CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 960	**Date: September 8, 2011**
	Change Request 7321

Transmittal 885, dated April 22, 2011, is being rescinded and replaced by Transmittal 960, dated September 8, 2011 to change Effective Date October 1, 2011 and Implementation date October 3, 2011 to be Effective January 1, 2012 and Implemented January 3, 2012. All other information Remain the Same.

SUBJECT: Update the existing ViPS Medicare System (VMS) Utilization Parameter files for ICD-10.

I. SUMMARY OF CHANGES: In order for the ViPS Medicare System (VMS) to be compliant with accepting ICD-10 diagnosis codes by October 1, 2013, the Accumulation File Number (AFN) Parameters, Review Utilization Line Edit (RULE) Parameters, existing AFN and RULE to allow ICD-10 diagnosis code entry on the ViPS Medicare Automated Parameter (VMAP)/6 screen and to correctly process these transactions when ICD-10 diagnosis codes are present on Durable Medical Equipment (DME) claims must be converted.

EFFECTIVE DATE: January 1, 2012
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):
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: 960	Date: September 8, 2011	Change Request: 7321

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SUBJECT: Update the existing ViPS Medicare System (VMS) Utilization Parameter files for ICD-10

Effective Date: January 1, 2012
Implementation Date: January 3, 2012

I. GENERAL INFORMATION

A. Background: The ICD-10 Final Rule, published in the Federal Register on January 16, 2009, adopts modifications to the Transactions and Code Sets Final Rule published in the Federal Register on August 17, 2000, for coding diagnoses and inpatient hospital procedures. Specifically, with a compliance date of October 1, 2013. The International Classification of Diseases, 10th Revision, Clinical Modification (ICD–10–CM) for diagnosis coding, including the Official ICD–10–CM Guidelines for Coding and Reporting, as maintained and distributed by the U.S. Department of Health and Human Services (HHS). In this CR, this code set will be referred to as ICD-10-CM. For dates of service on and after October 1, 2013, entities covered under the Health Insurance Portability and Accountability Act of 1996 (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 VMS is directed to convert the existing user controlled parameter files and records - Accumulation File Number (AFN) Parameters, Review Utilization Line Edit (RULE) Parameters, existing AFN and RULE to allow ICD-10 diagnosis code entry on the ViPS Medicare Automated Parameter (VMAP)/6 screen and to correctly process these transactions when ICD-10 diagnosis codes are present on Durable Medical Equipment (DME) claims.

B. Policy: CMS requires that the VMS shall be able to accept ICD-10 diagnosis codes by October 1, 2013.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7321.1	VMS shall make system changes to convert and expand the AFN/RULE records on the existing VMS PARMFILE to accept ICD-10 diagnosis codes.		X						X		
7321.2	VMS shall make updates to VMS batch programs that		X						X		

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	activate the AFN/RULE logic to correctly recognize and use ICD-10 diagnosis codes when included as a parameter for claims editing.										
7321.3	VMS shall update the existing AFN and RULE screens to allow input of ICD-10 codes.		X						X		

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	None.										

IV. SUPPORTING INFORMATION

In order for the VMS to be compliant with accepting ICD-10 diagnosis codes by October 1, 2013, the Accumulation File Number (AFN) Parameters, Review Utilization Line Edit (RULE) Parameters, existing AFN and RULE to allow ICD-10 diagnosis code entry on the VMAP/6 screen and to correctly process these transactions when ICD-10 diagnosis codes are present on DME claims must be converted.

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	None.

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Katie Wickrowski (410) 786-5084, Katie.Wickrowski@cms.hhs.gov
Tammy Amendola (410) 786-1149, Tammy.Amendola@cms.hhs.gov

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)*:

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.