CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 950	**Date: August 19, 2011**
	Change Request 7492

SUBJECT: Medicare Fee-For-Service Claims Processing Guidance for Implementing International Classification of Diseases, 10th Edition (ICD-10)

I. SUMMARY OF CHANGES: The CR is to provide guidance on reporting, claims submissions and date span requirements for ICD-10 effective October 1, 2013.

EFFECTIVE DATE: October 1, 2013
IMPLEMENTATION DATE: January 3, 2012

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	

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

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 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.

IV. ATTACHMENTS:

One-Time Notification

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

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 950	Date: August 19, 2011	Change Request: 7492

SUBJECT: Medicare Fee-For- Service Claims Processing Guidance for Implementing International Classification of Diseases, 10th Edition (ICD-10)

Effective Date: October 1, 2013

Implementation Date: January 3, 2012

I. GENERAL INFORMATION

A. Background: On October 1, 2013, all Medicare claims submissions of diagnosis and hospital inpatient procedure coding will change from the International Classification of Diseases, 9th Edition (ICD-9) to the 10th Edition (ICD-10). All entities covered by the Health Insurance Portability and Accountability Act (HIPAA) must make the transition including systems changes throughout the entire health care industry.

B. Policy: For dates of service on and after October 1, 2013, entities covered under HIPAA are required to use the ICD-10 code sets in standard transactions adopted under HIPAA. The HIPAA standard health care claim transactions are among those for which ICD-10 codes must be used for dates of service on and after the compliance date. The following provides information on reporting guidelines, claims submissions and date span requirements for ICD-10.

General Reporting of ICD-10

As with ICD-9 codes today, providers and suppliers are still required to report all characters of a valid ICD-10 code on claims. ICD-10 diagnosis codes have different rules regarding specificity and providers/suppliers are required to submit the most specific diagnosis codes based upon the information that is available at the time. Please refer to www.cms.hhs.gov/ICD10, for more information on the format of ICD-10 codes. In addition, ICD-10 procedure codes (PCS) will only be utilized by inpatient hospital claims as is currently the case with ICD-9 procedure codes.

NOTE: CMS will provide instructions for Beneficiary submitted claims in a future CR.

Claims Submissions

ICD-9 codes will no longer be accepted on claims (including electronic and paper) with FROM dates of service or dates of discharge/THROUGH dates on institutional claims and on professional and supplier claims on or after October 1, 2013. A claim cannot contain both ICD-9 codes and ICD-10 codes. Institutional claims will be returned to provider (RTP). Professional and Supplier claims will be returned as unprocessable.

Claims that Span the ICD-10 Implementation Date

The Centers for Medicare and Medicaid Services (CMS) has identified potential claims processing issues for institutional, professional and supplier claims that could span the implementation date; that is where ICD-9 codes are effective for services on September 30, 2013 and earlier and ICD-10 codes effective for services October 1, 2013 and later. In some cases, depending upon the policies associated with those services, there

cannot be a break in service or time (i.e., anesthesia) although the new ICD-10 codes set must be used effective October 1, 2013.

This instruction also provides details on what course of action will be required (*i.e., processing using the 'From' or 'Through/'To' dates*) if claims from institutional facilities, practitioners, or suppliers are submitted for processing and the claim/services spans the timeframes between ICD-9 codes sets and the official transition to ICD-10 on October 1, 2013.

NOTE: Claims processed under this policy will either be Return to Provider (RTP) or Returned as Unprocessable, however NOT denied, therefore the suggested standard narrative language in BR.7492.1.1 through 7492.7.1 is only being provided for use during the maintainers' development of reason codes/edits.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement

Number	Requirement	Responsibility is indicated by an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
7492.1	Contractors shall return to provider (RTP) institutional claims including ICD-9 codes received with dates of service or dates of discharge/through dates on or after October 1, 2013.	X		X		X	X				CEM
7492.1.1	The following message can be used when the standard system create their reason codes/edits to RTP these claims: "For dates of service on or after October 1, 2013, claims may not contain ICD-9 codes. Please re-submit claim with the appropriate ICD-10 code".	X		X		X	X				
7492.2	Contractors shall return as unprocessable any professional or supplier claims received with FROM dates of service on or after October 1, 2013, that are billed with ICD-9 diagnosis codes.	X	X		X	X					CEDI (VMS-For informational purposes only)
7492.2.1	The following message can be used when the standard systems/contractors create their edits to return as unprocessable these claims: "For dates of service on or after October 1, 2013, claims may not contain ICD-9 codes. Please re-submit claim with the appropriate ICD-10 code".	X	X		X	X					(VMS-For informational purposes only)
7492.3	Contractors shall RTP any claim with dates of service or dates of discharge/through dates **prior** to October 1,	X		X		X	X				CEM

Number	Requirement	Responsibility is indicated by an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
	2013 that are billed with ICD-10 diagnosis codes.										
7492.3.1	The following message can be used when the standard systems create their reason codes/edits to RTP these claims: "For dates of service prior to October 1, 2013, claims may not contain ICD-10 codes. Please re-submit claim with the appropriate ICD-9 code".	X		X		X	X				
7492.4	Contractors shall return as unprocessable any professional or supplier claims received with FROM dates of service **prior** to October 1, 2013, that are billed with ICD-10 diagnosis codes.	X	X		X	X					CEDI
7492.4.1	The following message can be used when the standard systems/contractors create their edits to RTP these claims: "For dates of service prior to October 1, 2013, claims may not contain ICD-10 diagnosis codes. Please re-submit claim with the appropriate ICD-9 diagnosis code".	X	X		X	X					
7492.5	Contractors shall RTP inpatient hospital claims that are billed with ICD-9 procedure codes on or after October 1, 2013.	X		X			X				CEM
7492.5.1	The following message can be used when the standard systems create their reason codes/edits to RTP these claims: "For dates of service on or after October 1, 2013, claims may not contain ICD-9 procedure codes. Please re-submit claim with the appropriate ICD-10 procedure code".	X		X			X				
7492.6	Contractors shall RTP/return as unprocessable all claims that are billed with **both** ICD-9 and ICD-10 **diagnosis** codes on the same claim.	X	X	X	X	X	X				CEDI/CEM
7492.6.1	The following message can be used when the standard systems/contractors create their reason codes/edits to RTP/return as unprocessable these claims: "Claims may not be submitted with both ICD-9 and ICD-10 diagnosis codes. Please correct. For dates of service prior to October 1, 2013 resubmit with the appropriate ICD-9 diagnosis code. For dates of service on or after	X	X	X	X	X	X				

Number	Requirement	Responsibility is indicated by an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
	October 1, 2013 resubmit with the appropriate ICD-10 diagnosis code".										
7492.7	Contractors shall RTP/return as unprocessable all claims that are billed with **both** ICD-9 and ICD-10 **procedure codes** on the same claim.	X		X							CEM
7492.7.1	The following message can be used when the standard systems create their reason codes/edits to RTP these claims: "Claims may not be submitted with both ICD-9 and ICD-10 procedure codes. Please correct. For dates of service prior to October 1, 2013 resubmit with the appropriate ICD-9 procedure code. For dates of service on or after October 1, 2013 resubmit with the appropriate ICD-10 procedure code".	X		X							
7492.8	Contractors shall use the attached Matrix (**Section A and Section A.1**) as direction to develop systems changes for institutional claims with dates of services that span the ICD-10 implementation; that is where services begin on September 30, 2013 and earlier and span through October 1, 2013 and later**.**	X		X		X	X				
7492.9	Contractors shall use the attached Matrix (**Section B**) as direction to develop systems changes for Professional claims with dates of service that span the ICD-10 implementation date to use the **FROM** line item date of service to determine whether ICD-9 or ICD-10 applies.	X			X						
7492.10	Contractors shall use the attached Matrix (**Section C**) as direction to develop system changes for Supplier claims with dates of service that span the ICD-10 implementation date to use the **FROM** line item date of service to determine whether ICD-9 or ICD-10 applies.		X			X					(VMS-For informational purposes only)
7492.11	MCS should automatically add an end date of September 30, 2013 to all of the ICD-9 diagnosis codes without an end date on the Master diagnosis file to ensure this code set is accessible after cutover.	X			X			X			
7492.12	Contractors shall continue to have ICD-9 codes accessible in their systems in order to process claims with dates of service prior to October 1, 2013, including as needed for redeterminations/appeal decisions with dates of service prior to October 1, 2013.	X	X	X	X	X	X				(CWF - For informational purposes only)

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility is indicated by an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
7492.13	A provider education article related to this instruction will be available at http://www.cms.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 site 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 your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with local information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X	X	X	X					

IV. SUPPORTING INFORMATION

Should" denotes a recommendation.

Section A: Recommendations and supporting information associated with listed requirements:

X-Ref Requirement Number	Recommendations or other supporting information:
CR 6889	

Section B: All other recommendations and supporting information:
For Business requirements 7492.1, 7492.3, 7492.5, 7492.6, and 7492.7 please take into consideration the Integrated Outpatient Code Editor (I/OCE) and Medicare Code Editor (MCE) Edits.

V. CONTACTS

Pre-Implementation Contact(s): Institutional claims: Antoinette Johnson, Antoinette.johnsom@cms.hhs.gov, 410-786-9326 .Professional claims: Kathleen Kersell and Joscelyn Lissone, kathleen.kersell@cms.hhs.gov and Joscelyn.lissone@cms.hhs.gov , 410-786-2033 and 410-786-5116. Supplier claims: Felicia Rowe; Felicia.rowe@cms.hhs.gov, 410-786-5655

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

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs)* and/or *Carriers*:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *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 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.

Attachment

Section A – Institutional Providers

Bill Type(s)	Facility Type/Services	Claims Processing Requirement	Use FROM or THROUGH Date
11X	Inpatient Hospitals (*incl. TERFHA hospitals, PPS hospitals, LTCHs, CAHs*)	If the hospital claim has a discharge and/or through date on or after 10/1/13, then the entire claim is billed using ICD-10.	**THROUGH**
12X	Inpatient Part B Hospital Services	Split Claims- Requires providers split the claim so all ICD -9 codes remain on one claim and all ICD-10 codes remain on the other claim.	**FROM**
13X	Outpatient Hospital	Split Claims - Require providers split the claim so all ICD -9 codes remain on one claim and all ICD-10 codes remain on the other claim.	**FROM**
14X	Non-patient Lab Services	Split Claims - Require providers split the claim so all ICD -9 codes remain on one claim and all ICD-10 codes remain on the other claim.	**FROM**
18X	Swing Beds	If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/13, then the entire claim is billed using ICD-10.	**THROUGH**
21X	Skilled Nursing (Inpatient Part A)	If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/13, then the entire claim is billed using ICD-10.	**THROUGH**
22X	Skilled Nursing Facilities (Inpatient Part B)	Split Claims - Require providers split the claim so all ICD -9 codes remain on one claim and all ICD-10 codes remain on the other claim.	**FROM**
23X	Skilled Nursing Facilities (Outpatient)	Split Claims - Require providers split the claim so all ICD -9 codes remain on one claim and all ICD-10 codes remain on the other claim.	**FROM**

Bill Type(s)	Facility Type/Services	Claims Processing Requirement	Use FROM or THROUGH Date
32X	Home Health (Inpatient Part B)	Allow HHAs to use the payment group code derived from ICD-9 codes on claims which span 10/1/2013, but require those claims to be submitted using ICD-10 codes.	**THROUGH**
3X2	Home Health – Request for Anticipated Payment (RAPs)*	* NOTE - RAPs can report either an ICD-9 code or an ICD-10 code based on the one (1) date reported. Since these dates will be equal to each other, there is no requirement needed. The corresponding final claim, however, will need to use an ICD-10 code if the HH episode spans beyond 10/1/2013.	***See Note**
34X	Home Health – (Outpatient)	Split Claims - Require providers split the claim so all ICD -9 codes remain on one claim and all ICD-10 codes remain on the other claim.	**FROM**
71X	Rural Health Clinics	Split Claims - Require providers split the claim so all ICD -9 codes remain on one claim and all ICD-10 codes remain on the other claim.	**FROM**
72X	End Stage Renal Disease (ESRD)	Split Claims - Require providers split the claim so all ICD -9 codes remain on one claim and all ICD-10 codes remain on the other claim.	**FROM**
73X	Federally Qualified Health Clinics *(prior to 4/1/10)*	N/A – Always ICD-9 code set.	**N/A**
74X	Outpatient Therapy	Split Claims - Require providers split the claim so all ICD -9 codes remain on one claim and all ICD-10 codes remain on the other claim.	**FROM**
75X	Comprehensive Outpatient Rehab facilities	Split Claims - Require providers split the claim so all ICD -9 codes remain on one claim and all ICD-10 codes remain on the other claim.	**FROM**
76X	Community Mental Health Clinics	Split Claims - Require providers split the claim so all ICD -9 codes remain on one claim and all ICD-10 codes remain on the other claim.	**FROM**
77X	Federally Qualified Health Clinics *(eff 4/4/10)*	Split Claims - Require providers split the claim so all ICD -9 codes remain on one claim and all ICD-10 codes remain on the other claim.	**FROM**
81X	Hospice- Hospital	Split Claims - Require providers split the claim so all ICD -9 codes remain on one claim and all ICD-10 codes remain on the other claim.	**FROM**
82X	Hospice – Non hospital	Split Claims - Require providers split the claim so all ICD -9 codes remain on one claim and all ICD-10 codes remain on the other claim.	**FROM**

Bill Type(s)	Facility Type/Services	Claims Processing Requirement	Use FROM or THROUGH Date
83X	Hospice – Hospital Based	N/A	**N/A**
85X	Critical Access Hospital	Split Claims - Require providers split the claim so all ICD -9 codes remain on one claim and all ICD-10 codes remain on the other claim.	**FROM**

Section A.1 - Special Outpatient Claims Processing Circumstances

Scenario	Claims Processing Requirement	Use FROM or THROUGH Date
3-day /1-day Payment Window	Since all outpatient services (with a few exceptions) are required to be bundled on the inpatient bill if rendered within three (3) days of an inpatient stay; if the inpatient hospital discharge is on or after 10/1/2013, the claim must be billed with ICD-10 for those bundled outpatient services.	**THROUGH**

Section B – Professional Claims

Type of Claim	Claims Processing Requirement	Use FROM or THROUGH Date
All anesthesia claims	Anesthesia procedures that begin on 9/30/13 but end on 10/1/13 are to be billed with ICD-9 diagnosis codes and use 9/30/13 as both the FROM and THROUGH date.	**FROM**

Section C –Supplier Claims

Supplier Type	Claims Processing Requirement	Use FROM or THROUGH/TO Date
DMEPOS	Billing for certain items or supplies (such as caped rentals or monthly supplies) may span the ICD-10 compliance date of 10/1/13 (i.e., the FROM date of service occurs prior to 10/1/13 and the TO date of service occurs after 10/1/13).	**FROM**