CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1122	**Date: September 14, 2012**
	Change Request 7818

SUBJECT: International Classification of Diseases (ICD)-10 Conversion from ICD-9 and Related Code Infrastructure of the Medicare Shared Systems as They Relate to CMS National Coverage Determinations (NCDs) (CR 1 of 3) (ICD-10)

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to both create and update national coverage determination (NCD) hard-coded shared system edits that contain ICD-9 diagnosis codes with comparable ICD-10 diagnosis codes plus all associated coding infrastructure such as procedure codes, HCPCS/CPT codes, denial messages, frequency edits, POS/TOB/provider specialties, etc. The requirements described herein reflect the operational changes that are necessary to implement the conversion of the Medicare shared system diagnosis codes specific to the attached Medicare NCDs

EFFECTIVE DATE: October 1, 2014
IMPLEMENTATION DATE: January 7, 2013

Please note that the implementation date is prior to the effective date in order to be prepared to meet the timeline to implement the new ICD-10 diagnosis codes on October 1, 2014. The shared systems shall begin implementation of the necessary changes to the NCDs in the January 2013 systems release. No VMS and/or DME MAC systems are included in this CR. They will be addressed in a subsequent CR. All remaining changes to the shared systems as they relate to Medicare NCDs will be made in subsequent releases.

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
Funding or implementation activities will be provided to contractors through the regular budget process

For Medicare Administrative Contractors (MACs):
The Medicare Administrative contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question

and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One-Time Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment - One-Time Notification

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I. GENERAL INFORMATION

A. Background: On October 1, 2014, as currently proposed in CMS-0040-P, all Medicare claims submissions will convert from the International Classification of Diseases, 9th Edition (ICD-9) to the 10th Edition (ICD-10). The transition will require business and systems changes throughout the health care industry. All covered entities, as defined by the Health Insurance Portability and Accountability Act (HIPAA), must adhere to the conversion.

In accordance with HIPAA, the Secretary of the Department of Health and Human Services adopts standard medical data code sets for use in standard transactions adopted under this law. According to the ICD-10 Final Rule, published in the Federalof January 16, 2009, the Secretary adopts the ICD-10-CM and ICD-10-PCS code sets for use in appropriate HIPAA standard transactions, including those for submitting health care claims electronically, for dates of service on and after October 1, 2013. Entities covered under HIPAA, which include Medicare and its providers submitting claims electronically, are bound by these requirements and must comply. Medicare will also require submitters of paper claims to use ICD-10 codes on their claims according to the same compliance date.

B. Policy: The purpose of this change request (CR) is to both create and update national coverage determination (NCD) hard-coded shared system edits that contain ICD-9 diagnosis codes with comparable ICD-10 diagnosis codes, along with all related coding infrastructure such as procedure codes, HCPCS/CPT codes, messages, frequency edits, POS/TOB and provider specialties, etc. The requirements described herein reflect the operational changes that are necessary to implement the conversion of the Medicare shared system diagnosis codes specific to the attached Medicare NCDs. In order to be prepared to meet the timeline to implement the new ICD-10 diagnosis codes on October 1, 2014, as currently proposed, the shared systems shall begin implementation of the necessary changes to the NCDs in the January 2013 systems release. No VMS and/or DME MAC systems are included in this CR but will be addressed in a subsequent CR.**All remaining changes to the shared systems as they relate to Medicare NCDs will be made in subsequent releases.**

THIS EXERCISE IN NO WAY IS INTENDED TO EXPAND, RESTRICT, OR ALTER EXISTING MEDICARE NATIONAL COVERAGE. NOR IS IT INTENDED TO MINIMIZE THE AUTHORITY GRANTED TO MEDCARE ADMINISTRATIVE CONTRACTORS IN THEIR DISCRETIONARY IMPLEMENTATION OF NCDs OR LCDs. HOWEVER, WHERE HARD-CODED EDITS WERE NOT INITIALLY IMPLEMENTED DUE TO TIME AND/OR RESOURCE CONSTRAINTS, DOING SO AT

THIS TIME WILL BETTER SERVE THE INTENT AND INTEGRITY OF NATIONAL COVERAGE AND THE MEDICARE PROGRAM OVERALL.

Spreadsheets are attached to this CR indicating all affected ICD-9 codes and their corresponding ICD-10 codes as they relate to their respective NCDs, in addition to the rest of the coding infrastructure specific to each NCD .

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement.

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
7818.1	The SSMs shall implement the edits/logic associated with the attached NCD-related ICD-10 diagnosis codes using the attached Excel spreadsheets.							X	X		X	
7818.2	Medicare contractors shall complete all ICD-10 tasks that involve updates to shared system edits/tables associated with the attached NCDs in this CR by January 7, 2013.	X	X			X		X				
7818.3	The SSMs shall ensure the ICD-10 diagnosis codes associated with NCDs are not implemented until October 1, 2014, as currently proposed.							X	X		X	
7818.4	CWF shall post next eligible date on provider inquiry screens HUQA, NGD, MBD for 76977, 77078, 77080, 77081 &G0130.										X	
7818.5	CWF shall create a new frequency edit to allow HCPCS for bone density 1 x per 23 month period. Allow 1 PROF, 1 TECH. Allow override for dates of service on and after 10/1/2014 for 76977, 77078, 77080, 77081 &G0130.										X	

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility					
		A/B MAC	DME	FI	CAR	RHH	Other

		Part A	Part B	MAC		RIER	I	
7818.6	MLN Article : A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X			X		

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: NA

V. CONTACTS

Pre-Implementation Contact(s): Patricia Brocato-Simons, 410-786-0261 or patricia.brocatosimons@cms.hhs.gov , Katherine Tillman, 410-786-9252 or katherine.tillman@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:
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Section B: For Medicare Administrative Contractors (MACs):
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obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.