CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 261	**Date: JANUARY 19, 2007**
	Change Request 5411

Subject: Institutional Value Code Changes

I. SUMMARY OF CHANGES: The National Uniform Billing Committee (NUBC) has restricted the use of value codes A1, A2, A7, B1, B2, B7, C1, C2, and C7 to paper claims. These value codes are no longer available for use on the X12N 837 institutional claim transaction.

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. 100-20	Transmittal: 261	Date: January 19, 2007	Change Request: 5411

SUBJECT: Institutional Value Code Changes

Effective Date: July 1, 2007

Implementation Date: July 2, 2007

I. GENERAL INFORMATION

A. Background: The National Uniform Billing Committee (NUBC) has restricted the use of value codes A1, A2, A7, B1, B2, B7, C1, C2, and C7 to paper claims. These value codes are no longer available for use on the X12N 837 institutional claim transaction.

B. Policy: N/A

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	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5411.1	FISS shall create edits to restrict the use of value codes A1, A2, A7, B1, B2, B7, C1, C2, and C7 to paper claims.							X				
5411.2	Contractors that do not use the FISS translator or the FISS Implementation Guides edits process shall create edits to restrict the use of value codes A1, A2, A7, B1, B2, B7, C1, C2, and C7 to paper claims.	X		X			X					
5411.3	FISS shall create edits to not allow the use of value codes A1, A2, A7, B1, B2, B7, C1, C2, or C7 on direct data entry claims.							X				
5411.4	FISS shall ensure that any paper claim data from value codes A1, A2, A7, B1, B2, B7, C1, C2, or C7 be migrated to the appropriate X12N 837 2320 Claim Level Adjustment (CAS) segment (claim adjustment reason code "PR") before creating the coordination of benefits flat file.							X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5411.5	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			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:
5411.4	The value codes x1, x2, and x7 can be represented in a single CAS segment. An example would look like this: CAS*PR*1*100**2*20**3*10~ PR = Patient Responsibility 1 = Deductible 100 = Ded Amt 2 = Coinsurance 20 = Coins Amt 3 = Copay 10 = Copay Amt

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Matt Klischer (matthew.klischer@cms.hhs.gov)

Post-Implementation Contact(s): Matt Klischer (matthew.klischer@cms.hhs.gov)

VI. FUNDING

A. *For TITLE XVIII Contractors,* use only one of the following statements:
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),* use only one of the following statements:

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.