CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11939	**Date: April 5, 2023**
	Change Request 13154

SUBJECT: Process Improvements for the National Coordination of Benefits Agreement (COBA) Detailed Error Reporting Notification Process

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to allow A/B Medicare Administrative Contractors (MACs) and Durable Medical Equipment Medicare Administrative Contractors (DME MACs) the option of informing providers that their patients' claims could not be crossed over through other communication options besides direct mailing of a special notification letter or report.

EFFECTIVE DATE: July 6, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 6, 2023
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	28/70.6.1- Coordination of Benefits Agreement (COBA) Detailed Error Report Notification Process

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

Pub. 100-04	Transmittal: 11939	Date: April 5, 2023	Change Request: 13154

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I. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to communicate to all A/B Medicare Administrative Contractors (MACs) and Durable Medical Equipment Medicare Administrative MACs (DME MACs) that they have the option of using other methods of communication with providers (e.g., notification through a provider portal) rather than direct mailing of special notification letters or reports when Medicare cannot cross over their patients' Medicare claims to COBA trading partners (i.e., supplemental insurers or payers).

Since 2004 the Centers for Medicare & Medicaid Services (CMS) has relied on the COBA system, supported by the Benefits Coordination & Recovery Center (BCRC), to notify all A/B MACs and DME MACs when their adjudicated Medicare claims cannot be crossed over, along with the reason. This procedure is known as the "COBA Detailed Error Report Notification Process." Traditionally, this process has resulted in the shared system maintainers generating error reports for their MACs for their review. Then, after five (5) days, if no other action is taken, such as placing the errored claims on hold, the shared system automatically creates a special provider notification letter or report that is mailed to the provider's on-file correspondence mailing address.

At the suggestion of a joint A/B MAC and DME MAC workgroup, CMS is now formally allowing A/B MACs and DME MACs the opporutnity to notify their providers or suppliers that certain Medicare claims cannot be crossed over through more modern communication methods. (**Note:** This instruction is intended to be a non-systems change action.)

B. Policy: CMS is making no changes to the operational policy contained in the Internet Only Manual.

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	
13154.1	A/B MACs and DME MACs shall have the discretion of continuing to mail automated special provider notification letters or reports when beneficiary claims	X	X	X	X					

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	cannot be crossed over or using other modernized notification mechanisms to communicate that beneficiary claims cannot be crossed over (e.g., notification via a provider portal).									

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: 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

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

70.6.1 - Coordination of Benefits Agreement (COBA) Detailed Error Report Notification Process

(Rev. 11939; Issued:04-05-23; Effective:07-06-23, Implemtation:07-06-23)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Effective with the July 2005 release, CMS implemented an automated process to notify physicians/ practitioners, suppliers, and providers that specific claims that were previously tagged by the Common Working File (CWF) for crossover will not be crossed over due to claim data errors. Claims transmitted via ASC X12 837 flat file by the A/B MAC and DME MAC shared systems to the Benefits Coordination & Recovery Center (BCRC) may be rejected at the flat file level, at a HIPAA ASC X12 pre-edit validation level, or by trading partners as part of a financial dispute arising from an invoice received.

Effective with the April 2005 release, the A/B MAC and DME MAC shared systems began to populate the BHT 03 (Beginning of Hierarchical Reference Identification) portion of their ASC X12 837 COB flat file submissions to the BCRC with a unique 22-digit identifier. This unique identifier will enable the BCRC to successfully tie a claim that is rejected by the BCRC at the flat file or HIPAA ASC X12 pre-edit validation levels as well as claims disputed by trading partners back to the original ASC X12 837 flat file submissions.

Effective October 4, 2005, A/ B MACs and DME MACs and their shared systems began to receive notification via the BCRC Detailed Error Reports, whose file layout structures appear below, that a COBA trading partner is in test or production mode via the BHT 03 identifier that is returned from the BCRC.

Effective April 3, 2011, all A/B MACs and DME MACs shall include an extra 1-byte “Original versus Adjustment Claim Indicator” value within the BHT03 identifier on all ASC X12 837 institutional and professional claims they transmit to the *BCRC* for crossover purposes. The BCRC shall, in turn, return this value to the appropriate A/B MAC and DME MAC via the BCRC Detailed Error Report process. In addition, the DME MAC shared system shall send an additional 1-byte value (defined as “reserved for future use”) as spaces in field 504-F4 (Message) of the NCPDP flat file sent to the BCRC. The BCRC shall, in turn, also return this value to the appropriate DME MAC via the BCRC Detailed Error Report process.

Effective April 1, 2013, CMS added a new 1-byte Original versus Adjustment indicator to the suite of possible 1-byte options for position 23 of the BHT03 identifier, as reflected below.

Effective with April 7, 2014, CMS has added 2 new 1-byte Original versus Adjustment indicators to the suite of possible options for position 23 of the BHT03 identifier, as reflected below.

A. Inclusion of the Unique 23-Digit Identifier on the ASC X12 837 Flat File and NCPDP File

1. Populating the BHT 03 Portion of the ASC X12 837 Flat File

The A/B MAC and DME MAC shared systems shall populate the BHT 03 (Beginning of Hierarchical Transaction Reference Identification; **field length=30 bytes**) portion of their ASC X12 837 flat files that are sent to the BCRC for crossover with a 23-digit Contractor Reference Identifier (CRI). The identifier shall be formatted as follows:

a. A/B MAC or DME MAC number (9-bytes; until the 9-digit MAC number is used, report the 5-digit MAC number, left-justified, with spaces for the remaining 4 positions);

b. Julian date as YYDDD (5 bytes);

c. Sequence number (5 bytes; this number begins with "00001," so the sequence number should increment for each ST-SE envelope, which is specific to a trading partner, on a given Julian date);

d. Claim version indicator (2 bytes, numeric, to denote claim version)
**Acceptable values = 50 (for ASC X12 claims), and 20 (for NCPDP D.0 claims);

e. COBA Test/Production Indicator (1-byte alpha indicator; acceptable values = "T" [test] and "P" [production]) or "R" if the claims were recovered for a "production" COBA trading partner (see §70.6.3 of this chapter for more details;

f. Original versus Adjustment Claim Indicator (1-byte alpha indicator); acceptable values are defined as the following:

E - for reprocessed claims that formerly included an electronic prescribing (e-RX) negative adjustment amount;

O - for original claims;

P - for Affordable Care Act or other congressional imperative mass adjustments;

M - for non-Affordable Care Act mass adjustments tied to Medicare Physician Fee Schedule (MPFS);

S - for mass adjustment claims—all others;

R - for RAC adjustment claims*;*

A - for routine adjustment claims, not previously classified*;* and
C – for CMS-directed mass adjustment action (use specified by CMS).

The following indicator is only applicable to FISS-generated claims:
V - Void/cancel only claim

The 23-digit CRI shall be left-justified in the BHT 03 segment of the 837 flat file, with spaces used for the remaining 8 positions. (**NOTE:** The CRI is unique inasmuch as no two files should ever contain the same combination of numbers.)

2. NCPDP 23-Digit Unique Identifier

Effective April 3, 2011, the DME MAC shared system shall also adopt a unique 23-digit format, referenced directly above under "Populating the BHT 03 Portion of the ASC X12 837 Flat File." However, prior to April 7, 2014, the system shall populate the unique 23-digit identifier (defined as "future use") with spaces in field 504-F4 (Message) within the NCPDP file (field length=35 bytes). The DME MAC shared system shall populate the unique identifier, left justified, in the field. Spaces shall be used for the remaining bytes in the field.

Effective April 7, 2014, the DME MAC shared system shall ensure that its DME MACs have the ability to 1) execute actions that will result in the transmission of their HUDC claims to CWF with Mass Adjustment Indicator set to "O"; and 2) transmit mass adjusted NCPDP D.0 COB claims to the BCRC under a 504-F04 (Message) field identifier of "C" (CMS-directed mass adjustment action) or "P" (mass adjustments tied to Affordable Care Act or Congressional/legislative mandate) as appropriate to the situation.

In addition, the DME MAC shared system shall ensure that all NCPDP D.0 crossover claims will now be sent to the BCRC with the 23rd byte 504-F04 (Message) field indicator completed, when appropriate, as indicated below.

O -- for all "original" NCPDP D.0 claims transmitted;

A-- for "routine adjustment claims" transmitted; and

R-- for recovery audit claims (RAC) adjustment claims transmitted.

B. BCRC Institutional, Professional, and NCPDP Detailed Error Reports

The A/B MAC and DME MAC shared systems shall accept the BCRC Institutional, Professional, and NCPDP Detailed Error Reports received from the COB&R system supporting the BCRC.

Effective with April 5, 2021, the datasets that the COB&R system supporting BCRC will use to convey the BCRC Detailed Error Reports to the VDCs representing the MACs are as follows:

xxxx.FISP.HBADR.GHI.COB5ERR(+1) [For Institutional Claims]
xxxx.MCSP.HBXDR.ADyy5ERC(+1) [For Professional non-DMEPOS Claims]
xxxx.VMSP.COBC.A5010.ERROR.FILE(+1) [For Professional DMEPOS Claims]

The formats for each of the Detailed Error Reports appear below.

Beginning with July 2007, all A/B MAC and DME MAC systems shall no longer interpret the percentage values received for ASC X12 837 institutional and professional claim "222" and "333" errors via the BCRC Detailed Error Reports as if the values contained a 1-position implied decimal (e.g., "038" =3.8 percent). DME MACs shall also no longer interpret the percentage values received for NCPDP claims for "333" errors via the BCRC Detailed Error Report for such claims as if the values should contain a 1-position implied decimal.

In addition, A/B MACs and their systems shall now base their decision-making calculus for initiation of a claims repair of "111" (flat file) errors upon the number of errors received rather than upon an established percent parameter, as otherwise described within this section.

Effective with July 2009, the A/B MAC and DME MAC shared systems shall accept the modified versions of the BCRC Detailed Error Reports for institutional and professional claims as reflected below. As part of the July 2009 changes, the BCRC will, at CMS's direction, expand the length of the "error description" field. (**NOTE:** This means that the shared systems shall therefore include the expanded error description code as part of their special provider notification letters.)

The Institutional Error File Layout, including summary portion, will be used for Part A claim files.

BCRC Detailed Error Report

Institutional Error File Layout - (Detail Record)

Field	Description	Field Size	Record Location
1	Date	8	1-8
2	Control Number	9	9-17
3	COBA ID	10	18-27
4	Subscriber ID/Medicare ID	12	28-39
5	Claim DCN/ICN	14	40-53
6	Record Number	9	54-62
7	Record/Loop Identifier	6	63-68
8	Segment	3	69-71
9	Element	2	72-73
10	Error Source Code	3	74-76 ('111', '222', or '333')
11	Error/Trading Partner Dispute Code	6	77-82
12	Filler	100	83-182
13	Field Contents	50	183-232
14	BHT 03 Identifier	30	233-262 (23 bytes used)
15	Claim DCN/ICN	23	263-285
16	Error Description	300	286-585
17	Filler	15	586-600

Institutional Error File Layout - (Summary Record)

Field	Description	Field Size	Record Location
1	Date	8	1-8
2	Total Number of Claims for Processing Date	10	9-18
3	Number of '111' Errors	10	19-28
4	Number of '222' Errors	10	29-38
5	Percentage of '222' Errors	3	39-41
6	Number of '333' Errors	10	42-51
7	Percentage of '333' Errors	3	52-54
8	Filler	19	55-73
9	Summary Record ID Error Source Code	3	74-76 ('999')
10	Filler	524	77-600

The Professional Error File Layout, including summary portion, will be used for Part B and DME MAC claim files.

BCRC Detailed Error Report

Professional Error File Layout - (Detail Record)

Field	Description	Field Size	Record Location
1	Date	8	1-8
2	Control Number	9	9-17
3	COBA ID	10	18-27
4	Subscriber ID/Medicare ID	12	28-39
5	Claim DCN/ICN	14	40-53
6	Record Number	9	54-62
7	Record/Loop Identifier	6	63-68
8	Segment	3	69-71
9	Element	2	72-73
10	Error Source Code	3	74-76 ('111', '222', '333')
11	Error/Trading Partner Dispute Code	6	77-82
12	Filler	100	83-182
13	Field Contents	50	183-232
14	BHT 03 Identifier	30	233-262 (23 bytes used)
15	Claims DCN/ICN	23	263-285
16	Error Description	300	286-858
17	Filler	15	586-600

Professional Error File Layout – (Summary Record)

Field	Description	Field Size	Record Location
1	Date	8	1-8
2	Total Number of Claims for Processing Date	10	9-18
3	Number of '111' Errors	10	19-28
4	Number of '222' Errors	10	29-38
5	Percentage of '222' Errors	3	39-41
6	Number of '333' Errors	10	42-51
7	Percentage of '333' Errors	3	52-54
8	Filler	19	55-73
9	Summary Record ID Error Source Code	3	74-76 ('999')
10	Filler	524	77-600

The NCPDP Error File Layout, including summary portion, will be used by DME MACs for Prescription Drug Claims

BCRC Detailed Error Report

NCPDP Error File Layout - (Detail Record)

Field	Description	Field Size	Record Location
1	Date	8	1-8
2	Batch Number	7	9-15
3	COBA ID	5	16-20
4	Medicare ID	12	21-32
5	CCN	14	33-46
6	Record Number	9	47-55
7	Batch Record Type	2	56-57
8	Segment ID	2	58-59
9	Error Source Code	3	60-62 ('111', or '333')
10	Error/Trading Partner Dispute Code	6	63-68
11	Error Description	100	69-168
12	Field Contents	50	169-218
13	Unique File Identifier	30	219-248 (23 bytes used)
14	CCN	23	249-271
15	Filler	18	272-289

NCPDP Error File Layout - (Summary Record)

Field	Description	Field Size	Record Location
1	Date	8	1-8
2	Total Number of Claims for Processing Date	10	9-18
3	Number of '111' Errors	10	19-28
4	Number of '333' Errors	10	29-38
5	Percentage of '333' Errors	3	39-41
6	Filler	18	42-59
7	Summary Record ID Error Source Code	3	60-62 ('999')
10	Filler	524	63-289

If the BCRC has rejected back to the A/B MAC and DME MAC shared system for 2 or more COBA Identification Numbers (IDs), the shared system shall receive a separate error record for each COBA ID. Also, if a file submission from a shared system to the BCRC contains multiple provider, subscriber, or patient level errors for one COBA ID, the shared system will receive a separate error record for each provider, subscriber, or patient portion of the file on which errors were found.

C. Further Requirements of the COBA Detailed Error Report Notification Process

1. Error Source Code

A/B MACs and DME MACs, or their shared systems, shall use all information supplied in the BCRC Detailed Error Report (particularly error source codes provided in Field 10 of Attachment B) to (1) identify shared system changes necessary to prevent future errors in test mode or production mode (Test/Production Indicator= T or P) and (2) to notify physicians, suppliers, and providers that claims with the error source codes "111," "222," and "333" will not be crossed over to the COBA trading partner.

2. Time Frames for Notification of All MACs Financial Management Staff and Providers

A/B MACs and DME MACs, or their shared systems, shall provide notification to MAC financial management staff for purposes of maintaining an effective reconciliation of crossover fee/ complementary credits received within five (5) business days of receipt of the BCRC Detailed Error Report.

Effective with the October 2005 release, A/B MACs and DME MACs and their shared systems shall receive BCRC Detailed Error Reports that contain BHT03 identifiers that indicate "T" (test) or "P" (production) status for purposes of fulfilling the provider notification requirements. (**Note:** The "T" or the P" portion of the BHT03 indicator will be identical to the Test/Production indicator originally returned from CWF on the processed claim.)

a) **Special Automated Provider Correspondence**

A/B MACs and DME MACs, or their shared systems, shall also take the following actions indicated below only when they determine via the Beneficiary Other Insurance (BOI) reply trailer (29) that a COBA trading partner is in crossover production mode with the BCRC (Test/Production Indicator=P). After an A/B MAC or DME MAC, or its shared system, has received a BCRC Detailed Error Report that contains claims with error source codes of "111" (flat file error), "222" (HIPAA ASC X12 error), or "333" (trading partner dispute), it shall take the following two specified actions within five (5) business days:

1. Notify the physician/practitioner, supplier, or provider via automated letter *or other electronic or automated method* that the claim did not cross over. The letter *or report/notification* shall include specific claim information, not limited to, Internal Control Number (ICN)/Document Control Number (DCN), Medicare beneficiary identifier, Medical Record Number (for Part A only), Patient Control Number (only if it is contained in the claim), beneficiary name, date of service, and the date claim was processed.
2. Effective with July 2007, A/B MACs and DME MACs and their systems shall ensure that, in addition to the standard letter language (the claim(s) was/were not crossed over due to claim data errors and was/were rejected by the supplemental insurer), their A/B MACs' and DME MACs' special provider letters *or* reports*/notifications*, which are generated for '222' and '333' error rejections in accordance with CR 4277, now include the following additional elements, as derived from the BCRC Detailed Error Report: 1) HIPAA H-series rejection code or other rejection code, and 2) the rejection code's accompanying description.

NOTE: A/B MACs or DME MACs, or their shared systems, are **not** required to reference the COBA trading partner's name on the above described automated letter *or report/notification*, since the original remittance advice (RA)/electronic remittance advice (ERA) would have listed that information, if appropriate.

2. Update its claims history to reflect that the claim(s) did not cross over as a result of the generation of the automated letter *or report.*

Effective with October 1, 2007, all A/B MACs and DME MACs shall modify their special provider notification letters that are generated for "111," "222," and "333" error situations to include the following standard language within the opening paragraph of their letters *or reports*: "This claim(s) was/were not crossed over due to claim data errors or was/were rejected by the supplemental insurer."

A/B MACs and DME MACs shall reformat their provider notification letters *or reports* to ensure that, in addition to the new standard letter language, they continue to include the rejection code and accompanying description, as derived from the BCRC Detailed Error Report, for "222" or "'333" errors in association with each errored claim.

Effective with the July 7, 2009, release, upon receipt of the BCRC Detailed Error Report (DER), the A/B MAC (A) and A/B MAC (HH) shared system shall configure the existing 114 report, as derived from the BCRC DER, so that it*:* 1) continues to display in landscape format; and 2) includes a cover page that contains the provider's correspondence mailing address.

b) Special Exemption from Generating Provider Notification Letters*/Reports*

Effective July 7, 2008, upon their receipt of BCRC Detailed Error Reports that contain "222" error codes 000100 ("Claim is contained within a BHT envelope previously crossed; claim rejected") and 00010 ("Duplicate claim; duplicate ST-SE detected"), all shared systems shall automatically suppress generation of the special provider notification letters *or reports/notifications* that they would normally generate for their associated A/B MACs and DME MACs in accordance with the requirements of this section as well as §70.6.3 of this chapter. In addition, upon receipt of BCRC Detailed Error Reports that contain "333" (trading partner dispute) error code 000100 (duplicate claim) or 000110 (duplicate ISA-IEA) or 000120 (duplicate ST-SE), all shared systems shall automatically suppress generation of the special provider notification letters *or reports/notifications*, as would normally be required in accordance with this section as well as §70.6.3 of this chapter.

NOTE: When suppressing their provider notification letters *or reports/notifications* for the foregoing qualified situations, the A/B MACs and DME MACs shall also not update their claims histories to reflect the non-crossing over of the associated claims. A/B MACs and DME MACs should, however, continue to *account for* the volume of claims that they are suppressing for financial reconciliation purposes.

Effective with October 6, 2008, when the BCRC returns the "222" error code "N22225" to A/B MACs and DME MACs via the BCRC Detailed Error Report, the A/B MACs and DME MACs' shared systems shall suppress generation of the special provider notification letters *or reports/notifications* that they would normally issue in accordance with CRs 3709 and 5472.

When suppressing their provider notification letters *or reports/notifications* following their receipt of a "N22225" error code, the A/B MACs' and DME MACs' shared systems shall also not update their claims histories to reflect the non-crossing over of the associated claims. A/B MACs and DME MACs should, however, continue to *account for* the volume of claims that they are suppressing for financial reconciliation purposes.

Effective with January 5, 2009, when the BCRC returns claims on the BCRC Detailed Error Report whose COBA ID falls in the range 89000 through 89999 (range designates "Other-Health Care Pre-payment Plan [HCPP] and HMO Cost Plan"), the A/B MACs' and DME MACs' systems shall take the following actions:

1) Suppress generation of the special provider letters *or reports/notifications*; and

2) Not update their affiliated A/B MACs and DME MACs' claims histories to indicate that the BCRC will **not** be crossing the affected claims over.