CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1743	**Date: November 4 2016**
	Change Request 9808

SUBJECT: Modifications to the National Coordination of Benefits Agreement (COBA) Crossover Process

I. SUMMARY OF CHANGES: Through this instruction, the Centers for Medicare & Medicaid Services (CMS) addresses several gap-fill or systems fill issues involving 837 professional Coordination of Benefits (COB) claims. CMS also addresses a current vulnerability involving incorrect reporting of Patient Reason for Visit on 837 institutional COB claims.

EFFECTIVE DATE: April 1, 2017
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 3, 2017

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 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

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 1743	Date: November 4, 2016	Change Request: 9808

SUBJECT: Modifications to the National Coordination of Benefits Agreement (COBA) Crossover Process

EFFECTIVE DATE: April 1, 2017
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I. GENERAL INFORMATION

A. Background: This instruction addresses three (3) separate issues associated with the COBA claims crossover process: Making sure that the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) shared system has a standard gap-fill solution to apply when an invalid foreign country code is reported in specified situations**;** creating an edit within the Part A shared system to prevent the inclusion of a Patient Reason for Visit diagnosis code on inpatient hospital-oriented claims**;** and, creating a standard Part B systems-fill solution to deal with a syntactically incorrect Clinical Laboratory Improvement Amendment (CLIA) number as part of the 837 Coordination of Benefits (COB) claims creation process.

Our Part B Medicare Administrative Contractors (MACs) and DME MACs currently encounter situations where incoming 837 professional claims contain invalid foreign country codes. This causes negative spill-over effects on 837 professional COB crossover claims. The Part B shared system has a current workaround for this issue. However, the DME MAC shared system does not. The CMS remedies this issue through a simple gap- fill solution.

Currently, providers include a Patient Reason for Visit diagnosis code on incoming 837 institutional claims, as well as hard copy UB-04 and Direct Data Entry (DDE) claims, when it is inappropriate to do so, such as on inpatient hospital claims. The 837 Institutional Technical Report Version 3 Guide (TR-3) stipulates that a Patient Reason for Visit in only required on outpatient claims. Therefore, the BCRC is rejecting 837 institutional Coordination of Benefits (COB) claims that violate this requirement with error code H46539--"The Patient Reason for Visit was found but was not expected because the claim is for inpatient services." The CMS addresses this concern at the MAC (Part A) level through this instruction.

Lastly, Medicare COB trading partners are encountering situations where the CLIA number reported in outbound 837 Part B professional claims is syntactically incorrect. The TR-3 Guide for the 837 professional claim includes an example CLIA number whereby position 3 always contains a "D" and the number reported is 10 bytes in length. The CMS establishes a shared systems fill solution to help address this issue.

B. Policy: When creating outbound 837 professional COB claims, the DME MAC shared system shall gap-fill 2300 CLM11-4 (State or Province Code) with "MD" if the inbound Medicare claim contains a reported 2300 CLM11 (Related Causes Information) composite and when: 1) the CLM11-1 and/or CLM-11-2 (Related-Cause Code) equals AA (auto accident); and 2) CLM11-4 contains an invalid value. The Part B shared system shall continue to derive the value for CLM11-4 from the provider's Billing Provider Address, or if unavailable from the Rendering Provider Address, or if unavailable from the Performing Provider Address. The Part B shared system shall ensure that it never maps spaces to 2300 CLM11-4 when CLM11-1 or CLM11-2 equals AA. To avert this possibility, the Part B shared system shall always map a State Code to the 2300 CLM11-4 as derived from one of the following: Billing Provider state code, Rendering Provider state code, or Performing Provider state code.

The Part A shared system shall develop an edit that will activate when an incoming 837 institutional claim, as well as a paper UB04 or DDE-submitted claim, for Type of Bill (TOB) 11x, 18x, 21x, or 41x (which represent inpatient services) contains a Patient Reason for Visit Code. MACs (Part A) shall Return-to-Provider (RTP) any electronic, paper, or DDE-submitted claims on which they encounter the newly developed edit.

In creating 837 professional COB/crossover claims, the Part B shared system shall ensure that the format of the CLIA number will always conform to a format of 10 bytes, with position 3 being "D." If the incoming claim is paper (hard copy) and does not include a valid formatted CLIA number, the Part B shared system shall: 1) Gap-fill the CLIA number with "12D1111111"; and 2) include this value on the outbound 837 professional COB claim. (**Note:** The CMS will address the adding of a new Contractor Common Edits Module (CCEM) edit, as appropriate, for incoming Part B electronic claims with syntactically incorrect CLIA number through a separate Recurring Change Request.)

II. 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	
9808.1	When creating outbound 837 professional COB claims, the DME MAC shared system shall gap-fill 2300 CLM11-4 (State or Province Code) with "MD" if the inbound Medicare claim contains a reported 2300 CLM11 (Related Causes Information) composite under the following conditions: 1) the CLM11-1 and/or CLM11-2 (Related-Cause Code) equals AA (auto accident); and 2) CLM11-4 contains an invalid value.							X		
9808.1.1	The Part B shared system shall ensure that it never maps spaces to 2300 CLM11-4 when CLM11-1 or CLM11-2 equals AA.						X			
9808.1.1.1	To avert this possibility, the Part B shared system shall always map a State Code to the 2300 CLM11-4 as derived from one of the following: Billing Provider state code, Rendering Provider state code, or Performing Provider state code.						X			
9808.2	The Part A shared system shall develop an edit that will activate when an incoming 837 institutional claim, as well as a paper UB04 or DDE-submitted claim, for Type of Bill (TOB) 11x, 18x, 21x, or 41x (which represent inpatient services) contains a Patient Reason for Visit Code. (**Note:** The editing shall activate based upon the claim's date of receipt versus					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	date of service.)									
9808.2.1	MACs (Part A) shall RTP any electronic, paper, or DDE-submitted claims on which they encounter the newly developed edit.	X								
9808.3	In creating 837 professional COB/crossover claims, the Part B shared system shall ensure that the format of the CLIA number will always conform to a format of 10 bytes, with position 3 being "D."						X			
9808.3.1	If the incoming claim is paper (hard copy) and does not include a valid formatted CLIA number, the Part B shared system shall: 1) Shared systems fill the CLIA number with "12D1111111"; and 2) include this value on the outbound 837 professional COB claim. (**Note:** A requirement for a new CCEM edit to address invalid CLIA number syntax on incoming electronic Part B claims will be handled, as appropriate, through a separate change request.)						X			

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

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: N/A

V. CONTACTS

Pre-Implementation Contact(s): Brian Pabst, 410-786-2487 or brian.pabst@cms.hhs.gov

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

VI. 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