CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 13084	**Date: March 13, 2025**
	Change Request 13927

SUBJECT: Update to the Internet Only Manual (IOM) Publication (Pub.) 100-04 Chapter 3, Inpatient Hospital Billing, Section 20.2.1

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update Chapter 3, Inpatient Hospital Billing, Section 20.2.1 with updated hyper links to the updated International Classification of Diseases, Nineth Revision, Clinical Modification (ICD-9-CM) and ICD-10-CM websites. This CR also updated the MS-DRG Classifications-and-Software hyper link to correct the page not found error.

EFFECTIVE DATE: April 11, 2025
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 11, 2025

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
R	3/ 20/ 20.2/ 20.2.1 Medicare Code Editor (MCE)

III. FUNDING:
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:
Business Requirements
Manual Instruction

Attachment - Business Requirements

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II. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to update Chapter 3, Inpatient Hospital Billing, Section 20.2.1 with updated hyper links to the updated International Classification of Diseases, Nineth Revision, Clinical Modification (ICD-9-CM) and ICD-10-CM websites. This CR also updated the MS-DRG Classifications-and-Software hyper link to correct the page not found error.

B. Policy: There is no new policy associated with this instruction.

III. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13927.1	Medicare contractors shall be aware of the manual updates in Pub 100-04, Chapter 3, Section 20.2.1	X								

IV. PROVIDER EDUCATION

None

Impacted Contractors: None

V. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

VI. CONTACTS

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VII. FUNDING

Section A: 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.

ATTACHMENTS: 0

20.2.1 - Medicare Code Editor (MCE)

(Rev. 13084; Issued: 03-13-25; Effective: 04-11-25; Implementation: 04-11-25)

A. - General

The MCE edits claims to detect incorrect billing data. In determining the appropriate MS-DRG for a Medicare patient, the age, sex, discharge status, principal diagnosis, secondary diagnosis, and procedures performed must be reported accurately to the Grouper program. The logic of the Grouper software assumes that this information is accurate and the Grouper does not make any attempt to edit the data for accuracy. Only where extreme inconsistencies occur in the patient information will a patient not be assigned to a MS-DRG. Therefore, the MCE is used to improve the quality of information given to Grouper.

The MCE addresses three basic types of edits which will support the MS-DRG assignment:

- **Code Edits -** Examines a claim for the correct use of diagnosis and procedure codes. They include basic consistency checks on the interrelationship among a patient's age, sex, and diagnoses and procedures reported.

- **Coverage Edits -** Examines the type of patient and procedures performed to determine if the services are covered.

- **Clinical Edits -** Examines the clinical consistency of the diagnostic and procedural information on the claim to determine if they are clinically reasonable and, therefore, should be paid.

B. - Implementation Requirements

The A/B MAC (A) processes all inpatient Part A discharge/transfer claims for both PPS and non-PPS facilities (including waiver States, long-term care hospitals, and excluded units) through the MCE. It processes claims that have been reviewed by the QIO prior to billing through the MCE only for edit types 1, 2, 3, 4, 7, and 12. It does not process the following kinds of claims through the MCE:

- Where no Medicare payment is due (amounts reported by value codes 12, 13, 14, 15, or 16 equal or exceed charges).

- Where no Medicare payment is being made. Where partial payment is made, editing is required.

- Where QIO reviewed prior to billing (condition code C1 or C3). It may process these exceptions through the program and ignore development codes or bypass the program.

The MCE software contains multiple versions. The version of the MCE accessed by the program depends upon the patient discharge date entered on the claim.

C. - Bill System/MCE Interface

The A/B MAC (A) installs the MCE online, if possible, so that prepayment edit requirements identified in subsection C can be directed to hospitals without clerical handling.
The MCE needs the following data elements to analyze the claim:

- Age;

- Sex;

- Discharge status;

- Diagnosis (25 maximum - principal diagnosis and up to 24 additional diagnoses);
- Procedures (25 maximum); and
- Discharge date.

The MCE provides the A/B MAC (A) an analysis of "errors" on the claim as described in subsection D. The A/B MAC (A) develops its own interface program to provide data to MCE and receive data from it.

The MCE Installation Manual describes the installation and operation of the program, including data base formats and locations.

D. - Processing Requirements

The hospital must follow the procedure described below for each error code. For claims returned to the provider, the A/B MAC (A) considers the claim improperly completed for control and processing time purposes. (See chapter 1.)

NOTE: The following instructions are based on ICD-9-CM diagnosis and procedure codes, ICD-10-CM and ICD-10-PCS codes.

1. Invalid Diagnosis or Procedure Code

The MCE checks each diagnosis code, including the admitting diagnosis, and each procedure code against a table of valid diagnosis and procedure codes. An admitting diagnosis, a principal diagnosis, and up to 24 additional diagnoses may be reported. Up to 25 total procedure codes may be reported on an inpatient claim. If the recorded code is not in this table, the code is invalid, and the A/B MAC (A) returns the claim to the provider.

For a list of valid diagnosis or procedure codes see the "International Classification of Diseases" revision applicable to the date of the inpatient discharge or other service and the "Addendum/Errata" and new codes furnished by the A/B MAC (A). The hospital must review the medical record and/or face sheet and enter the correct diagnosis/procedure codes before returning the claim.

2. External Cause of Injury Code as Principal Diagnosis

External Cause of Injury codes describe the circumstances that caused an injury, not the nature of the injury, and therefore are not recognized by the Grouper program as acceptable principal diagnoses. In ICD-9-CM the external cause of injury diagnosis codes begin with the letter E. In ICD-10-CM the external cause of injury codes begin with the letters V, W, X and Y. For a list of all External cause of injury codes, see *https://www.cms.gov/medicare/coding-billing/icd-10-codes*, Clinical Modification (ICD-9-CM), and the *https://archive.cdc.gov/#/details?url=https://www.cdc.gov/nchs/icd/icd9.htm* .The hospital must review the medical record and/or face sheet and enter the correct diagnosis before returning the claim.

3. Duplicate of Principal Diagnosis

Any secondary diagnosis reported on the claim that is the same code as the principal diagnosis reported on the claim is identified as a duplicate of the principal diagnosis. This is unacceptable because the secondary diagnosis may cause an erroneous assignment to a higher severity level MS-DRG. Hospitals may not repeat a diagnosis code. The A/B MAC (A) will delete the duplicate secondary diagnosis and process the claim.

4. Age Conflict

The MCE detects inconsistencies between a patient's age and any diagnosis on the patient's record. Examples are:

- A 5-year-old patient with benign prostatic hypertrophy.
- A 78-year-old who delivers a baby.

In the above cases, the diagnosis is clinically impossible in a patient of the stated age. Therefore, either the diagnosis or age is presumed to be incorrect. Four age code categories are described below.

- A subset of diagnoses is intended only for "perinatal/newborn." These are diagnoses that occur during the perinatal or newborn period of age 0.
- Certain diagnoses are considered reasonable only for children between the ages of 0 and 17. These are "Pediatric" diagnoses.
- Diagnoses identified as "Maternity" are coded only for patients between the ages of 9 and 64.
- A subset of diagnoses is considered valid only for patients over the age of 14. These are "Adult" diagnoses. For "Adult" diagnoses the age range is 15 through 124.

The list of diagnoses that are acceptable for each age category can be located in the most current version of the Definition of Medicare Code Edits manual which is posted at:
https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/ms-drg-classifications-and-software

Prior versions of the manual can be located at:
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS
and *select MS-DRG Classifications and Software,* and scroll down to the *prior Fiscal Year (FY) CCYY Version XX* Definition of Medicare Code Edits link.

If the A/B MAC (A) edits online, it will return claims for a proper diagnosis or correction of age as applicable. If the A/B MAC (A) edits in batch operations after receipt of the admission query response, it uses the age based on CMS records and returns claims that fail this edit. The hospital must review the Electronic Health Record (EHR), paper medical record, and/or face sheet and enter the proper diagnosis or patient's age before returning the claim.

5. Sex Conflict

Deactivated as of 10/01/2024. Medicare Contractors shall no longer assign this edit for any dates of service.

6. Manifestation Code as Principal Diagnosis

A manifestation code describes the manifestation of an underlying disease, not the disease itself, and therefore, cannot be a principal diagnosis. The MCE contains listings of diagnosis codes identified as manifestation codes. The hospital should review the EHR, paper medical record, and/or face sheet and enter the proper diagnosis before returning the claim.

7. Nonspecific Principal Diagnosis

Effective October 1, 2007 (FY 2008), the non-specific principal diagnosis edit was discontinued and is only applicable when processing claims using MCE version 2.0-23.0 only.

8. Questionable Admission

There are some diagnoses which are not usually sufficient justification for admission to an acute care hospital.

The MCE contains a listing of diagnosis codes identified as "Questionable Admission" when used as principal diagnosis.

The A/B MACs (A) may review on a post-payment basis all questionable admission cases. Where the A/B MAC (A) determines the denial rate is sufficiently high to warrant, it may review the claim before payment.

9. Unacceptable Principal Diagnosis

There are selected codes that describe a circumstance which influences an individual's health status but is not a current illness or injury; therefore, they are unacceptable as a principal diagnosis. For example, the diagnosis code for family history of a certain disease would be an unacceptable principal diagnosis since the patient may not have the disease.

In a few cases, there are codes that are acceptable as a principal diagnosis if a secondary diagnosis is coded. If no secondary diagnosis is present the message "requires secondary dx" will be returned by the MCE. The A/B MAC (A) may review claims with codes from the Unacceptable Principal Diagnosis section and a secondary diagnosis. A/B MACs (A) may choose to review as a principal diagnosis if data analysis deems it a priority.

If codes from the unacceptable principal diagnosis edit code list are identified without a secondary diagnosis, the A/B MAC (A) returns the claim to the hospital and requests that the applicable secondary diagnosis be entered. Also, any claims containing other "unacceptable principal diagnosis" codes are returned.

The hospital reviews the EHR, paper medical record, and/or face sheet and enters the appropriate principal diagnosis that describes the illness or injury before resubmitting the claim.

10. Nonspecific O.R. Procedures

Effective October 1, 2007 (FY 2008), the non-specific O.R. procedure edit was discontinued and is only applicable when processing claims using MCE version 2.0-23.0 only.

11. Noncovered O.R. Procedures

There are some O.R. procedures for which Medicare does not provide payment.
The A/B MAC (A) will return the claim requesting that the non-covered procedure and its associated charges be removed from the claim, Type of Bill (TOB) 11X. If the hospital wishes to receive a Medicare denial, etc., the hospital may submit a non-covered claim, TOB 110, with the non-covered procedure/charges. (For more information on billing non-pay claims, see Chapter 1 of this Manual, Section 60.1.4).

12. Open Biopsy Check

Effective October 1, 2010, the open biopsy check edit was discontinued and is only applicable when processing claims using MCE version 2.0 - 26.0.

13. Bilateral Procedure

Effective October 1, 2015, the bilateral procedure edit was discontinued and is only used when processing claims using MCE version 2.0-33.0.

14. Invalid Age

If the hospital reports an age over l24, the A/B MAC (A) requests the hospital confirm if it made a claim preparation error. If the beneficiary's age is confirmed to be over l24, the hospital enters 123.

15. Invalid Sex

A patient's sex *may be necessary for appropriate DRG determination. The sex code reported must be 0 (unknown),* 1 (male), or 2 (female).

16. Invalid Discharge Status

A patient's discharge status is sometimes necessary for appropriate MS-DRG assignment. Discharge status must be coded according to the Form CMS-1450 and UB-04 conventions. See Chapter 25.

17. Limited Coverage

For certain procedures whose medical complexity and serious nature incur extraordinary associated costs, Medicare limits coverage to a portion of the cost.

18. Wrong Procedure Performed

Certain external causes of morbidity codes indicate that the wrong procedure was performed.

19. Procedure inconsistent with length of stay (LOS)

The following procedure code should only be coded on claims when the respiratory ventilation is provided for greater than four **consecutive** days during the length of stay.

Effective with discharges on and after October 1, 2015, ICD-10-PCS code, 5A1955Z - Respiratory Ventilation, Greater than 96 Consecutive Hours

Prior to this date, discharges on and after October 1, 2012, ICD-9-CM procedure code, 96.72, Continuous invasive mechanical ventilation for 96 consecutive hours or more

20. Unspecified Code

Unspecified codes exist for circumstances when documentation in the medical record does not provide the level of detail needed to support reporting a more specific code. However, in the inpatient setting, there should generally be very limited and rare circumstances for which the laterality (right, left, bilateral) of a condition is unable to be documented and reported.

Effective April 1, 2022, the Unspecified Code edit will be triggered for certain unspecified diagnoses codes currently designated as either a Complication or Comorbidity (CC) or Major Complication or Comorbidity (MCC), that include other codes available in that code subcategory that further specify the anatomic site, when entered on the claim. This edit message indicates that a more specific code is available to report. It is the provider's responsibility to determine if a more specific code from that subcategory is available in the medical record documentation by a clinical provider.

If, upon review, additional information to identify the laterality from the available EHR or paper medical record, or documentation by any other clinical provider is unable to be obtained or there is documentation in the record that the physician is clinically unable to determine the laterality because of the nature of the disease/condition, then the provider must enter that information into the remarks section.

The provider should submit the billing note/remarks that best identifies the primary reason why specificity could not be determined:

Billing Note/Remarks	**Definition**
UNABLE TO DET LAT 1	Provider is unable to obtain additional information to specify laterality.
UNABLE TO DET LAT 2	Physician is clinically unable to determine laterality.