CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-01 Medicare General Information, Eligibility, and Entitlement	Centers for Medicare & Medicaid Services (CMS)
Transmittal 87	**Date: August 8, 2014**
	Change Request 8639

Transmittal 83, dated March 14, 2014, is being rescinded and replaced by Transmittal 87, dated August 8, 2014, to change the effective and implementation dates for ICD-10. Additionally, a reference to intermediary is replaced with A/B MAC (A). All other information remains the same.

SUBJECT: Update to Pub. 100-01, Chapter 7 for Language-Only Changes for ICD-10

I. SUMMARY OF CHANGES: This transmittal updates Chapter 7 of Pub 100-01 for language-only changes for ICD-10, and deletes an outdated example in section 40.3.10 that uses ICD-9 codes. Example 1 is deleted and Example 2 is renumbered to become Example 1. There are no changes in procedure. Implementation of ICD-10 has been communicated through earlier instructions.

No other chapters in Pub 100-01 require update for this purpose.

EFFECTIVE DATE: Upon implementation of ICD-10
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: Upon implementation of ICD-10

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	7/40.3.10/ Test Case Specification Standard

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. 100-01	Transmittal: 87	Date: August 8, 2014	Change Request: 8639

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EFFECTIVE DATE: Upon implementation of ICD-10
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: Upon implementation of ICD-10

I. GENERAL INFORMATION

A. Background: This transmittal updates Chapter 7 of Pub 100-01 for language-only changes for ICD-10, and deletes an outdated example in section 40.3.10 that uses ICD 9 codes. Example 1 is deleted and Example 2 is renumbered to become Example 1.

B. Policy: There are no changes in procedure. Implementation of ICD-10 has been communicated through earlier instructions.

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	
8639.1	All MACs shall be aware of the changes described in this transmittal.	X	X	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

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

V. CONTACTS

Pre-Implementation Contact(s): Not Applicable

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

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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General Information, Eligibility, and Entitlement Manual

Chapter 7 - Contract Administrative Requirements

40.3.10 - Test Case Specification Standard

(Rev.87, Issued: 8-8-14, Effective: Upon Implementation of ICD-10, Implementation: Upon Implementation of ICD-10)

Purpose: This standard establishes a controlled outline for the contents and presentation of a Test Case Specification used by the standard system maintainers and the Beta testing contractors.

Applicability: This standard is applicable to all Test Case Specifications developed by the standard system maintainers and the Beta testing contractors.

Data Element	Description	Allowable Values or Format	Comments
Test Case Specification Identifier	Multi-part indicator that uniquely identifies the test case specification.	See Test Case Specification Identifier Standard.	
Test Purpose	A free form field that captures the intent of the test and identifies any key components of the test, e.g., specific codes.	See attached example.	
Input Specification	A free form field that captures critical information used to exercise the system functionality. Information could be grouped into the following topics: Claim Data Requirements Claims History Beneficiary Information Provider Information	See attached example.	
Intercase Dependencies (Predecessor Transaction Identifier)	The test case specification identifier of the transaction that must be entered into and processed by the system prior to processing the transaction described by the test case specification.	See Test Case Specification Identifier Standard.	
Output Specification	A free form declarative statement that identifies the expected results from performing all the steps, as a collection, within the test.		
Test Type	A one-character indicator to identify whether the test is positive or negative.	P = Positive Test N = Negative Test	**TestDirector Plan Tab (Required**

Originator	A one-character indicator to identify the originating entity (designer) of the test case.	B = Beta C = CMS/QRTM M = Maintainer	**User Defined Fields)**
Test Status	Summary indicator for a test case.	PS = Passed FA= Failed NR = Not Run IN = Incomplete ID = Invalid Data IC = Invalid Case	**Required Test Execution (Run) Elements**
Test Results	Free form declarative statement of actual results for a test case when the actual results do not match the expected results.		

Optional Information: Industry best practices demonstrate that additional granularity may be necessary to document discrete key test actions that should be executed and documented. These items are referred to as test steps. A test case specification may have one or more test steps. When documenting test steps, the following standard applies:

Step Number	Unique identifier for each test step.	"Step n" Where "n" is a sequential counter for each step starting at 1. There is at least one test step in each test case specification, but usually contains multiple test steps.	**Optional Test Case Elements**
Step Description	A free form declarative statement that identifies the action taken to perform the test. The step description statement usually begins with a verb.		
Expected Step Results	A free form declarative statement that identifies the expected results from performing the associated step description.		

Example *#1*

	Test Case Identifier	4419-2825-5.2-001
	Test Purpose	To confirm that the *A/B MAC (A)* claims processing systems accept, process, and assign reason code *30 (Payment adjusted because the patient has not met the required eligibility, spend down, waiting or residency requirements) to Inpatient Hospital claims submitted on Type of bill (TOB) 111 (Hospital Inpatient Part A; admit through discharge) with Dates of Service (DOS) on 01/01/2004 when a beneficiary is not lawfully present in the United States.*
Input Specification	**Claims History**	*None*
	Beneficiary Information	*Beneficiary must be unlawfully present in United States.* Beneficiary elected English as primary language
	Provider Information	*Provider Number Range = XX0001-XX0999*
	Claim Data Requirements	TOB = *111* *DOS = 01/01/2004*
	Intercase Dependencies	None
	Output Specification	*Claim will be assigned reason code 30 indicating beneficiary is not lawfully present in the United States, generating MSN message 5.7 (Medicare payment may not be made for the item or service because on the date of service, you were not lawfully present in the United States).*
	Test Type	P
	Originator	C
	Test Status	PS
	Test Results	Claim was assigned appropriate reason code