

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



A new fast fact is now available on [MLN Provider Compliance](#). This web page provides the latest educational products designed to help Medicare Fee-For-Service providers understand – and avoid – common billing errors and other improper activities. Please bookmark this page and check back often as a new fast fact is added each month!

MLN Matters® Number: MM7704

Related Change Request (CR) #: 7704

Related CR Release Date: February 3, 2012

Effective Date: October 1, 2013

Related CR Transmittal #: R10390TN

Implementation Date: July 2, 2012

International Classification of Diseases - 10th Edition (ICD-10), Inclusion of Type of Bill 33X

Note: MM7704 was revised on July 6, 2013, to add a reference to MLN Matters® article MM8244 (<http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM8244.pdf>), to alert Home Health Agencies that, beginning October 1, 2013, they should use Type of Bill 032X for claims for Home Health episodes. Beginning October 1, 2013, Original Medicare will no longer accept such claims submitted on Type of Bill 33X. All other information remains unchanged.

Provider Types Affected

This MLN Matters® Article is intended for Home Health Agencies (HHAs) who submit claims to Medicare Fiscal Intermediaries (FIs), Medicare Administrative Contractors (MACs), or Regional Home Health Intermediaries (RHHIs) for services provided to Medicare beneficiaries.

Provider Action Needed



STOP – Impact to You

You must include International Classification of Diseases, 10th Edition (ICD-10) codes on 33x Type of Bills (TOB) that you submit with Dates of Service /Discharge on or

Disclaimer

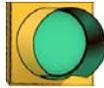
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2011 American Medical Association.

after October 1, 2013, and ICD-9 codes on those that you submit with Dates of Service/Discharge before that date. Do not submit such bills with both types of codes included.



CAUTION – What You Need to Know

Change Request (CR) 7704, from which this article is taken, provides guidance on reporting claims submissions and date span requirements for 33x TOBs containing ICD-10 codes with dates of service **on and after** October 1, 2013.



GO – What You Need to Do

You should make sure that your billing staffs are aware of these 33x TOB coding requirements.

Background

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

The Centers for Medicare & Medicaid Services (CMS) released CR7492, on August 19, 2011, to provide guidance on reporting, claims submissions and date span requirements for ICD-10 diagnosis codes, effective October 1, 2013. You can find the MLN Matters® Article associated with this CR ("Medicare Fee-For-Service (FFS) Claims Processing Guidance for Implementing International Classification of Diseases, 10th Edition (ICD-10)") at <http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM7492.pdf> on the CMS website.

CR7492, however, did not include TOB 33X as a bill type for the requirements provided. CR7704, from which this article is taken, adds TOB 33X to all requirements identified in CR7492.

You should note that your FI, A/B MAC or RHHI will Return to Provider (RTP) 33X bill types they receive that include ICD-9 codes, and which have dates of service or dates of discharge/through dates on or after October 1, 2013. When they do RTP these claims, they will use the following message:

"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".

Further, they will RTP any 33X TOB with through dates **prior** to October 1, 2013, which are billed with ICD-10 diagnosis codes, using the following message:

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2011 American Medical Association.

"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".

Finally, they will RTP all claims that are billed with both ICD-9 and ICD-10 diagnosis codes on the same claim; using the following message:

"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 after October 1, 2013, resubmit with the appropriate ICD-10 diagnosis code".

Note: Medicare will allow HHAs to use the payment group code derived from ICD-9 codes on claims, which span October 1, 2013, but will require those claims to be submitted using ICD-10 codes.

Additional Information

You can find more information about the inclusion of TOB 33x in the ICD-10 requirements by going to CR7704, located at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1039OTN.pdf> on the CMS website.

See article MM7818, available at <http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM7818.pdf>, for information on the creation and updating of hard-coded Medicare shared system edits that contain ICD-9 diagnosis codes with comparable ICD-10 diagnosis codes and the operational changes needed to implement the conversion.

If you have any questions, please contact your FI, A/B MAC, or RHHI at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

For current information on the new ICD-10 implementation date of October 1, 2014, see article SE1239 at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1239.pdf> on the CMS website.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2011 American Medical Association.