Related MLN Matters Article #: MM5441

Date Posted: January 23, 2007

Related CR #: 5441

Processing All Diagnosis Codes Reported on Claims Submitted to Carriers

Key Words

MM5441, CR5441, R1157CP, Diagnosis

Provider Types Affected

All physicians and suppliers who submit claims to Carriers or Part A/B Medicare Administrative Contractors (A/B MACs) for services provided to Medicare beneficiaries

Key Points

- The effective date of the instruction is July 1, 2007.
- The implementation date is July 2, 2007.
- While the ANSI 837P 4010A allows a maximum of eight diagnosis codes to be reported for each claim, the Medicare Part B standard systems and the carrier claims processing systems have historically used only the first four diagnosis codes reported on the claim when processing the Health Insurance Portability and Accountability Act format claims.
- Carriers have used a manual process to consider the remaining diagnosis codes in the Medicare payment determinations.
- MLN article MM5441 and Change Request (CR5441) announce the requirement that (effective for claims processed July 1, 2007, and later) the Part B standard systems and the carrier claims processing systems capture and process up to eight diagnosis codes on all provider claims (both paper and electronic).

Important Links

The related MLN Matters article can be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5441.pdf* on the CMS website.

The official instruction (CR5441) regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1157CP.pdf* on the CMS website.

If providers/suppliers have questions, they may contact their Medicare carriers or A/B MACs at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.