CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2756	**Date: August 5, 2013**
	Change Request 8279

Contractors please note: Transmittal 2746, dated July 26, 2013, has been rescinded and replaced by Transmittal 2756, dated August 5, 2013 to include the correct date on Transmittal. All other information remains the same.

SUBJECT: Revision to the ViPS Medicare System Diagnosis Code Editing on the CMS-1500

I. SUMMARY OF CHANGES: This Change Request (CR) provides instructions for handling claims submitted on a CMS Form-1500 that have an invalid, header-level, diagnosis code.

EFFECTIVE DATE: January 1, 2014
IMPLEMENTATION DATE: January 6, 2014

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	N/A

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with 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 obliged 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:

Business Requirements

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

Attachment – Business Requirement

Pub. 100-04	Transmittal: 2756	Date: August 5, 2013	Change Request: 8279

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SUBJECT: Revision to the ViPS Medicare System Diagnosis Code Editing on the CMS-1500

EFFECTIVE DATE: January 1, 2014
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I. GENERAL INFORMATION

A. Background: This Change Request (CR) provides instructions for handling claims submitted on a CMS Form-1500 that have an invalid, header-level, diagnosis code. The Medicare Claims Processing Manual at Pub.100-04, Chapter 1, §80.3.2.1.2 requires that claims submitted with an incorrect or truncated diagnosis codes in item 21 of the CMS Form-1500 be returned to the provider/supplier as unprocessable. Currently, durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) claims have been processed and replicated where an invalid diagnosis code was present in the claim header and there was no diagnosis pointer on any service line pointing to the invalid diagnosis code. The processing resulted in the passing on of invalid diagnosis codes and splitting of the claim. CR 7700 corrected this issue for claims that are crossed to a Coordination of Benefits Agreement (COBA) trading partner for coordination of benefits purposes, but the issue remains for all other DMEPOS claims.

This CR instructs DMEPOS contractors to return as unprocessable claims that contain an incorrect or truncated diagnosis codes in item 21 of the CMS Form- 1500.

B. Policy: Claims must contain correct diagnosis codes and such codes may not be truncated. In addition, all service diagnosis codes reported on the claim line must point to a valid diagnosis code in the header. Claims submitted on CMS Form-1500, with dates of service on and after January 1, 2014, that contain an invalid header-level diagnosis code will be returned as unprocessable.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8279.1	Contractors shall return as unprocessable an inbound CMS-1500 form claim that contains an invalid diagnosis code in the header of the claim, whether pointed to at the line level, or not.				X						X		
8279.2	Contractors shall use the following remittance advice messages and group code for claims returned as unprocessable, per 8279.1:				X						X		

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
	Claim Adjustment Reason Code (CARC) 16 - Claim/service lacks information which is needed for adjudication. Remittance Advice Remark Code (RARC) M 76– Missing/incomplete/invalid diagnosis or condition. RARC MA130- Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information. Group Code: Contractual Obligation (CO)												

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility							
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Other
		A	B	HHH					
8279.3	MLN Article : A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/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 sites 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 the contractor's 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				

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information:

V. CONTACTS

Pre-Implementation Contact(s): Teira Canty, 410-786-1974 or Teira.Canty@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:

No additional funding will be provided by CMS; Contractors activities are to be carried out with 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 do 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.