CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1363	**Date: NOVEMBER 2, 2007**
	Change Request 5030

SUBJECT: Analysis and Design Only - Processing All Diagnosis Codes Reported on Claims Submitted to Durable Medical Equipment Medicare Administrative Contractors (DME MACs).

I. SUMMARY OF CHANGES: The VMS standard system shall capture and process all diagnosis codes reported on a claim. The CWF shall accept all diagnosis codes reported by the VMS to CWF up to the maximum allowed by the ASC X12N 837P Transaction, Version 4010A1 claim format.

New / Revised Material
Effective Date: April 1, 2008
Implementation Date: April 7, 2008

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:

SECTION A: For Fiscal Intermediaries and Carriers:
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.

IV. ATTACHMENTS:

One-Time Notification

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1363	Date: November 2, 2007	Change Request: 5030

SUBJECT: Analysis and Design Only—Processing All Diagnosis Codes Reported on Claims Submitted to Durable Medical Equipment Medicare Administrative Contractors (DME MACs).

Effective Date: April 1, 2008

Implementation Date: April 7, 2008

I. GENERAL INFORMATION

A. Background: The ASC X12N 837P Transaction, Version 4010A1 electronic claim format allows a maximum of eight diagnosis codes to be reported for each claim in accordance with standards established by the Health Insurance Portability and Accountability Act (HIPAA). However, the ViPS Medicare System (VMS) applies only the first four diagnosis codes on the claim. The remaining diagnosis codes are not used in the payment determination for Medicare.

The purpose of this instruction is to implement requirements in the VMS so that all diagnosis codes reported on a claim are processed up to the maximum allowed by the ASC X12N 837P Transaction, Version 4010A1 claim format and mandated by HIPAA. Generally, paper claims should have only four diagnoses. However, if more than four are reported on a paper claim, VMS shall capture up to the maximum allowed by the ASC X12N 837P Transaction, Version 4010A1 claim format—that is, up to eight diagnosis codes.

This Change Request (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. This is the first phase which includes only the analysis and design.

B. Policy: The VMS standard system shall capture and process all diagnosis codes reported on a claim up to the maximum allowed by the ASC X12N 837P Transaction, Version 4010A1 claim format. The CWF shall accept all diagnosis codes reported by the VMS to CWF up to the maximum allowed by the ASC X12N 837P Transaction, Version 4010A1 claim format. The effective date for these changes will be announced in the implementation CR.

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	
5030.1	VMS shall conduct a systems analysis and identify all design considerations necessary to expand its system to accept and process up to eight (8) diagnosis codes versus the current system limitation of four.		X						X		
5030.1.1	VMS shall conduct a systems analysis and identify all		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	
	design considerations necessary to ensure that it continues to accept all diagnosis codes reported in the 2300 HI segment of the ASC X12N 837P Transaction, Version 4010A1 claim.										
5030.2	VMS shall conduct a systems analysis and identify all design considerations necessary to accept and process all diagnosis codes reported on a paper claim up the amount allowable on an electronic claim (currently eight diagnosis codes).		X						X		
5030.3	CWF shall conduct a systems analysis and identify all design considerations necessary to process and maintain all diagnosis codes reported, including all eight on the header record, on a claim by a carrier for the HUDC.									X	
5030.4	CWF shall conduct a systems analysis and identify all design considerations necessary to pass all diagnosis codes reported, including all eight on the header record, to the NCH to be stored.									X	NCH
5030.5	NCH shall conduct a systems analysis and identify all design considerations necessary to create a place for all diagnosis codes reported, including all eight on the header record, for storage.										NCH
5030.6	VMS shall conduct a systems analysis and identify all design considerations necessary to include all eight (8) diagnosis codes submitted on the ASC X12N 837P Transaction, Version 4010A1, and paper claims for Coordination of Benefits purposes, even if they are not used for Medicare payment determination.								X		
5030.7	VMS shall note that the Certificate of Medical Necessity (CMN) will continue to hold four diagnosis codes and for paper CMNs, no changes are needed.		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	
5030.8	None.										

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:

B. For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): Tracey Hemphill, Tracey.Hemphill@cms.hhs.gov or (410) 786-7169

Post-Implementation Contact(s): Tracey Hemphill, Tracey.Hemphill@cms.hhs.gov or (410) 786-7169

VI. FUNDING

A. For *Fiscal Intermediaries and Carriers*, 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 2008 operating budgets.

B. *For Medicare Administrative Contractors (MACs)*, use the following statement:

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 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.