DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CENTER FOR MEDICARE

DATE: September 25, 2015

TO: All Medicare Advantage Organizations, Part D Sponsors, PACE Organizations, Cost Plans, Medicare-Medicaid Plans, and Demonstrations

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SUBJECT: Guidance Regarding ICD-10 and Medicare Advantage

New and revised clarifying questions related to flexibilities in ICD-10 implementation ("the Guidance") can be found at https://www.cms.gov/Medicare/Coding/ICD10/Clarifying-Questions-and-Answers-Related-to-the-July-6-2015-CMS-AMA-Joint-Announcement.pdf.

Below are frequently asked questions about how the Guidance applies to Medicare Advantage and Part D.

Question: Do the Medicare fee-for-service audit and quality program flexibilities apply to Medicare Advantage?

Answer: No, the Guidance applies only to Medicare fee-for-service claims from physicians or other practitioners billed under the Medicare Fee-for-Service Part B physician fee schedule. Medicare Advantage risk adjustment payment and audit criteria remain unchanged.

Question: Does the Guidance change coding guidelines?

Answer: No, coding guidelines are unchanged.

Question: Will the Medicare review contractors be auditing the Medicare Advantage services according to this Guidance?

Answer: The Medicare review contractors only review Medicare fee-for-service claims. This Guidance does not apply to the Medicare Advantage plans.

Question: How will this transition to ICD-10 impact quality reporting for the Medicare Advantage and Part D programs?

Answer: Since the Healthcare Effectiveness Data and Information Set (HEDIS) measures use look-back periods, during the transition measure specifications will reference both ICD-9 and ICD-10 codes. More specifically, they will reference:

- International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM).
- International Classification of Diseases, 10th Revision, Clinical Modification (ICD 10-CM).
- International Classification of Diseases, 10th Revision, Procedure Coding System (ICD 9-PCS).

Question: How does the implementation of ICD-10 affect coverage and appeal decisions made by Part D plan sponsors and Medicare Advantage organizations?

Answer: Beginning October 1, 2015, all 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. In order to support a favorable coverage or appeal decision related to a date of service on or after that date, the plan must ensure that the medical documentation includes any necessary ICD-10 code applicable to the coverage request. If a plan receives supporting medical documentation that includes an ICD-9 code (and the plan does not otherwise have the appropriate ICD-10 information within its processing system), the plan is responsible for making reasonable attempts to contact the provider/prescriber to have the diagnosis code corrected to the appropriate ICD-10 code. If the correct diagnosis code cannot be obtained, the plan will make an unfavorable coverage or appeal decision within the applicable adjudication timeframe.

Please direct any additional questions you may have as follows:

- For questions regarding the ICD-10 transition and risk adjustment data, please e-mail riskadjustment@cms.hhs.gov and specify "ICD-10" in the subject line.
- For questions regarding HEDIS measures and the ICD-10 transition, please contact NCQA through their Policy Clarification Support (PCS) system at http://my.ncqa.org.
- For questions related to ICD-10 implementation for coverage and appeals decisions, please e-mail Part_C_appeals@cms.hhs.gov or PartD_appeals@cms.hhs.gov, as appropriate.