

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 309	Date: JANUARY 11, 2008
	Change Request 5851

Subject: New Coordination of Benefits Agreement (COBA) Editing to Address Duplicate Crossover Claim File Submissions

I. SUMMARY OF CHANGES: The Centers for Medicare and Medicaid Services (CMS) will institute a new "222" edit through its Coordination of Benefits Contractor (COBC) to address situations where contractor Data Centers erroneously include duplicate Beginning of the Hierarchical Transaction Reference Identifier (BHT-03) claims within their 837 flat file claim transmissions to the COBC. This instruction also reminds contractors that, in accordance with Transmittal 837 (Change Request 4277), they shall transmit all "repaired" claims using different ST-SE envelopes as distinguished from regular claim transmissions.

New / Revised Material

Effective Date: January 1, 2008

Implementation Date: January 18, 2008

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	

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:

No additional funding will be provided by CMS; Contractor activities are to be carried out within 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 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

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

Attachment – One-Time Notification

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SUBJECT: New Coordination of Benefits Agreement (COBA) Editing to Address Duplicate Crossover Claim File Submissions

Effective Date: January 1, 2008

Implementation Date: January 18, 2008

I. GENERAL INFORMATION

A. Background: Currently, as Medicare contractor data centers prepare to transmit their adjudicated claims to the Coordination of Benefits Contractor (COBC) for Coordination of Benefits Agreement (COBA) crossover purposes, they include a Beginning of the Hierarchical Transaction Reference Identifier (BHT-03) in association with every ST-SE claim envelop to facilitate tracking of the claims throughout the COBC COBA system. In addition, in accordance with Transmittal 837, change request (CR) 4277, as contractors repair claims that contain severe error conditions or otherwise exceed established “111,” “222,” or “333” error parameters, they are to transmit their repaired claims in a separate ST-SE envelope, utilizing a different BHT-03 identifier as compared to the one included on the originally transmitted claims.

B. Policy: With the implementation of this instruction, the COBC will start applying a new “222” (Health Insurance Portability and Accountability Act American National Standards Institute (HIPAA ANSI) 837 compliance error) code to those Medicare contractor claims whose BHT-03 identifier was previously utilized (duplicated) within a transmitted 837 flat file. If a Medicare contractor’s data center erroneously includes a duplicate BHT-03 identifier as part of its 837 flat file claim transmissions to the COBC, the COBC will return a new “222” error code—000101 (“Claim is contained within a BHT envelope previously crossed; claim rejected”)—for the affected claims via the applicable COBC Detailed Error Report to the contractor’s data center. When contractors receive error code 000101 on their COBC Detailed Error Reports, they shall take the following actions: 1) Retransmit any “repaired” claims to the COBC, in accordance with CR 4277, in a separate ST-SE envelope, utilizing a different BHT-03 identifier as compared to the BHT-03 utilized for the original 837 flat file transmission to the COBC; and 2) hold (not mail) any system-generated provider notification letters tied to the new error code. All contractors shall take the latter action because the affiliated provider should not be responsible for taking any action to mitigate a Medicare contractor’s inadvertent transmission of duplicate BHT-03 envelopes to the COBC.

II. BUSINESS REQUIREMENTS TABLE

“Shall” denotes a mandatory requirement.

Number	Requirement	Responsibility (place an “X” in each applicable column)					
		A / B	D M E	F I I	C A R	R H H	Shared- System Maintainers

		A / B M A C	D M E M A C	F I I E R	C A R R I E R	R H I	Shared-System Maintainers				OT H E R
							F I S S	M C S	V M S	C W F	
	None										

"Should" denotes a recommendation.

IV. SUPPORTING INFORMATION

A. Recommendations and supporting information associated with listed requirements: None

X-Ref Requirement Number	Recommendations or other supporting information:

B. All other recommendations and supporting information: None

V. CONTACTS

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

Post-Implementation Contact(s): Brian Pabst (brian.pabst@cms.hhs.gov; 410-786-2487)

VI. FUNDING

A. For Fiscal Intermediaries, Carriers, and the Durable Medical Equipment Regional Carrier (DMERC):

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

B. For Medicare Administrative Contractors (MAC):

The Medicare Administrative Contractor (MAC) is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as changes to the MAC Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified 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.