CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 562	**Date: September 25, 2009**
	Change Request 6640

SUBJECT: Activation of New Coordination of Benefits Agreement (COBA) Trading Partner Dispute Error Code Within the National Crossover Process

I. SUMMARY OF CHANGES: This instruction conveys a new COBA trading partner dispute error code that the Coordination of Benefits Contractor (COBC) will return to Medicare contractors when certain claims are not accepted by supplemental payers.

New / Revised Material
Effective Date: October 26, 2009
Implementation Date: October 26, 2009

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	

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

Pub.100-20	Transmittal: 562	Date: September 25, 2009	Change Request: 6640

SUBJECT: Activation of New Coordination of Benefits Agreement (COBA) Trading Partner Dispute Error Code Within the National Crossover Process

Effective Date: October 26, 2009

Implementation Date: October 26, 2009

I. GENERAL INFORMATION

A. Background: Transmittals 474 and 1189 created and then further refined the Coordination of Benefits Contractor (COBC) Detailed Error Report process. Under this process, the COBC reports to Medicare contractors, via a standard Detailed Error Report layout, any of the following error conditions that resulted in their claims not being crossed over: 1) incoming flat file contained structural problems ("111" flat file errors); 2) incoming flat file contained claims with Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) compliance errors ("222" errors); and 3) the COBA trading partner rejected the contractors' claims ("333" trading partner dispute errors). Depending upon the error percentage encountered in association with errored claims, the Medicare contractors then, after five (5) business days, automatically generate special provider notification letters informing the affected physician/supplier/provider that the beneficiary's claim(s) cannot be crossed over.

In earlier instructions the Centers for Medicare & Medicaid Services (CMS) directed Medicare contractors to suppress creation of their standard provider notification letters when they receive any of the following "333" dispute reason codes via the COBC Detailed Error Reports: 00100—duplicate claim; 000110—duplicate claim within the same ISA-IEA loop; and 000120—duplicate claim within the same ST-SE loop. The CMS made this decision primarily for two reasons: First, CMS believed these particular error conditions were out of the control of the billing provider. And, second, it would be futile for the provider to bill the claims to the COBA trading partner outside the crossover process given that the entity had already received the claim, as witnessed by its lodging of a dispute on the basis of duplicate claim receipt.

Currently, the only in-use "333" dispute codes that will trigger provider notification letters are the following: 000200—claim for provider ID/state should have been excluded; 000300—beneficiary not on eligibility-file; 000500—incorrect claim count; 000600—claim does not meet selection criteria; 000700—HIPAA Error; and "009999"—Other. Through this instruction, CMS will activate the previously inactive 000400 dispute reason code.

B. Policy: Through this instruction, the COBC shall activate dispute reason code 000400 (previously reserved for future use). As a result of this action, the COBC shall 1) transmit error code 000400 to Medicare contractor when indicated via the COBC Detailed Error Report; and 2) include within the error description field on the COBC Detailed Error Report the following standard message: "No provider agreement with Medicaid/other payer; claims crossover not possible." All Medicare contractors shall accept the new error code and accompanying error description message for inclusion on their outgoing provider notification letters.

The Centers for Medicare & Medicaid Services (CMS) has determined that it needs to activate a new trading partner dispute reason code for use in its national Coordination of Benefits Agreement (COBA) Medicare

crossover program. To better identify disputed crossover claims where the provider is not registered/enrolled with a supplemental payer (e.g., California Medicaid), CMS will now require supplemental payers that encounter this issue to report dispute reason code 000400 as part of their claims dispute process with the Coordination of Benefits Contractor (COBC). This action will result in the affected providers receiving code 000400 with the description 'No provider agreement with Medicaid/other payer; crossover not possible' within the special provider notification letters that their local Medicare contractors generate when their patients' claims are not successfully crossed over to supplemental payers. When providers note this message on the special notification letters, they should contact the supplemental payer identified in the supplemental notification letter for further instructions."

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement.

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6640.1	The COBC shall activate dispute reason code 000400 (previously reserved for future use).										X COBC/COBA
6640.1.1	As a result of this action, the COBC shall 1) transmit error code 000400 to Medicare contractor when indicated via the COBC Detailed Error Report; and 2) include within the error description field on the COBC Detailed Error Report the following standard message: "Provider does **not** have a provider agreement with this patient's Medicaid program/ supplemental payer; crossover acceptance not possible."										X COBC/COBA
6640.1.2	All Medicare contractors shall accept the new error code and accompanying error description message for inclusion on their outgoing provider notification letters. (**NOTE:** This should **not** impose any shared system maintainer changes.)	X	X	X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6640.2	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X	X	X	X					

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space: N/A

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); or Anne Wood (anne.wood@cms.hhs.gov; 410-786-3374).

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers,* use only one of the following statements:

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),* include the following statement:

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.