5010 COBC ISSUES LOG

Loop and Item #	Issue	Shared System	Contractor Number/File Creation Date	Date First Identified	GHI Comments	DMBP Comments (formerly DDIS)	X12	Status: N, O, FS, C, D	Maintainer Comments	Fix Resp: M, C, G, T	Prob #	Prob Fix Date	CMS and Contractor Comments	Contractor Fix Date	Trading Partner Information
2300-001a	**H60401:** 'Patient's Reason for Visit' (2300 HI-01=PR) is required on all outpatient visits.	FISS	21027300340008ORA 00326 102740000350T	10/13/10	**02/23/11**: The HIPAA validation software was updated on 02/20/11 , adding Error code H60401:'Patient's Reason For Visit' (2300 HI-01 = PR) is required on all outpatient visits. Given the "disagree" ruling, the error is being bypassed 11/12/10: For the example provided, except for the bill type, none of the other condidions seems to be met. The segments from within the claim are included CLM*PL4DGRE3710204*404.2***85:A:I**A*Y*Y~ CL1**1*01~ SV2*0260*HC:96372*59.4*UN*2~ SV2*0300*HC:36415*16.5*UN*1~ SV2*0301*HC:84443*74.3*UN*1~ SV2*0636*HC:J1650*254*UN*2~ Please see the Trading Partner's comments in the "issue" column. Please review and determine (Agree/Disagree) whether this is a valid HIPAA error. The example is for TOB 85:A:I, and there was no HI*PR present. The data in the claim is as follows: CLM*PL4DGRE3710204*404.2***85:A:I**A*Y*Y~ HI*BK:V1251~ HI*BF:7295*BF:2449*BF:V5869~ HI*BE:A2:::6268~ HI*BG:D1*BG:M0~	**11-15-10**: **DISAGREE**. Claim does not contain revenue code 045X, 0616, 0526, 0r 0762 per the NUBC's definition of unscheduled outpatient visits. **11-09-10:** More information is needed. Patient Reason for Visit is required only per the NUBC's definition of unscheduled outpatient visits. That is Bill type 013X or 085X, together with Form Locator 14 (Priority of Visit/Type of Admission) codes 1, 2, or 5 and revenue codes 045X, 0516, 0526, or 0762 (observation). Were codes 1, 2, or 5 and revenue codes 045X, 0516, 0526, or 0762 submitted?		C							
2300-002b	**H45209:** 'Rendering Provider Name' was not found, but was expected because both the Billing and Pay-To Providers are present (2010AA and 2010AB) and the Billing/Pay-To Provider Specialty Information (2000A PRV) is not present, so the Rendering Provider must be identified.	MCS	2210280650110 04402 102930000450T	10/25/10	**11/19/10:** Claims are rejecting to the Medicare contractors with the error indicated in the "Issue" column. Please see the comments from the medicare contractor, in the "CMS and Contractor Comments" column, and advise if this is a valid HIPAA error (Agree) or if it should be bypassed (Disagree).	**11/22/2010: DISAGREE**: There is no TR3 rule requiring the rendering provider when the billing and pay to providers are submitted AND the taxonomy code is not submitted. In fact, taxonomy is situational and has no bearing whether present or not. BSR		C					Trailblazer: The ICNs I looked at do have the 2010AA and 2010AB loops because of different addresses but the Billing Provider is a laboratory and there is no other Rendering Provider. I don't see any notes in the 5010 IG that say the Rendering Provider loop must be present if the 2010AA and 2010AB loops are present. The 2000A PRV is not required either.		
2300-003b	**H46210**:The Accident Date is required when CLM11-1 or CLM11-2 has a value of 'EM' and this claim is the result of an accident.	MCS	2210333084350 04102 103440003650T	12/16/10	**12/16/10**: Claims are rejecting to the Medicare contractors with the error indicated in the "Issue" column. Please see the comments from the medicare contractor, in the "CMS and Contractor Comments " column, and advise if this is a valid HIPAA error or if it should be bypassed. The data in the 2300 loop are as follows: CLM*SFI00104120201*138***11:B:1*Y*A*Y*Y*P*EM~ REF*F5*N~ HI*BK:7224*BF:73730~	**12-20-10: DISAGREE**. The requirement for accident date (when value is EM) only applies "if" there is an accident. CEM does not currently have an edit to require the accident date for EM. Bsr		C					Tralblazer: ICN 2210333084350 for contractor 04102 was rejected with H46210 because there was no 2300 DTP for an accident date when the value of EM was present in the CLM11-1. Based on the TR3 there should not be an edit requiring the Accident DTP when the CLM11-1 or -2 has a value of EM as the note indicates it should only be submitted when the Related Cause is Employment (EM) and is Accident Related. If the Related Cause is Employment, it does not necessarily mean there was an accident. For example, someone who develops carpal tunnel, the visit would be Employment related but there would not be an accident date. I think a ruling will be required for this issue before any MCS system change can be considered.		

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D = TP Disagreed

Responsibility:
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Loop and Item #	Issue	Shared System	Contractor Number/File Creation Date	Date First Identified	GHI Comments	DMBP Comments (formerly DDIS)	X12	Status: N, O, FS, C, D	Maintainer Comments	Fix Resp: M, C, G, T	Prob #	Prob Fix Date	CMS and Contractor Comments	Contractor Fix Date	Trading Partner Information
2300-007b	**H40139**:Admission Date (DTP-01=435) was not expected because this claim is not for Inpatient Services	MCS	0211069109630 00512 110940000650TO 0211080029650 12402 110940004650TO	04/06/11	The error listed in the "Issue" column is being encountered on the 837P file during COBC's testing of a recently released version of the HIPAA Validation software. Please advise if this error should be enforced or bypassed. For the ICN examples provided, the CLM05 value is indicated below. 0211069109630 CLM05 = 41:B:1 0211080029650 CLM05 = 41:B:1	**4-15-11** DMBP **DISAGREES**. The TR3 also includes ambulance services (when the patient is known to be admitted) in the requirement for the admission date. POS 41 (from the example) is Ambulance-Land . BSR		C							
2300-009a	The occurrence code has been used more than once	FISS	21108200314504V AA 00453 110950006750TO	05/09/11	**05/20/11**: P lease see the comments in the"issue" column, as submitted by two partners. Please advise if this is a valid (Agree) error or not (Disagree). In the example provided, the data is presented as follows: CLM*18783*5671.54***21:A:2**A*Y*Y~ HI*BH:50:D8:20110215*BH:50:D8:20110221~	**05/24/11**: **DISAGREE**. There is nothing in the TR3 or NUBC manual that prohibits this. MAK		C							
2330A-001a	**H45153**:'Other Subscriber City/State/ZIP Code' was not found, but was expected because the Other Insured Address Line (N3-01) is present	FISS	21115100003202S CA; 00380 111530000850TO 21115100001802S CA; 00380 111530000850TO	03/17/11	**03/22/11**: During STC testing for CR7202, COBC is rejecting claims with the error identified in the "Issue" column. For the ICN being reviewed, this is occurring on the 2330A of Medicare's 2320 loop. When translated, the 2330A is as follows NM1*IL*1*Vxxxxxxxxx*Lxxxxxxxx****MI*xxxxxxxxxD ~ N3*111 PARK ST~ Please advise if this is a valid error, or if the COBC should be bypassing this error for the 2330A loop on 5010 errata claims.	**03/22/11**: **DISAGREE**. The N4 errata situational rule does not require N4 when N3 is present.		C							
2400-001b	**H40480**:The Place of Service Code at Service Line level is the same as the Place of Service Code at Claim level (CLM-05-1).	MCS VMS	MCS - 0210287001450 00880 102890000150T VMS - 10013856092000 44410 102790000150P	08/30/10	As we process the 5010 test claims with the STC, we've noticed 837P claims rejecting with the message identified in the "issue" column. Please verify whether this is a valid HIPAA error For ICN 0210287001450 - MCS, the data is CLM*814940011A-5010*50***11:B:1*Y*A*Y*Y*P~ SV1*HC:99214:::::NOT OTHERWISE CLASSIFIED*50*UN*1*11**1~ For ICN 10013856092000 - VMS, the data is CLM*WRIWINKG00223861*100***12:B:1*Y*A*Y*Y ~ SV1*HC:A4256:KX*100*UN*2*12**1~	**8-31-2010** : **DISAGREE**. Per section 1.12.5 of the TR3, transactions cannot be rejected for containing uneeded information. bsr		C							

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