Program Memorandum Carriers

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal B-02-027 **Date: APRIL 26, 2002**

CHANGE REQUEST 2108

SUBJECT: Annual Updating of ICD-9-CM Codes Must Be Date of Service Driven

The purpose of this Program Memorandum (PM) is to have Medicare carriers become compliant with the rules of the Health Insurance Portability and Accountability Act (HIPAA) in that diagnosis codes must be processed using date of service and not date received.

According to HIPAA, national code sets must be date of service compliant. In order for Medicare carriers and standard systems to be HIPAA compliant, all carriers and standard systems must be able to process the annual update of ICD-9-CM codes based on date of service instead of date of receipt.

The CMS plans to implement this change in two phases. For those carriers that process claims on the Multi-Carrier System (MCS), effective for claims processed on or after October 1, 2002, MCS carrier systems must be able to edit for the validity of diagnosis codes based on the date of service of the procedure code to which the diagnosis code is correlated. The ViPS Medicare System (VMS) and their carriers will implement this change at a future date. Another instruction will be released advising VMS of the their implementation date. HCFA Part B Standard System (HPBSS) is exempt from this instruction.

The MCS carrier systems must be modified (if needed) to accommodate date parameters for diagnosis editing. The MCS should automatically establish an effective date of January 1, 1990, for all diagnoses currently on the file. An end date of December 31, 2001, should automatically be established for any diagnosis codes currently flagged as truncated. Actual effective and end dates should be used when new diagnosis codes are issued or current codes become truncated with the annual ICD-9-CM updates.

The 90-day grace period will still apply. You must be able to accept old and new codes for dates of service October 1, 2002, through December 31, 2002.

This instruction does not change the number of diagnosis codes that you normally process today (up to four in the header plus the line item). It only requires that you process using date of service and not date of receipt. Therefore, diagnosis codes will be processed in a fashion similar to HCPCS codes (by date of service).

The MCS standard systems must make the necessary changes in order to comply with the HIPAA requirement that coding updates be based on date of service. These changes must be made by October 1, 2002.

Publish information regarding this change as soon as possible in your next bulletin and on your web site. Providers need to be aware of this change as well as software vendors that use ICD-9-CM codes in their product. Providers and their billing staff must understand that they will need to know which diagnosis code was in effect at the time the services are rendered.

The effective date for this PM is October 1, 2002.

The implementation date for this PM is October 1, 2002.

These instructions should be implemented within your current operating budget.

This PM may be discarded after October 31, 2003.

If you have any questions, contact Patricia Gill on (410) 786-1297.

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