

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1157	Date: JANUARY 19, 2007
	Change Request 5441

Subject: Processing All Diagnosis Codes Reported on Claims Submitted to Carriers (Final Phase)

I. SUMMARY OF CHANGES: The Centers for Medicare and Medicaid Services (CMS) is requiring that all standard systems for carrier claims process all diagnosis codes reported in the adjudication of the claim. This Change Request (CR) will be implemented in multiple phases. The first phase included the analysis and design. The second phase included finalization of the requirements and coding development. This is the final phase of implementation and includes requirements for documentation and testing.

New / Revised Material

Effective Date: July 1, 2007

Implementation Date: July 2, 2007

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:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

One-Time Notification

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

Attachment – One-Time Notification

Pub. 100-04	Transmittal: 1157	Date: January 19, 2007	Change Request: 5441
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SUBJECT: Processing All Diagnosis Codes Reported on Claims Submitted to Carriers (Final Phase)

Effective Date: July 1, 2007

Implementation Date: July 2, 2007

I. GENERAL INFORMATION

A. Background: The ANSI 837P 4010A allows a maximum of eight diagnosis codes to be reported for each claim. In processing the HIPAA format claim, the Multi-Carrier System (MCS) applies the first four diagnosis codes on the claim. The remaining diagnosis codes are not used in the payment determination for Medicare.

The clinical laboratory negotiated rulemaking committee agreed that Medicare will consider all diagnosis codes reported in the processing of claims for clinical laboratory services. Heretofore, the enforcement of this requirement was generally done manually. This process has not always worked effectively and many times claim development is initiated when the proper diagnosis had already been reported on the initial claim. This change request (CR) implements the Negotiated Rulemaking agreement to automatically consider all diagnosis codes reported.

This CR will also require the MCS to process all diagnosis information submitted on the approved HIPAA claim format for all other types of claims. The purpose of this instruction is to implement requirements in the MCS standard system and the Part B carrier systems that all diagnosis codes reported on **any** claim are processed in these systems up to the maximum allowed by the ANSI 837P 4010A1 claim format. Generally, paper claims should have only four diagnoses. If more are reported, the MCS standard system and the Part B carrier systems should capture up to the maximum allowed by the ANSI 837 4010A1 claim format. This CR will also implement requirements to pass this information to the Common Working File (CWF) for processing and the National Claims History (NCH) for storage.

This CR is being implemented in multiple phases. The first phase, which included the analysis and design, was implemented in the April 2006 standard system release. (See CR 4097, Transmittal 735, issued on October 31, 2005.) The second phase of the implementation, which becomes effective on April 1, 2007, includes finalization of the requirements and coding development. (See CR 4276, Transmittal 1095, issued on October 27, 2005.) This CR implements the final phase, effective July 1, 2007, and includes requirements for documentation and testing.

B. Policy: Effective for claims processed July 1, 2007 and later, the MCS standard system and the Part B carrier systems shall capture and process up to eight diagnosis codes reported on a claim. Effective for claims processed July 1, 2007 and later, the Common Working File (CWF) shall accept all diagnosis codes reported by the MCS to CWF. Within 45 days of the implementation of the coding changes effective on July 1, 2007, the carriers shall make the appropriate updates to their edits and audits to read all diagnosis codes reported on the claim.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A / B M A C	D M M A C	F I I E R	C A R R E R	D M R R I C	R E H R I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F		
5441.1	MCS, and to the extent necessary, carriers/Medicare Administrative Contractors (MACs), shall expand their systems to accept and process up to eight diagnosis codes reported in the 2300 loop of the ANSI 837P 4010A1 claim versus the current limitation of four and continue to accept all diagnosis codes reported in the 2400 loop of the ANSI 837P 4010A1 claim.	X			X				X			
5441.2	MCS and carriers/MACs shall accept and process all diagnosis codes submitted on a paper claim, up to the maximum of eight diagnoses.	X			X				X			
5441.3	MCS shall accept and process all diagnosis codes reported on an electronic claim and all diagnoses reported on a paper claim, up to the maximum of eight diagnoses.								X			
5441.4	CWF shall process and maintain all diagnosis codes reported, including all eight on the header record, on a claim by a carrier for the HUBC and HUDC.										X	
5441.5	CWF shall pass all diagnosis codes reported, including all eight on the header record, to the National Claims History (NCH) to be stored.										X	National Claims History
5441.6	NCH shall create a place for all diagnosis codes reported, including all eight on the header record, for storage.											National Claims History
5441.7	Within 45 days of the implementation of the coding changes effective on July 1, 2007, carriers/MACs shall make the appropriate updates to their edits and audits to read all diagnosis codes reported on the claim.	X			X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M M A C	F I	C A R R E R	D M R C	R E H I	Shared-System Maintainers			
							F I S S	M C S	V M S	C W F	
5441.8	A provider education article related to this instruction will be available at http://www.cms.hhs.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 localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X			X						

IV. SUPPORTING INFORMATION

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:
5441.1-5441.7	Implement in accordance with CR 4097 and CR 4276.

B. For all other recommendations and supporting information, use the space below: N/A

V. CONTACTS

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Post-Implementation Contact(s): Susan Webster, (410) 786-3384, susan.webster@cms.hhs.gov

VI. FUNDING

A. *For TITLE XVIII Contractors:*

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

B. *For Medicare Administrative Contractors (MAC):*

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified 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.