CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 420	**Date: December 19, 2008**
	Change Request 6068

NOTE: Transmittal 360, dated July 18, 2008 is rescinded and replaced with Transmittal 420, dated December 19, 2008. The Effective and Implementation dates have changed from July to October 2009. Additionally, this will be implemented across the April, July and October releases as stated in the Background section of the One Time Notification.

Subject: Implementation - Processing All Diagnosis Codes Reported on Claims Submitted to Durable Medical Equipment Medicare Administrative Contractors (DME MACs)

I. SUMMARY OF CHANGES: The Centers for Medicare and Medicaid Services (CMS) is requiring that the VMS standard system capture and process all diagnosis codes reported on a claim up to the maximum allowed by the ASC X12N 837P Transaction, Version 4010A 1 claim format. This Change Request (CR) will be implemented in multiple phases. The first phase included the analysis and design. This CR includes the final business requirements, which will be implemented across three standard system releases, and will become effective on October 1, 2009. The April 2009 release will include finalization of the systems requirements and coding development. The July 2009 release will include additional coding development. The final phase of implementation, scheduled for the October 2009 release, will include final coding changes, documentation and testing.

New / Revised Material
Effective Date: October 1, 2009
Implementation Date: October 5, 2009

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

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 – One-Time Notification

Pub. 100-20	Transmittal: 420	Date: December 19, 2008	Change Request: 6068

NOTE: Transmittal 360, dated July 18, 2008 is rescinded and replaced with Transmittal 420, dated December 19, 2008. The Effective and Implementation dates have changed from July to October 2009. Additionally, this will be implemented across the April, July and October releases as stated in the Background section of the One Time Notification.

SUBJECT: Implementation - Processing All Diagnosis Codes Reported on Claims Submitted to Durable Medical Equipment Medicare Administrative Contractors (DME MACs)

Effective Date: October 1, 2009

Implementation Date: October 5, 2009

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 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, as mandated by the HIPAA.

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 will be implemented in multiple phases. The first phase included the analysis and design. (See CR 5030, Transmittal 1363 Pub. 100-04, issued on November 2, 2007.) This CR includes the final business requirements, which will be implemented across three standard system releases, and will become effective on October 1, 2009. The April and July 2009 releases will include the first two phases of coding changes. The final phase of implementation will be on the October 2009 release and will include final coding, documentation and testing.

With respect to the phases described herein and elsewhere in the CR, these phases are predicated on the attached VMS analysis deliverable for CR 5030.

B. Policy: Effective for claims processed October 5, 2009 and later, 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.

NOTE: These instructions do not apply to paper claims.

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	
6068.1	The VMS shared system maintainer shall expand its' system to accept and process up to eight (8) diagnosis codes versus the current system limitation of four.								X		
6068.2	The VMS shared system maintainer shall ensure that it continues to accept all diagnosis codes reported in the 2300 HI segment of the ASC X12N 837P Transaction, Version 4010A1 claim.		X						X		
6068.3	The CWF maintainer shall process and maintain all diagnosis codes reported, including all eight on the header record, on a claim by a carrier for the HUDC.									X	
6068.4	The CWF maintainer shall pass all diagnosis codes reported, including all eight on the header record to the NCH to be stored.									X	NCH
6068.5	NCH shall create a place for all diagnosis codes reported, including all eight on the header record for storage.										NCH
6068.6	The VMS shared system maintainer shall include all eight (8) diagnosis codes submitted on the ASC X12N 837P Transaction, Version 4010A1 even if they are not used for Medicare payment determination.								X		
6068.7	The VMS shared system maintainer shall note that the Certificate of Medical Necessity (CMN) will continue to hold four (4) 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	
	None.										

IV. SUPPORTING INFORMATION

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:
6068.1-7	Implement in accordance with CR 5030, Transmittal 1363 Pub. 100-04, issued on November 2, 2007.
6068.1-7	The VMS shared system maintainer shall coordinate any front-end edit changes with the CEDI.
6068.1-7	The VMS shared system maintainer shall continue the existing process of storing diagnosis codes at the claim header level and using a diagnosis pointer at the line level to associate one diagnosis code to a procedure code.

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

V. CONTACTS

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

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

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Carriers, and 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.