CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3049	**Date: August 25, 2014**
	Change Request 8646

Transmittal 2895, dated March 7, 2014, is being rescinded and replaced by Transmittal 3049, dated August 25, 2014 to change the effective and implementation dates for ICD-10 and ASC X12. Additionally, references to the FI have been replaced with the A/B MAC (A) in the sections that are updated by this transmittal. Also, a reference to fiscal intermediary claims processing system has been changed to FISS claims processing system. All other information remains the same.

SUBJECT: Update to Pub. 100-04, Chapter 19 to Provide Language-Only Changes for ICD-10, ASC X12, and Medicare Administrative Contractors (MAC) Implementation

I. SUMMARY OF CHANGES: This CR contains language-only changes for updating ICD-10, ASC X12, and MAC language in Pub 100-04, Chapter 19. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

EFFECTIVE DATE:

ICD-10: Upon Implementation of ICD-10
ASC-X12: January 1, 2012

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

IMPLEMENTATION DATE:

ICD-10: Upon Implementation of ICD-10
ASC X12: September 23, 2014

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
R	19/Table of Contents
R	19/100/ A/B MAC (A) Payment Policy and Claims Processing
R	19/100.3.1/ A/B MAC (A) - Inpatient Acute Care - Medicare Part A - Claims Processing

III. FUNDING:
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:

Business Requirements
Manual Instruction

Business Requirements

Pub. 100-04	Transmittal: 3049	Date: August 22, 2014	Change Request: 8646

Transmittal 2895, dated March 7, 2014, is being rescinded and replaced by Transmittal 3049, dated August 25, 2014 to change the effective and implementation dates for ICD-10 and ASC X12. Additionally, references to the FI have been replaced with the A/B MAC (A) in the sections that are updated by this transmittal. Also, a reference to fiscal intermediary claims processing system has been changed to FISS claims processing system. All other information remains the same.

SUBJECT: Update to Pub. 100-04, Chapter 19 to Provide Language-Only Changes for ICD-10 and ASC X12

EFFECTIVE DATE:
ICD-10: Upon Implementation of ICD-10
ASC-X12: January 1, 2012
**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE:
ICD-10: Upon Implementation of ICD-10
ASC X12: 30 Days from issuance

I. GENERAL INFORMATION

A. Background: This Change Request (CR) contains language-only changes for updating ICD-10, ASC X12, and MAC language in Pub 100-04, Chapter 19.

B. Policy: There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8646.1	A/B MACs shall be aware of the updated language for ICD-10 and for ASC X12 in Pub. 100 - 04, Chapter 19.	X	X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility

		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
N/A	N/A

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): N/A

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: 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.

Medicare Claims Processing Manual
Chapter 19 – Indian Health Services

Table of Contents
(Rev.3049, 08-14)

100 - *A/B MAC (A)* Payment Policy and Claims Processing

(Rev.3049, Issued; 08-25-14, Effective: ICD-10 - Upon Implementation of ICD-10; ASC-X12-01-01-12, Implementation: ICD-10 - Upon Implementation of ICD-10; ASC-X12 – 09-23-14)

Bills are submitted to the *A/B MAC (A)* by IHS providers (including CAHs) using the *ASC-X12 837 institutional claim format.* In exceptional circumstances, a hardcopy Form CMS-1450 may be accepted by the designated *A/B MAC (A)*.

The IHS providers are identified by Provider Type 08 in the Provider Specific File in the *FISS* claims processing system. The *A/B MAC (A)* uses specific IHS related edits, current outpatient edits for non-outpatient prospective payment system (non-OPPS) providers, and current inpatient prospective payment system (IPPS) edits on IPPS bills, as well as other edits applicable to CAHs.

Medical review is done in accordance with current procedures. IHS provider bills are processed subject to existing CWF edits. International Classification of Diseases-9-Clinical Modification (ICD-9-CM) codes are required on all bill types *for services before implementation of ICD-10. Upon implementation of ICD-10, ICD-10-CM diagnosis codes are required on inpatient and outpatient claims, and ICD-10-PCS procedure codes are required on inpatient claims.*

For services provided to AI/AN individuals in IHS providers (including CAHs) deductible and coinsurance amounts are applied by Medicare, but are waived by the IHS, and the MSN is suppressed. Third party payers may be billed for applicable deductible and coinsurance amounts.

100.3.1 - *A/B MAC (A)* - Inpatient Acute Care - Medicare Part A - Claims Processing

(Rev.3049, Issued; 08-25-14, Effective: ICD-10 - Upon Implementation of ICD-10; ASC-X12-01-01-12, Implementation: ICD-10 - Upon Implementation of ICD-10; ASC-X12 – 09-23-14)

All charges are combined and reported under revenue code 0100 (all-inclusive room and board plus ancillary) on type of bill (TOB) 11X (hospital inpatient). Inpatient services are billed from admission through discharge. Interim billing is not allowed.

See Chapter 1, §50.2 of Pub. 100-04, Medicare Claims Processing Manual, for more information on frequency of billing and the exceptions for interim billing.

In order to receive the appropriate payment under the IPPS, it is important that the applicable diagnosis *and* procedure codes are reported on the bill.

The MSN is suppressed.