand around the time of ICD-10 implementation.
  - Free billing software available from MAC websites
  - Use of MACs provider internet portals that allow for the submission of professional claims. This option is not available for submission of DMEPOS or institutional claims. As of May 1, 2015, the MAC jurisdictions that offer submission on their provider internet portals are:
    - Jurisdiction H (Novitas – Texas, Mississippi, Arkansas, Colorado, New Mexico)
    - Jurisdiction K (NGS – Maine, New Hampshire, Vermont, Massachusetts, Connecticut, Rhode Island, New York)
    - Jurisdiction L (Novitas – Pennsylvania, New Jersey, Delaware, Maryland, Washington, D.C.)
    - Jurisdiction 5 (WPS – Nebraska, Kansas, Iowa, Missouri)
    - Jurisdiction 6 (NGS – Wisconsin, Minnesota, Illinois)
    - Jurisdiction 8 (WPS – Michigan, Indiana)
    - Jurisdiction 11 (Palmetto – Virginia, West Virginia, North Carolina, South Carolina)
    - Jurisdiction 15 (CGS – Ohio, Kentucky)
- Remind providers of available tools for ICD-9 to ICD-10 conversion:
  - General Equivalence Mappings (GEMs)
  - Medicare Coverage Database (National and Local Coverage Determinations)
  - Existing Medicare Learning Network® (MLN) products
  - Content would be determined during discussion of the issue. Content may be addressed through MLN Matters® Articles and Medicare Learning Network Fact Sheets, Educational Tools, or Booklets. Content examples:
  - Rules for paper submission
  - How to access free billing software
  - Portal information, with registration links
- Funding: No additional funding would be provided. MACs will reprioritize workloads as needed if there is any cost for this contingency.

SCENARIO 2

Provider failure to submit correct ICD-10 codes on Medicare FFS claims beginning October 1, 2015. Providers are able to submit ICD-10 codes, but they are submitting the incorrect codes and are being appropriately denied based on Medicare FFS claims processing edits. ICD-10 continues to be required on all Medicare FFS claims with dates of service on and after October 1, 2015.

- CMS Actions: Provider education - Content would be determined during discussion of the issue. Content may be addressed through MLN Matters Articles and Medicare Learning Network Fact Sheets, Educational Tools, or Booklets. Remind providers of available tools for ICD-9 to ICD-10 conversion:
  - General Equivalence Mappings (GEMs)
  - Medicare Coverage Database (National and Local Coverage Determinations)
  - Existing Medicare Learning Network products

- Determine if there are higher levels of denials for certain edits than others and develop educational messages as appropriate.
- Reach out to partner organizations to gather feedback.
- Work proactively with the Medicare Enrollment and Appeals Group to identify specific areas of high volume reopenings and reconsiderations potentially related to ICD-10 denials and to develop related educational materials.
- Funding: No additional funding would be provided. MACs will reprioritize workloads as needed if there is any cost for this contingency.

SCENARIO 3

Medicare FFS systems are not working as expected. Large number of inappropriate rejects and/or denials due to CMS ICD-10 related system issues. ICD-10 continues to be required on all Medicare FFS claims; CMS must resolve identified issues.

CMS Actions: Reduce inappropriate claims rejects/denials

- Implement claims hold while issues being assessed
  - The typical claims holds implemented in Medicare fee-for-service claims processing are done AFTER the front end; the claims need to get into the system before we can hold them
    - There is a high level of confidence based on successful acknowledgement testing that holding claims prior to the front ends will not be necessary.
    - CMS has no experience holding claims prior to the front end processing. While technically possible this is an untested process that could prove risky and may require additional resources (e.g., for extra storage). **Holding claims prior to front end processing is therefore not recommended.**
  - Will potentially need to move to a rolling hold if claims need to be held longer than 10 business days. This will minimize as much as possible the volume of claims that need reprocessing.
  - May start with a total claims hold and reduce types of claims held if issues related only to certain edits and/or provider types
    - Could potentially hold longer than 10 business days if a smaller set of claims are impacted
  - Claims held for extensive periods of time (e.g., greater than 30 days) may require payment of interest once they are processed.
- Invoke the OTS Emergency Response Team (ERT).
  - The ERT, in consultation with CMS, will determine the appropriate actions for shared systems and CWF issues.
  - If fixes can be made quickly the claims hold may be sufficient.
  - If a decision is made that additional action is needed prior to fixes being installed direction could be given to bypass specific system edits causing issues, as applicable.
    - The total number of edits that include ICD-10 editing is relatively small compared to the universe of edits.

      - FISS and CWF each have around 100 edits that utilize ICD codes. MCS has very few; VMS has none in the core system.
    - Bypasses are allowable for:
      - MAC controlled edits
      - LCDs
      - Most NCDs
    - Direction would be provided to the MACs via Technical Direction Letter.
      - We could choose to bypass edits or suspend claims.
      - Timing to implement depends upon the issue.
- If CCEM or CEDI issues are identified, the ICD-10 edits can be turned off temporarily. The CCEM ICD-10 editing can be turned off in 10 business days. The CEDI ICD-10 editing can be turned off in 30 calendar days.
- In all cases, turning off edits would be temporary until fixes are made. For each case, CMS would need to determine whether or not claims reprocessing is necessary once the edits are turned back on.
- Use established communication channels to inform submitters of status
  - CMS will have shell documents prepared and ready to release upon receipt of detailed information should this contingency be invoked.
- Potential impact on appeals activities is being assessed via CR.
- From a Medicare Coordination of Benefits (COB)/claims crossover perspective, it would be better to hold claims as long as possible and then release them for adjudication after the issues have been resolved, rather than turn off edits and have to reprocess claims once edits are turned back on.
  - OFM, through the Benefit Coordination and Recovery Center (BCRC), can alert all COBA trading partners nationally if this scenario is realized.
  - If reprocessing occurs, OFM would instruct the MACs via TDL to send all reprocessed crossover claims to the BCRC with indicators that ensure commercial payers would not encounter the per claim crossover fee a second time for the reprocessed claims.
  - Trading partners will inform the BCRC if they are having any ICD-10 implementation issues that may impede receipt of crossover claims.
    - The BCRC does not have the ability to hold crossover claims files and not send them to trading partners experiencing issues; the BCRC will observe a hard cutover for all trading partners at the same time.
    - OFM does not currently have information regarding whether or not trading partners can accept but not process crossover claims files. If a trading partner is having significant issues OFM would not typically simply terminate the agreement because there a many facets to the agreements that would need to be addressed.
- A successful contingency plan table top exercise with CMS and our contractors was held on December 10, 2014.
  - OTS was the lead for planning the table top exercise.
  - Staff from maintainers, MACs and CMS were included.
  - The exercise included scenarios for both hard coded and MAC controlled edits.

- Funding: Funds for shared systems and CWF fixes, should any be needed, are obligated to carry through January 31, 2016.

SCENARIO 4

Additional delay in ICD-10 implementation. CMS systems must continue ICD-9 processing after October 1, 2015.

<u>CMS Actions</u>:

- Modification of front end edits – requirements vary by system
    - CCEM – Needs 10 business days' notice to allow ICD-9 past October 1, 2015.
    - CEDI – Needs 30 calendar days' notice to allow ICD-9 past October 1, 2015.
- Shared systems (defined as MCS, FISS and VMS) and CWF have ability to switch back to ICD-9 in an all-or-nothing approach. Core edits set up using a "parm date." If a decision is made to revert back to ICD-9 the only change would be to the parm date, not to each individual edit. Maintainers need 10 business days' notice to allow ICD-9 past October 1, 2015.
    - This is MAC controlled for FISS, MCS and VMS and Host controlled for CWF.
- Impacted CMS-Supplied Software
    - 3M Suite of Software
        - Groupers, I/OCE, MCE – 3M is developing both ICD-9 and ICD-10 versions of all of the software they develop for Medicare fee-for-service claims processing
        - Code Translation Tool (CTT) licenses
    - Pricers – Developed internally by CM
        - CM staff need 2 weeks from final specification receipt to develop and release impacted Pricers
        - Final Pricers for the October 2015 release will be available August 2015
    - Lab Edit Module – Developed by Fu Associates
        - 3 to 4 months lead time needed to make necessary updates, depending upon phase of the release schedule
- MACs are currently maintaining LCD policies with both ICD-9 and ICD-10 codes.
    - Crosswalks for LCDs were posted April 1, 2014.
        - Translated LCDs will receive a new policy number which will make them easily distinguishable from current policy.
        - Policies containing ICD-9 codes will be retired on October 2, 2015, and will be moved into the LCD archive on January 1, 2016.
    - MACs took different approaches to their LCDs: some used a date within the LCD edit itself and others had them all in a separate module.
        - Some MACs have hundreds of LCDs; it would take 4 to 6 months for those MACs that put the data parameter in each LCD to make the necessary changes.
- We expect that industry will request additional end-to-end testing availability during the implementation delay period
- Would need a new ICD-10 implementation regulation (OEI)
- Depending upon timing could have impact on payment regulations

- Potential significant impacts on submitters and Medicare COB trading partners ready for ICD-10. The BCRC needs 90 calendar days' notice to delay installation of its intended ICD-10 edit software prior to October 1, 2015.
- Additional funding would be required to implement another ICD-10 implementation delay.
- Contract actions would be required to change statements of work and fund contractor activities to implement an ICD-10 delay.
- Ideally, in order to avoid significant impacts to regulations a delay decision would be necessary by March 1, 2015.
- **Without taking into account regulation preparation issues, in order to avoid claims holds, a delay decision would be necessary by June 1, 2015.**

Additional Reference Document: ICD-10 FFS Budget for ICD-10 Implementation Delay

SCENARIO 5

Problems with the October 1, 2015, Medicare fee-for-service claims processing systems release unrelated to ICD-10 implementation occur. Industry blames issues on ICD-10 implementation. ICD-10 continues to be required on all Medicare FFS claims with dates of service on and after October 1, 2015.

CMS Actions:

- Proactively review the complexity of CRs planned for the October 1, 2015, release and advocate reducing complexity as much as possible (e.g., by targeting complex CR implementation for a later release when possible).
- Use established communication channels to educate providers pre-release regarding planned claims holds and post-release regarding claims holds instituted due to release issues, and any other issues as necessary.
- OTS invokes ERT to identify/remedy problems.
- Reach out to partner organizations to educate on the nature/root causes of the problems and planned CMS actions.
- Keep the BCRC and all COB trading partners appropriately informed as CMS TDLs are issued.
- Develop specific provider communications materials as needed. Content would be determined during discussion of the issue. Content may be addressed through MLN Matters Articles and Medicare Learning Network Fact Sheets, Educational Tools, or Booklets.
- Funding: No additional funding would be provided. MACs may reprioritize workloads as needed if there is any cost for this contingency.