CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services(CMS)**
Transmittal 1727	**Date: May 1, 2009**
	Change Request 6420

SUBJECT: Coordination of Benefits Agreement (COBA) Repair and Claims Recovery Requirements Stemming from the Health Insurance Portability and Accountability Act (HIPAA) 5010 Claims Transactions

I. SUMMARY OF CHANGES: Through this instruction, the Centers for Medicare and Medicaid Services (CMS) outlines its COBA claims repair and recovery requirements that Medicare contractors and their shared systems shall follow prior to and after the transition to HIPAA 5010.

New / Revised Material
Effective Date: October 1, 2009
Implementation Date: October 5, 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	28/70/70.6.1.1/ Coordination of Benefits Agreement (COBA) 837 5010 Coordination of Benefits (COB) Flat File Errors
R	28/70/70.6.2/Coordination of Benefits Agreement (COBA) Full Claims Repair Process
R	28/70/70.6.3/Coordination of Benefits Agreement (COBA) Eligibility File Claims Recovery Process

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:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1727	Date: May 1, 2009	Change Request: 6420

SUBJECT: Coordination of Benefits Agreement (COBA) Repair and Claims Recovery Requirements Stemming from the Health Insurance Portability and Accountability Act (HIPAA) 5010 Claims Transactions

Effective Date: October 1, 2009

Implementation Date: October 5, 2009

I. GENERAL INFORMATION

A. Background: Through Transmittal 837, Change Request (CR) 4277, the Centers for Medicare & Medicaid Services (CMS) developed a full claim file repair process. Under this process, Medicare contractors repair errored claims that meet certain prescribed thresholds unless CMS directs otherwise. Through Transmittal 1189, CR 5472, CMS directed all Medicare contractors to repair all claims that the Coordination of Benefits Contractor (COBC) returns as "111" (flat file) errors via the Detailed Error Report without regard to percentage threshold. Certain exceptions apply to this process, as discussed in the business requirements below. These same guidelines will apply to Medicare contractors and their associated systems relative to 5010 crossover claims during and after the transitional period. The "transitional period," of course, refers to the timeframe wherein COBA trading partners may be receiving either 4010-A1 or 5010 "production" crossover claims through the national COBA process.

Through CR 5250, CMS developed a claims recovery process that may be invoked when COBA trading partners inadvertently omit groups of individuals from their incoming coordination of benefits (COB) eligibility files or incorrectly apprised the COBC of incorrect claims selection options. This process will remain unchanged as CMS transitions from the usage of HIPAA 837 version 4010-A1 to HIPAA 5010 COB.

B. Policy: During the 5010 transitional period, all Medicare contractor systems shall accept and process two COBC Detailed Error Reports—one generated by the COBC for claims transmitted by Medicare contractors in the 837 4010-A1 COB flat file format, and another generated by the COBC for claims transmitted by the Medicare contractors in the 837 5010 COB flat file format. Contractors shall ensure that their affiliated Data Centers submit an Electronic Transmittal Form (ETF) to the COBC to request new file names for the Detailed Error Reports that the COBC will issue in association with HIPAA 5010 crossover claims.

Contractors and their systems shall issue special provider letters, in accordance with Transmittal 474, CR 3709, in association with production HIPAA 5010 COB claims in instances where: 1) the error percentages for "222" and "333" errors fall below four (4) percent; and 2) the volume of errors is **not** substantial enough to cause the Medicare contractor to request a claims repair.

Contractors and their shared systems shall repair "222" or "333" errors in association with HIPAA 5010 "production" claims if the error percentage meets or exceeds four (4) percent. Contractors shall alert their shared system or Data Center, as per established protocol, for purposes of initiating each needed claims repair process. Contractors and their systems shall issue special provider letters, as per Transmittal 474, CR 3709, in association with production HIPAA 5010 COB claims in instances where: 1) error percentages for "222" and "333" errors fall below four (4) percent; 2) the volume of errors is **not** substantial enough to cause the Medicare contractor to request a claims repair; or 3) the timeframes for claim repair, as determined by the associated shared system, are **not** acceptable to CMS. Contractors that wish to effectuate a repair of 5010 "production" claims whose error percentage falls below four (4) percent shall contact a member of the CMS COBA team

before attempting that action. As a rule, CMS will grant approval for such a repair if the volume of errored claims justifies that action and if the time frame for repair is acceptable.

While Medicare contractors are **not** expected to initiate the repair of "test" 4010-A1 claims or "test" 5010 claims, they shall continue to monitor the COBC Detailed Error Reports and notify their shared systems of errors returned so that necessary shared system changes to improve HIPAA compliance rates may be realized.

Per Transmittal 1189, CR 5472, if the COBC returns even one "111" (flat file) error to a Medicare contractor on a 5010 COB claim, the affected contractor and its shared system shall initiate a claim repair if the claim's associated COBA ID is in "production." The shared systems shall accept the "111" error codes (see Attachments B and C) that the COBC generates during its application of business level editing to incoming 837 5010 COB flat files. The shared systems shall make modifications to any "111" error tables that they maintain, in accordance with Attachments B and C, **only** in association with 837 5010 COB flat files.

As is true currently, Medicare contractors shall only issue special provider notification letters in association with their receipt of "111" errors if: 1) the timeframe for effectuating a claims repair falls outside acceptable parameters (e.g., will take 30-60 days or longer); and 2) the volume of affected claims is low (i.e., under 1,000 claims per week). Contractor crossover contacts should contact a member of the CMS COBA team if they have questions regarding how they should proceed in association with a given "111" error situation.

Contractors and their shared system(s) shall follow all requirements for COBA claims recovery processes, as outlined in CR 5250, during the transitional period from HIPAA 4010-A1 to HIPAA 5010. (**NOTE**: Durable Medical Equipment Medicare Administrative Contractors (DMACs) are exempted from these requirements.) The only changed COBA claims recovery requirement during the 4010-A1 to 5010 transitional period is that CMS will apprise Medicare Part A and B contractor crossover contacts via e-mail concerning which version of the 837 claim the COBA trading partner is accepting in production mode.

To ensure appropriate cutover to the HIPAA 5010 COB flat file format, all shared systems shall develop new date parameter logic to become operational as of January 1, 2012. The shared systems shall ensure that the new logic addresses all of the following scenarios: 1) repairing any errored 4010-A1 claims in the 5010 claim format; 2) converting claims held in suspense from a 4010-A1 format to the 5010 claim format; 3) converting previously adjudicated 4010-A1 claims to the 5010 "skinny" non-SFR COB claim format in adjustment claim situations; and 4) converting claims held in "provider alert status" from a 4010-A1 (or earlier) format to the 5010 "skinny' non-SFR COB claim format.

For claims repair scenarios involving claims previously sent to the COBC in the 4010-A1 format just prior to January 1, 2012, shared systems shall retransmit repaired claims to the COBC in the 5010 format. Shared systems shall utilize mapping and gap-filling guidance provided in change request 6308 and to be provided in change request 6374 when repairing their originally transmitted 4010-A1 errored crossover claims in the HIPAA 5010 claim format on and after January 1, 2012. In addition, the shared systems shall apply 5010 non-SFR "skinny" logic to claim repair situations where they originally transmitted claims to the COBC prior to January 1, 2012 in the 4010-A1 claim format. Contractors shall **not** repair errored 4010-A1 claims that they transmitted to the COBC just prior to January 1, 2012 if the errors returned via the COBC Detailed Error Report relate to a field or segment that no longer exists in the 5010 claim format. Instead, contractors shall issue provider notification letters for those errored claims to the affected providers.

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	
6420.1	During the transitional period, all Medicare contractor systems shall accept and process two COBC Detailed Error Reports—one generated by the COBC for claims transmitted by Medicare contractors in the 837 4010-A1 COB flat file format, and another generated by the COBC for claims transmitted by the Medicare contractors in the 837 5010 COB flat file format. (**NOTE:** The format of the COBC Detailed Error Reports produced in association with 5010 claims will be unchanged from the format produced for 4010-A1 claims.)						X	X	X		X COBC
6420.1.1	Contractor Data Centers, working on behalf of their affiliated Medicare contractors, shall submit an Electronic Transmittal Form (ETF) to the COBC to request new file names for the Detailed Error Reports that the COBC will issue in association with HIPAA 5010 claims (see Attachment A).	X	X	X	X	X					X Data Ctrs.
6420.1.2	To mitigate past retention concerns, the Part A shared system shall roll up COBC Detailed Error Reports received for both 4010-A1 and 5010 claims such that daily Report receipts from COBC are rolled into weekly stored reports that are retained for a minimum of 16 weeks or generations.						X				
6420.2	Contractors and their shared systems shall repair “222” or “333” errors in association with HIPAA 5010 “production” claims if the error percentage meets or exceeds four (4) percent.	X	X	X	X	X	X	X	X		
6420.2.1	Contractors shall alert their shared system or Data Center, as per established protocol, for purposes of initiating each needed claims repair process.	X	X	X	X	X					
6420.2.1.1	Part A contractors shall contact their respective Data Centers to request that they initiate a claims repair on their behalf.	X		X		X					
6420.2.2	Contractor crossover contacts shall copy CMS COBA team members on any e-mail communications from or with their shared systems concerning projected timeframes for individual claim repairs.	X	X	X	X	X					
6420.2.3	The CMS COBA team will notify contractor crossover contacts via e-mail of a CMS decision to abort claim repair processes due to anticipated timeframes to initiate and complete or other factors.										X CMS
6420.2.4	Contractors and their systems shall issue special provider letters, as per Transmittal 474, CR 3709, in	X	X	X	X	X		X	X		

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	
	association with production HIPAA 5010 COB claims in instances where: 1) the error percentages for "222" and "333" errors fall below four (4) percent; 2) the volume of errors on "production" 5010 COB is **not** substantial enough to cause the Medicare contractor to request a claims repair; or 3) the timeframes for claim repair, as determined by the associated shared system, are not acceptable to CMS.										
6420.2.5	Contractors that wish to effectuate a repair of 5010 "production" claims whose error percentage falls below four (4) percent shall contact a member of the CMS COBA team before attempting that action. (**NOTE:** As a rule, CMS will grant approval for such a repair if the volume of errored claims justifies that action **and** if the time frame for repair is acceptable.)	X	X	X	X	X					
6420.2.6	While Medicare contractors are **not** expected to initiate the repair of "test" 4010-A1 claims or "test" 5010 claims, they shall: 1) continue to monitor the COBC Detailed Error Reports; and 2) notify their shared systems of errors returned so that necessary shared system changes to improve HIPAA compliance rates may be realized.	X	X	X	X	X					
6420.3	In accordance with Transmittal 1189, CR 5472, if the COBC returns even one (1) "111" (flat file) error to a Medicare contractor on a 5010 COB claim, the affected contractor and its shared system shall initiate a claim repair if the claim's associated COBA ID is in "production."	X	X	X	X	X	X	X	X		
6420.3.1	The shared systems shall accept the "111" error codes (see Attachments B and C) that the COBC generates during its application of business level editing to incoming 837 5010 COB flat files.						X		X		
6420.3.2	The shared systems shall, in addition, make modifications to any "111" error tables that they maintain, in accordance with Attachments B and C, **only** in association with 837 5010 COB flat files.						X	X	X		
6420.3.3	As is true currently, Medicare contractors shall **only** issue special provider notification letters in association with their receipt of "111" errors if: 1) the timeframe for effectuating a claims repair falls outside acceptable parameters (e.g., will take 30-60 days or longer); and	X	X	X	X	X					

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	
	2) the volume of affected claims is low (i.e., under 1,000 claims per week).										
6420.3.4	Contractor crossover contacts should contact a member of the CMS COBA team if they have questions regarding how they should proceed in association with a given "111" error situation.	X	X	X	X	X					
6420.4	Contractors and their shared systems shall follow all requirements for COBA claims recovery processes, as outlined in CR 5250, during the transitional period from HIPAA 4010-A1 to HIPAA 5010. (**NOTE:** DME MACs are exempted from these requirements.)	X		X	X	X	X	X			
6420.4.1	During the transitional period, the only changed COBA claims recovery requirement is that CMS will apprise Medicare Part A and B contractor crossover contacts via e-mail concerning which version of the 837 claim the COBA trading partner is accepting in production mode for purposes of the claims recovery.										X CMS
6420.4.2	Contractor crossover contacts shall advise the shared system of the claim version that the COBA trading partner is accepting in production in association with claim recovery activities during the transitional period.	X		X	X	X					
6420.5	To ensure appropriate cutover to the HIPAA 5010 COB flat file format, all shared systems shall develop **new** date parameter logic to become operational as of January 1, 2012.						X	X	X		
6420.5.1	The shared systems shall ensure that the new logic addresses all of the following scenarios: 1) repairing any errored 4010-A1 claims in the 5010 claim format; 2) converting claims held in suspense from a 4010-A1 format to the 5010 claim format; 3) converting previously adjudicated 4010-A1 claims to the 5010 "skinny" non-SFR COB claim format in adjustment claim situations; and 4) converting claims held in "provider alert status" from a 4010-A1 (or earlier) format to the 5010 "skinny' non-SFR COB claim format.						X	X	X		
6420.5.2	For claims repair scenarios involving claims previously sent to the COBC in the 4010-A1 format just prior to January 1, 2012, the shared systems shall retransmit repaired claims to the COBC in the 5010 format.						X	X	X		

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	
6420.5.3	Shared systems shall utilize mapping and gap-filling guidance provided in change request 6308 and to be provided in change request 6374 when repairing their originally transmitted 4010-A1 errored crossover claims in the HIPAA 5010 claim format on and after January 1, 2012.						X		X		
6420.5.3.1	In addition, the shared systems shall apply 5010 non-SFR "skinny" logic to claim repair situations where they originally transmitted claims to the COBC prior to January 1, 2012, in the 4010-A1 claim format.						X	X	X		
6420.5.4	Contractors shall **not** repair errored 4010-A1 claims that they transmitted to the COBC just prior to January 1, 2012, if the errors returned via the COBC Detailed Error Report relate to a field or segment that no longer exists in the 5010 claim format.	X	X	X	X	X	X	X	X		
6420.5.5	Contractors shall instead issue provider notification letters for those errored claims to the affected providers.	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	
	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 (brian.pabst@cms.hhs.gov; 410-786-2487)

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

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.

ATTACHMENTS:

Attachment A---Electronic Transmittal Form

Attachment B – COBC Detailed Error Report "111" Error Criteria for Institutional COB Claims

Attachment C– COBC Detailed Error Report "111" Error Criteria for Professional COB Claims

Attachment A

ELECTRONIC TRANSMITTAL FORM

Project: Coordination of Benefits Agreement (COBA)

Task: COBC Detailed Error Report Processing

Contact Information

Company Name: _____ Medicare Contr # _____

Contact Name: _____ Phone #_____ext._____

Contact Email Address:_____

AGNS Account Information

Account ID: _____

Net ID: _____ Appl ID: _____

Production Requirements

Filename(s): Error Response File _____
Filename(s): Detailed Error Report _____
Filename(s): Recovery Eligibility File
_____

Special Instructions (e.g., file triggers):

_____
_____
_____
_____

Test Requirements

Filename(s): Error Response File _____
Filename(s): Detailed Error Report _____
Filename(s): Recovery Eligibility File
_____

Special Instructions (e.g., file triggers):

_____
_____
_____
_

ATTACHMENT B
COBC DETAILED ERROR REPORT "111" ERROR CRITERIA FOR INSTITUTIONAL COB CLAIMS

Error Code	Error Description	Control #	COBA ID	HICN	CCN	Loop ID	Segment	Element	Content	BHT 03	Reject Level
100	No ST Segment	NO	NO	NO	NO	NO	YES	NO	NO	NO	HEAD
101	No BHT Segment	YES	NO	NO	NO	NO	YES	NO	NO	NO	HEAD
103	Missing 1000A Records	YES	NO	NO	NO	YES	YES	NO	NO	YES	HEAD
104	Missing 1000B Records	YES	NO	NO	NO	YES	YES	NO	NO	YES	HEAD
105	Invalid 1000A.NM109	YES	NO	NO	NO	YES	YES	YES	YES	YES	HEAD
110	Invalid 1000B.NM103	YES	NO	NO	NO	YES	YES	YES	YES	YES	HEAD
115	Invalid 1000B.NM109	YES	YES	NO	NO	YES	YES	YES	YES	YES	HEAD
120	Multiple 1000A per ST/SE	YES	NO	NO	NO	YES	YES	NO	NO	YES	HEAD
125	Multiple 1000B per ST/SE	YES	NO	NO	NO	YES	YES	NO	NO	YES	HEAD
199	All 2000B Rejected	YES	YES	NO	NO	YES	YES	NO	NO	YES	HEAD
200	Missing 2000A	YES	YES	NO	NO	YES	YES	NO	NO	YES	PROV
201	Missing 2010AA	YES	YES	NO	NO	YES	YES	NO	NO	YES	PROV
210	Multiple 2010AA per 2000A	YES	YES	NO	NO	YES	YES	NO	NO	YES	PROV
211	Multiple 2010AB per 2000A	YES	YES	NO	NO	YES	YES	NO	NO	YES	PROV
212	Invalid presence of 2010AC per 2000A	YES	YES	NO	NO	YES	YES	NO	NO	YES	PROV
300	Missing 2000B	YES	YES	NO	NO	YES	YES	NO	NO	YES	SUB
301	Missing 2010BA	YES	YES	NO	NO	YES	YES	NO	NO	YES	SUB
302	Missing 2010BB Loop	YES	YES	YES	NO	YES	YES	NO	NO	YES	SUB
305	Multiple 2010BB per 2000B	YES	YES	YES	NO	YES	YES	NO	NO	YES	SUB

306	Multiple 2010BA per 2000B	YES	YES	YES	NO	YES	YES	NO	NO	YES	SUB
310	2010BB.NM109 not equal 1000B.NM109	YES	YES	YES	NO	YES	YES	YES	YES	YES	SUB
320	2010BB.N3 not equal spaces	YES	YES	YES	NO	YES	YES	YES	YES	YES	SUB
321	2010BB.N4 not equal spaces	YES	YES	YES	NO	YES	YES	YES	YES	YES	SUB
351	More than 100 2300 per 2000B	YES	YES	YES	NO	YES	YES	NO	NO	YES	SUB
Error Code	**Error Description**	**Control #**	**COBA ID**	**HICN**	**CCN**	**Loop ID**	**Segment**	**Element**	**Content**	**BHT 03**	**Error Code**
399	All 2300 Loops Rejected	YES	YES	YES	NO	YES	YES	NO	NO	YES	SUB
400	2010CA Found	YES	YES	YES	NO	YES	YES	NO	NO	YES	
500	2300 Not Found	YES	YES	YES	NO	YES	YES	NO	NO	YES	CLM
505	2320 Not Found	YES	YES	YES	NO	YES	YES	NO	NO	YES	CLM
515	2400 Not Found	YES	YES	YES	YES	YES	YES	NO	NO	YES	CLM
520	# of 2400 Loops GT 999	YES	YES	YES	YES	YES	YES	NO	NO	YES	CLM
575	2330A Not Found	YES	YES	YES	NO	YES	YES	NO	NO	YES	CLM
576	2330B Not Found	YES	YES	YES	NO	YES	YES	NO	NO	YES	CLM
580	2320.SBR01 not Equal P (must be at least one “P” segment)	YES	YES	YES	NO	YES	YES	YES	YES	YES	CLM
581	2320.SBR Field Invalid (SBR09 does not equal MB when Medicare is primary in SBR01)	YES	YES	YES	NO	YES	YES	NO	NO	YES	CLM
590	Multiple 2330A	YES	YES	YES	NO	YES	YES	NO	NO	YES	CLM
591	Multiple 2330B	YES	YES	YES	NO	YES	YES	NO	NO	YES	CLM
595	2330B.REF02 Equal	YES	YES	YES	YES	YES	YES	YES	YES	YES	CLM
596	2330B.NM109	YES	YES	YES	YES	YES	YES	YES	YES	YES	CLM

	Invalid COBA ID										
597	2330B REF not found	YES	YES	YES	YES	YES	YES	YES	YES	YES	CLM
598	2330B NM103 equals spaces and invalid COBA ID in 2330B NM109	YES	YES	YES	YES	YES	YES	YES	YES	YES	CLM
610	# of 2430 Loops greater than 15	YES	YES	YES	YES	YES	YES	NO	NO	YES	CLM
620	2430.SVD01 not equal 1000A.NM109	YES	YES	YES	YES	YES	YES	YES	NO	YES	CLM
999	SE Segment Missing	YES	YES	NO	NO	NO	YES	NO	NO	YES	HEAD

ATTACHMENT C

COBC DETAILED ERROR REPORT "111" ERROR CRITERIA FOR PROFESSIONAL COB CLAIMS

Error Code	Error Description	Control #	COBA ID	HICN	CCN	Loop ID	Segment	Element	Content	BHT 03	Reject Level
100	No ST Segment	NO	NO	NO	NO	NO	YES	NO	NO	NO	HEAD
101	No BHT Segment	YES	NO	NO	NO	NO	YES	NO	NO	NO	HEAD
103	Missing 1000A Records	YES	NO	NO	NO	YES	YES	NO	NO	YES	HEAD
104	Missing 1000B Records	YES	NO	NO	NO	YES	YES	NO	NO	YES	HEAD
105	Invalid 1000A.NM109	YES	NO	NO	NO	YES	YES	YES	YES	YES	HEAD
110	Invalid 1000B.NM103	YES	NO	NO	NO	YES	YES	YES	YES	YES	HEAD
115	Invalid 1000B.NM109	YES	YES	NO	NO	YES	YES	YES	YES	YES	HEAD
120	Multiple 1000A per ST/SE	YES	NO	NO	NO	YES	YES	NO	NO	YES	HEAD
125	Multiple 1000B per ST/SE	YES	NO	NO	NO	YES	YES	NO	NO	YES	HEAD
199	All 2000B Rejected	YES	YES	NO	NO	YES	YES	NO	NO	YES	HEAD
200	Missing 2000A	YES	YES	NO	NO	YES	YES	NO	NO	YES	PROV
201	Missing 2010AA	YES	YES	NO	NO	YES	YES	NO	NO	YES	PROV
210	Multiple 2010AA per 2000A	YES	YES	NO	NO	YES	YES	NO	NO	YES	PROV
211	Multiple 2010AB per 2000A	YES	YES	NO	NO	YES	YES	NO	NO	YES	PROV
212	Invalid presence of 2010AC per 2000A	YES	YES	NO	NO	YES	YES	NO	NO	YES	PROV
300	Missing 2000B	YES	YES	NO	NO	YES	YES	NO	NO	YES	SUB
301	Missing 2010BA	YES	YES	NO	NO	YES	YES	NO	NO	YES	SUB
302	Missing 2010BB Loop	YES	YES	YES	NO	YES	YES	NO	NO	YES	SUB
305	Multiple 2010BB per 2000B	YES	YES	YES	NO	YES	YES	NO	NO	YES	SUB
306	Multiple 2010BA per	YES	YES	YES	NO	YES	YES	NO	NO	YES	SUB

	2000B										
310	2010BB.NM109 not equal 1000B.NM109	YES	YES	YES	NO	YES	YES	YES	YES	YES	SUB
320	2010BB.N3 not equal spaces	YES	YES	YES	NO	YES	YES	YES	YES	YES	SUB
321	2010BB.N4 not equal spaces	YES	YES	YES	NO	YES	YES	YES	YES	YES	SUB
Error Code	**Error Description**	**Control #**	**COBA ID**	**HICN**	**CCN**	**Loop ID**	**Segment**	**Element**	**Content**	**BHT 03**	**Error Code**
351	More than 100 2300 per 2000B	YES	YES	YES	NO	YES	YES	NO	NO	YES	SUB
399	All 2300 Loops Rejected	YES	YES	YES	NO	YES	YES	NO	NO	YES	SUB
400	2010CA Found	YES	YES	YES	NO	YES	YES	NO	NO	YES	
500	2300 Not Found	YES	YES	YES	NO	YES	YES	NO	NO	YES	CLM
505	2320 Not Found	YES	YES	YES	NO	YES	YES	NO	NO	YES	CLM
515	2400 Not Found	YES	YES	YES	YES	YES	YES	NO	NO	YES	CLM
520	# of 2400 Loops GT 50	YES	YES	YES	YES	YES	YES	NO	NO	YES	CLM
575	2330A Not Found	YES	YES	YES	NO	YES	YES	NO	NO	YES	CLM
576	2330B Not Found	YES	YES	YES	NO	YES	YES	NO	NO	YES	CLM
580	2320.SBR01 not Equal P (must be at least one “P” segment)	YES	YES	YES	NO	YES	YES	YES	YES	YES	CLM
581	2320.SBR Field Invalid (SBR09 does not equal MB when Medicare is primary in SBR01)	YES	YES	YES	NO	YES	YES	NO	NO	YES	CLM
590	Multiple 2330A	YES	YES	YES	NO	YES	YES	NO	NO	YES	CLM
591	Multiple 2330B	YES	YES	YES	NO	YES	YES	NO	NO	YES	CLM
595	2330B.REF02 Equal	YES	YES	YES	YES	YES	YES	YES	YES	YES	CLM
596	2330B.NM109 Invalid COBA ID	YES	YES	YES	YES	YES	YES	YES	YES	YES	CLM

597	2330B REF not found	YES	YES	YES	YES	YES	YES	YES	YES	YES	CLM
598	2330B NM103 equals spaces and invalid COBA ID in 2330B NM109	YES	YES	YES	YES	YES	YES	YES	YES	YES	CLM
610	# of 2430 Loops greater than 15	YES	YES	YES	YES	YES	YES	NO	NO	YES	CLM
620	2430.SVD01 not equal 1000A.NM109	YES	YES	YES	YES	YES	YES	YES	NO	YES	CLM
999	SE Segment Missing	YES	YES	NO	NO	NO	YES	NO	NO	YES	HEAD

Medicare Claims Processing Manual
Chapter 28 - Coordination With Medigap, Medicaid, and Other Complementary Insurers

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(Rev.1727, 05-01-09)

70.6.1.1- Coordination of Benefits Agreement (COBA) 837 5010 Coordination of Benefits (COB) Flat File Errors

(Rev.1727, Issued: 05-01-09, Effective: 10-01-09, Implementation: 10-05-09)

Effective with the implementation of the Health Insurance Portability and Accountability Act (HIPAA) 837 5010 COB requirements, the Coordination of Benefits Contractor (COBC) will return the error codes shown in the chart below to Medicare contractors whose flat file submissions lack structural elements necessary for the building of outbound HIPAA compliant crossover claims.

*The shared systems shall, in addition, make modifications to any "111" error tables that they maintain, in accordance with the following charts, **only** in association with 837 5010 COB flat files.*

COBC DETAILED ERROR REPORT "111" ERROR CRITERIA FOR 837 VERSION 5010

INSTITUTIONAL COB CLAIMS

Error Code	Error Description	Control #	COBA ID	HICN	CCN	Loop ID	Segment	Element	Content	BHT 03	Reject Level
100	No ST Segment	NO	NO	NO	NO	NO	YES	NO	NO	NO	HEAD
101	No BHT Segment	YES	NO	NO	NO	NO	YES	NO	NO	NO	HEAD
103	Missing 1000A Records	YES	NO	NO	NO	YES	YES	NO	NO	YES	HEAD
104	Missing 1000B Records	YES	NO	NO	NO	YES	YES	NO	NO	YES	HEAD
105	Invalid 1000A.NM109	YES	NO	NO	NO	YES	YES	YES	YES	YES	HEAD
110	Invalid 1000B.NM103	YES	NO	NO	NO	YES	YES	YES	YES	YES	HEAD
115	Invalid 1000B.NM109	YES	YES	NO	NO	YES	YES	YES	YES	YES	HEAD
120	Multiple 1000A per	YES	NO	NO	NO	YES	YES	NO	NO	YES	HEAD

	ST/SE										
125	Multiple 1000B per ST/SE	YES	NO	NO	NO	YES	YES	NO	NO	YES	HEAD
199	All 2000B Rejected	YES	YES	NO	NO	YES	YES	NO	NO	YES	HEAD
200	Missing 2000A	YES	YES	NO	NO	YES	YES	NO	NO	YES	PROV
201	Missing 2010AA	YES	YES	NO	NO	YES	YES	NO	NO	YES	PROV
210	Multiple 2010AA per 2000A	YES	YES	NO	NO	YES	YES	NO	NO	YES	PROV
211	Multiple 2010AB per 2000A	YES	YES	NO	NO	YES	YES	NO	NO	YES	PROV
212	Invalid presence of 2010AC per 2000A	YES	YES	NO	NO	YES	YES	NO	NO	YES	PROV
300	Missing 2000B	YES	YES	NO	NO	YES	YES	NO	NO	YES	SUB
301	Missing 2010BA	YES	YES	NO	NO	YES	YES	NO	NO	YES	SUB
302	Missing 2010BB Loop	YES	YES	YES	NO	YES	YES	NO	NO	YES	SUB
305	Multiple 2010BB per 2000B	YES	YES	YES	NO	YES	YES	NO	NO	YES	SUB
306	Multiple 2010BA per	YES	YES	YES	NO	YES	YES	NO	NO	YES	SUB

	2000B										
310	2010BB.NM109 not equal 1000B.NM109	YES	YES	YES	NO	YES	YES	YES	YES	YES	SUB
320	2010BB.N3 not equal spaces	YES	YES	YES	NO	YES	YES	YES	YES	YES	SUB
Error Code	**Error Description**	**Control #**	**COBA ID**	**HICN**	**CCN**	**Loop ID**	**Segment**	**Element**	**Content**	**BHT 03**	**Reject Level**
321	2010BB.N4 not equal spaces	YES	YES	YES	NO	YES	YES	YES	YES	YES	SUB
351	More than 100 2300 per 2000B	YES	YES	YES	NO	YES	YES	NO	NO	YES	SUB
399	All 2300 Loops Rejected	YES	YES	YES	NO	YES	YES	NO	NO	YES	SUB
400	2010CA Found	YES	YES	YES	NO	YES	YES	NO	NO	YES	
500	2300 Not Found	YES	YES	YES	NO	YES	YES	NO	NO	YES	CLM
505	2320 Not Found	YES	YES	YES	NO	YES	YES	NO	NO	YES	CLM
515	2400 Not Found	YES	YES	YES	YES	YES	YES	NO	NO	YES	CLM
520	# of 2400 Loops GT	YES	YES	YES	YES	YES	YES	NO	NO	YES	CLM

	999										
575	2330A Not Found	YES	YES	YES	NO	YES	YES	NO	NO	YES	CLM
576	2330B Not Found	YES	YES	YES	NO	YES	YES	NO	NO	YES	CLM
Error Code	**Error Description**	**Control #**	**COBA ID**	**HICN**	**CCN**	**Loop ID**	**Segment**	**Element**	**Content**	**BHT 03**	**Reject Level**
580	2320.SBR01 not equal P (must be at least one “P” segment)	YES	YES	YES	NO	YES	YES	YES	YES	YES	CLM
581	2320.SBR Field Invalid (SBR09 does not equal MB when Medicare is primary in SBR01)	YES	YES	YES	NO	YES	YES	NO	NO	YES	CLM
590	Multiple 2330A	YES	YES	YES	NO	YES	YES	NO	NO	YES	CLM
591	Multiple 2330B	YES	YES	YES	NO	YES	YES	NO	NO	YES	CLM
595	2330B.REF02 Equal	YES	YES	YES	YES	YES	YES	YES	YES	YES	CLM
596	2330B.NM109	YES	YES	YES	YES	YES	YES	YES	YES	YES	CLM

	Invalid COBA ID										
597	2330B REF not found	YES	YES	YES	YES	YES	YES	YES	YES	YES	CLM
598	2330B NM103 equals spaces and invalid COBA ID in 2330B NM109	YES	YES	YES	YES	YES	YES	YES	YES	YES	CLM
Error Code	**Error Description**	**Control #**	**COBA ID**	**HICN**	**CCN**	**Loop ID**	**Segment**	**Element**	**Content**	**BHT 03**	**Reject Level**
610	# of 2430 Loops greater than 15	YES	YES	YES	YES	YES	YES	NO	NO	YES	CLM
620	2430.SVD01 not equal 1000A.NM109	YES	YES	YES	YES	YES	YES	YES	NO	YES	CLM
999	SE Segment Missing	YES	YES	NO	NO	NO	YES	NO	NO	YES	HEAD

COBC DETAILED ERROR REPORT "111" ERROR CRITERIA FOR PROFESSIONAL COB CLAIMS

Error Code	Error Description	Control #	COBA ID	HICN	CCN	Loop ID	Segment	Element	Content	BHT 03	Reject Level
100	No ST Segment	NO	NO	NO	NO	NO	YES	NO	NO	NO	HEAD
101	No BHT Segment	YES	NO	NO	NO	NO	YES	NO	NO	NO	HEAD
103	Missing 1000A Records	YES	NO	NO	NO	YES	YES	NO	NO	YES	HEAD
104	Missing 1000B Records	YES	NO	NO	NO	YES	YES	NO	NO	YES	HEAD
105	Invalid 1000A.NM109	YES	NO	NO	NO	YES	YES	YES	YES	YES	HEAD
110	Invalid 1000B.NM103	YES	NO	NO	NO	YES	YES	YES	YES	YES	HEAD
115	Invalid 1000B.NM109	YES	YES	NO	NO	YES	YES	YES	YES	YES	HEAD
120	Multiple 1000A per ST/SE	YES	NO	NO	NO	YES	YES	NO	NO	YES	HEAD
125	Multiple 1000B per ST/SE	YES	NO	NO	NO	YES	YES	NO	NO	YES	HEAD

Error Code	Error Description	Control #	COBA ID	HICN	CCN	Loop ID	Segment	Element	Content	BHT 03	Reject Level
199	All 2000B Rejected	YES	YES	NO	NO	YES	YES	NO	NO	YES	HEAD
200	Missing 2000A	YES	YES	NO	NO	YES	YES	NO	NO	YES	PROV
201	Missing 2010AA	YES	YES	NO	NO	YES	YES	NO	NO	YES	PROV
210	Multiple 2010AA per 2000A	YES	YES	NO	NO	YES	YES	NO	NO	YES	PROV
211	Multiple 2010AB per 2000A	YES	YES	NO	NO	YES	YES	NO	NO	YES	PROV
212	Invalid presence of 2010AC per 2000A	YES	YES	NO	NO	YES	YES	NO	NO	YES	PROV
300	Missing 2000B	YES	YES	NO	NO	YES	YES	NO	NO	YES	SUB
301	Missing 2010BA	YES	YES	NO	NO	YES	YES	NO	NO	YES	SUB
302	Missing 2010BB Loop	YES	YES	YES	NO	YES	YES	NO	NO	YES	SUB
305	Multiple 2010BB per 2000B	YES	YES	YES	NO	YES	YES	NO	NO	YES	SUB
306	Multiple 2010BA per 2000B	YES	YES	YES	NO	YES	YES	NO	NO	YES	SUB

Error Code	Error Description	Control #	COBA ID	HICN	CCN	Loop ID	Segment	Element	Content	BHT 03	Reject Level
310	2010BB.NM109 not equal 1000B.NM109	YES	YES	YES	NO	YES	YES	YES	YES	YES	SUB
320	2010BB.N3 not equal spaces	YES	YES	YES	NO	YES	YES	YES	YES	YES	SUB
321	2010BB.N4 not equal spaces	YES	YES	YES	NO	YES	YES	YES	YES	YES	SUB
351	More than 100 2300 per 2000B	YES	YES	YES	NO	YES	YES	NO	NO	YES	SUB
399	All 2300 Loops Rejected	YES	YES	YES	NO	YES	YES	NO	NO	YES	SUB
400	2010CA Found	YES	YES	YES	NO	YES	YES	NO	NO	YES	
500	2300 Not Found	YES	YES	YES	NO	YES	YES	NO	NO	YES	CLM
505	2320 Not Found	YES	YES	YES	NO	YES	YES	NO	NO	YES	CLM
515	2400 Not Found	YES	YES	YES	YES	YES	YES	NO	NO	YES	CLM
520	# of 2400 Loops GT 50	YES	YES	YES	YES	YES	YES	NO	NO	YES	CLM

575	2330A Not Found	YES	YES	YES	NO	YES	YES	NO	NO	YES	CLM
Error Code	**Error Description**	**Control #**	**COBA ID**	**HICN**	**CCN**	**Loop ID**	**Segment**	**Element**	**Content**	**BHT 03**	**Reject Level**
576	2330B Not Found	YES	YES	YES	NO	YES	YES	NO	NO	YES	CLM
580	2320.SBR01 not Equal P (must be at least one “P” segment)	YES	YES	YES	NO	YES	YES	YES	YES	YES	CLM
581	2320.SBR Field Invalid (SBR09 does not equal MB when Medicare is primary in SBR01)	YES	YES	YES	NO	YES	YES	NO	NO	YES	CLM
590	Multiple 2330A	YES	YES	YES	NO	YES	YES	NO	NO	YES	CLM
591	Multiple 2330B	YES	YES	YES	NO	YES	YES	NO	NO	YES	CLM
595	2330B.REF02 Equal	YES	YES	YES	YES	YES	YES	YES	YES	YES	CLM
596	2330B.NM109 Invalid COBA ID	YES	YES	YES	YES	YES	YES	YES	YES	YES	CLM
597	2330B REF not found	YES	YES	YES	YES	YES	YES	YES	YES	YES	CLM

598	2330B NM103 equals spaces and invalid COBA ID in 2330B NM109	YES	YES	YES	YES	YES	YES	YES	YES	YES	CLM
Error Code	**Error Description**	**Control #**	**COBA ID**	**HICN**	**CCN**	**Loop ID**	**Segment**	**Element**	**Content**	**BHT 03**	**Reject Level**
610	# of 2430 Loops greater than 15	YES	YES	YES	YES	YES	YES	NO	NO	YES	CLM
620	2430.SVD01 not equal 1000A.NM109	YES	YES	YES	YES	YES	YES	YES	NO	YES	CLM
999	SE Segment Missing	YES	YES	NO	NO	NO	YES	NO	NO	YES	HEAD

70.6.2 – Coordination of Benefits Agreement (COBA) Full Claim File Repair Process

(Rev.1727, Issued: 05-01-09, Effective: 10-01-09, Implementation: 10-05-09)

Effective with the July 2006 release, CMS will implement a full claim file repair process at its Medicare contractors to address situations where one or more of the contractor shared systems inadvertently introduced a severe error condition into the claims processing cycle, with the effect being that the Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X12-N 837 Coordination of Benefits (COB) Institutional and Professional crossover claims files or National Council for Prescription Drug Programs (NCPDP) claim files become unusable for COB purposes**.**

When a Medicare contractor, the COBC, or a COBA trading partner identifies a shared system problem that will prevent, or has prevented, the COBA trading partner from accepting a HIPAA ANSI X12-N 837 COB Institutional and Professional claims file from the COBC, the Medicare contractor shall work with its shared system maintainer to assess the feasibility of executing a full claim file repair. Contractors shall utilize the COBC Detailed Error Reports to determine the percentage of errors present for each error source code—"111" (flat file) errors, "222" (HIPAA ANSI X12-N 837 COB) errors, and "333" (trading partner dispute) errors. When the contractors or their shared system maintainers determine that the error percentages are at or above the parameters discussed later within this section, the contractors shall begin the process of analyzing the claim files for a possible full claim repair process. If the Medicare contractors and their shared systems subsequently initiate a full claim file repair process, that process shall be accomplished within a maximum of 14 work days, unless determined otherwise by CMS.

Effective with July 2, 2007, contractors 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 specified in §70.6.1 of this chapter. If a contractor receives even one (1) "111" error via the COBC Detailed Error Report, the contractor, working with its Data Center or shared system as necessary, shall immediately attempt a repair of the claims file, in accordance with all other requirements communicated within this section.

1. Medicare Contractor or Shared System Identification of a Full Claim File Problem and Subsequent Actions

When a contractor, working with its shared system maintainer, identifies a severe error condition that will negatively impact the claims that it has transmitted to the COBC, the contractor shall, upon detection, immediately notify CMS and the COBC by calling current COBC or CMS COBA crossover contacts and sending e-mail communications to: COBAProcess@cms.hhs.gov and cobva@ghimedicare.com.

The contractor shall work closely with its system maintainer to determine the timeframes for developing, testing, and applying a fix to correct the severe error(s) that was/were identified within the 837 or NCPDP files that were previously transmitted to the COBC. The Part A, Part B, or *DME MAC* shared system maintainers shall then report the timeframes for developing, testing, and applying a fix to the full claim file problem in accordance with their procedures as outlined in their systems maintenance contract. If CMS determines that the time frames for affecting a full claim file repair of the previously transmitted claims exceed what is considered reasonable (a maximum of 14 work days, unless determined otherwise by CMS), a designated COBA team representative will notify the Medicare contractors and their shared system maintainers via e-mail to abort the full claim file repair process. *(**NOTE**: This process will remain unchanged with the transition to claim version 5010.)*

Upon receipt of a notification from the CMS COBA team representative that indicates that the timeframes for fixing a full claim file problem exceed those that are acceptable to CMS, the contractors' shared systems shall abort the full claim file repair process. Contractors shall then follow the requirements provided in §70.6.1 of this chapter with respect to the special provider notification and other COBA crossover operational processes. In such cases, however, contractors shall not be required to wait the customary five (5) business days before generating the special provider notification letters to their affected physicians, suppliers, or other providers of service.

2. Alerting Contractors to the Possible Need for a Full Claim File Repair via the COBC Detailed Error Reports and Subsequent Contractor Actions

a. Severe Error Percentage Parameters and Suppression of the Special Provider Notification Letters

Effective with July 2006, the CMS, working in conjunction with the COBC, shall modify the COBC Detailed Error Report layouts, as found in §70.6.1 of this chapter, to include the following new elements: Total Number of Claims for Date of Receipt; Total Number of "111" (flat file) Errors and corresponding percentage; Total Number of "222" (HIPAA ANSI X12-N 837 COB) Errors and corresponding percentage; and Total Number of "333" (trading partner dispute) Errors and corresponding percentage.

Effective with July 2007, CMS is directing its Medicare contractors to now base their severe error decision calculus upon the number of "111" errors received rather than percentage of such errors. Therefore, when a contractor or its shared system maintainer receives a COBC Detailed Error Report that indicates that the trading partner is in production and the number of "111" (flat file) errors is equal to or greater than one, the contractor's shared system shall suppress the generation of special provider notifications, as provided in § 70.6.1 of this chapter, until after the severe error condition(s) has/have been analyzed. (**NOTE:** If the "222" and/or "333" errors indicated on the COBC

Detailed Error Report do **not** exceed the four (4) percent parameter, then the contractor shall continue with the generation of the provider notification letters for those errors while it is analyzing the "111" severe error(s).)

IMPORTANT: Effective with October 1, 2007, contractors and their systems shall have the capability to initiate a claims repair process, internally or at CMS direction, for situations in which they encounter high volume "222" or "333" error rejections that do not meet or exceed the established error threshold parameters. Before initiating a claims repair for error situations that fall below the established percentage parameters, the affected contractors shall first contact a member of the CMS COBA team to obtain clearance for that process.

When a contractor or its shared system maintainer receives a COBC Detailed Error Report that indicates that the trading partner is in production and the percentage of "222" (HIPAA ANSI X12-N 837) errors and "333" (trading partner dispute) errors is equal to or greater than four (4) percent, the contractor's shared system shall suppress the generation of special provider notifications, as provided in §70.6.1 of this chapter, until after the severe error condition(s) has/have been analyzed. **NOTE:** If the number of "111" errors indicated on the COBC Detailed Error Report is **not** equal to or greater than one (1), then the contractor shall continue with the generation of the provider notification letters for those errors while it is analyzing the "222" and "333" severe errors.

For each of the severe error situations discussed above, contractors, or their shared systems, shall suppress the special provider notification for a minimum of five (5) business days. The contractors' shared systems shall also have the capability to adjust the parameters for generation of the provider notification letters, as referenced in §70.6.1 of this chapter, of up to 14 work days while analysis of the claims that are being "held" for possible full claim file repair is proceeding.

Effective with October 1, 2007, all contractors shall have the capability to suppress their provider notification letters for a timeframe of up to 14 work days, or longer at CMS direction, where they initiate a claims repair process when claims with "222" or "333" errors fall below the "normally established" four (4) percent threshold.

Also, for each of the situations discussed above, the contractors' shared systems shall establish percentage parameters for each error source code (222 and 333) that allow for flexibility within a range (e.g., 1 to 10 percent).

b. Additional Information Highlighting Possible Severe Error Conditions on the COBC Detailed Error Reports.

Effective with July 2006, the COBC will report one of the following error sources and error codes/trading partner dispute codes that may be indicative of a severe error condition on the returned COBC Institutional and Professional Detailed Error Reports:

1.) Error source code "111" will be reported in field 10, along with a 6-digit error code in field 11 (note: unlike routine reporting of flat file errors, a full claim file error condition would be indicated if there were numerous instances of the same error code repeated throughout a Report); the description of the problem(s) that has/have caused the full claim file to be unusable will be reported in field 12 (error description);

2.) Error source code "222" will be reported in field 10, along with a 6-digit error code in field 11 that begins with an "N"; the description of the problem(s) that has/have caused the full claim file to be unusable will be reported in field 12 (error description);

3.) Error source code "333" will be reported in field 10; an error/trading partner dispute code "999" (trading partner dispute—"other") will be reported in field 11, left-justified and followed by spaces; and a description of the problem(s) that has/have caused the full claim file to be unusable will be reported in field 12 (error description).

DMAC contractors and their shared systems shall process NCPDP Detailed Error Reports returned from the COBC that contain the following combination of error source codes, error/trading partner dispute codes, and error descriptions within the Reports:

1.) Error source code "111" will be reported in field 9, along with a 6-digit error code in field 10 (NOTE: unlike routine reporting of flat file errors, a full claim file error condition would be indicated if there were numerous instances of the same error code repeated throughout a Report); and a description of the problem(s) that has/have caused the full claim file to be unusable will be reported in field 11; **or**

2.) Error source code "333" will be reported in field 9; an error/trading partner dispute code "999" will be reported in field 10, left-justified and followed by spaces; and a description of the problem(s) that has/have caused the full claim file to be unusable will be reported in field 11 (error description).

c. Contractor Actions Following Suppression of the Special Provider Notification Letters to Analyze Possible Severe Error Conditions

When contractors receive COBC Detailed Error Reports that contain “222” or “333” errors with percentages that are at or above the established parameters—or if the contractors receive “111” errors that are at or above zero (“0”)—they shall work closely with their system maintainers to determine the timeframes for developing, testing, and applying a fix to correct the severe error(s) that was/were identified within the 837 or NCPDP files that were previously transmitted to the COBC. The Part A, Part B, or DMAC shared system maintainers shall then report the timeframes for developing, testing, and applying a fix to the full claim file problem in accordance with their procedures as outlined in their systems maintenance contract. If CMS determines that the timeframes for affecting a full claim file repair of the previously transmitted claims exceed what is considered reasonable (a maximum of 14 work days, unless determined otherwise by CMS), a designated COBA team representative will notify the Medicare contractors and their shared system maintainers via e-mail to abort the full claim file repair process.

As noted above, effective with October 1, 2007, all contractors shall have the capability to suppress their provider notification letters for a timeframe of up to 14 work days, or longer at CMS direction, where they initiate a claims repair process when claims with “222” or “333” errors fall below the “normally established” four (4) percent threshold.

Upon receipt of a notification from the CMS COBA team representative that indicates that the timeframes for fixing a full claim file problem exceed those that are acceptable to CMS, the contractors’ shared systems shall abort the full claim file repair process. Contractors shall then follow the requirements provided in §70.6.1 of this chapter with respect to the special provider notification and other COBA crossover operational processes. In such cases, however, contractors shall not be required to wait the customary five (5) business days before generating the special provider notification letters to their affected physicians, suppliers, or other providers of service.

In the event that CMS indicates that a full claim file repair process is feasible, the contractors’ shared systems shall have the ability to cancel the generation of the provider notification letters, as stipulated in §70.6.1 of this chapter, for the “repaired” claims **and** only generate the provider notification letters for the claims containing legitimate 111, 222, or 333 errors not connected with the severe error condition(s).

3. Steps for Ensuring that Only “Repaired” Claims are Re-transmitted to the COBC

Once the contractors' shared systems have determined that they are able to affect a "timely" repair to the full claim files that were previously transmitted to the COBC, they shall take the following actions:

a.) Apply the fix to the unusable claims;

b.) Compare the claims files previously sent to the COBC with the repaired claims file to isolate the claims that previously did **not** contain the error condition(s);

c.) Strip off the claims that did not contain the error condition(s), including claims that contained 111, 222, and 333 errors that were not connected with the severe error condition(s). For the latter set of claims (those with 111, 222, and 333 errors that were **not** connected to the severe error condition), contractors shall then generate the provider notification letters, as stipulated in §70.6.1 of this chapter and specified in the concluding paragraph of the above sub-section entitled, "Contractor Actions Following Suppression of the Special Provider Notification Letters to Analyze Possible Severe Error Conditions";

d.) Recreate the job; and

e.) Send only the "repaired" claims to the COBC.

Contractors' shared systems shall add an indicator"18" to the BHT02 (Beginning of the Hierarchical Transaction/Transaction Set Purpose Code) segment of the HIPAA 837 flat file to designate that the file contains only repaired claims. In addition, the contractor systems shall include the repaired claims in different ST-SE envelopes to differentiate the repaired claims from normal 837 flat file transmissions.

The DMAC contractor system shall add an indicator "R" after the COBA ID reported in the Batch Header Record in the Receiver ID field (field number 880-K7) of the NCPDP claim when transmitting the repaired claims to the COBC.

4. COBA 4010-A1 to 5010 Transitional Requirements

A. Repairing 5010 Flat File ("111") Errors

*As is true of the current COBA crossover process involving the usage of 4010-A1 claims, all Medicare contractors shall effectuate repair of even one "111" errored 5010 COB claim if the COBA trading partner is currently in 5010 "production" mode. (**NOTE:** Parties interested in previewing a listing of all "111" errors that the COBC will apply to incoming 5010 COB flat files should refer to §70.6.1.1 of this chapter.) The shared systems shall accept the "111" error codes (see §70.6.1.1 of this chapter) that the COBC generates during its application of business level editing to incoming 837 5010 COB flat files. The shared systems shall make modifications to any "111" error tables that they maintain **only** in association with 837 5010 COB flat files.*

IMPORTANT: *As is true currently, Medicare contractors shall* ***only*** *issue special provider notification letters in association with their receipt of "111" errors if: 1) the timeframe for effectuating a claims repair falls outside acceptable parameters (e.g., will take 30-60 days or longer); and 2) the volume of affected claims is low (i.e., under 1,000 claims per week). Contractor crossover contacts should contact a member of the CMS COBA team if they have questions regarding how they should proceed in association with a given "111" error situation.*

B. Repairing "222" and "333" Errors Associated with 5010 Claims

Contractors and their shared systems shall repair "222" or "333" errors in association with "production" 5010 claims if the error percentage meets or exceeds four (4) percent. As happens with 4010-A1 claim repairs currently, contractors shall alert their shared system or Data Center, as per established protocol, for purposes of initiating each needed claims repair process in association with 5010 COB claims. ***IMPORTANT:*** *As is true of 4010-A1 claims, contractors that wish to effectuate a repair of 5010 "production" claims whose error percentage falls below four (4) percent shall contact a member of the CMS COBA team before attempting that action. (****NOTE:*** *As a rule, CMS will grant approval for such a repair if the volume of errored claims justifies that action* ***and*** *if the timeframe for repair is acceptable.)*

In accordance with §70.6.1 of this chapter, Medicare contractors shall issue special provider notification letters in those instances where 1) error percentages for "222" and "333" errors fall below four (4) percent; 2) the volume of errors on "production" 5010 COB is ***not*** *substantial enough to cause the Medicare contractor to request a claims repair; or 3) the timeframes for claim repair, as determined by the associated shared system, are* ***not*** *acceptable to CMS.*

C. Generally Applicable Requirements

While Medicare contractors are ***not*** *expected to initiate the repair of "test" 4010-A1 claims or "test" 5010 claims, they shall 1) continue to monitor the COBC Detailed Error Reports; and 2) notify their shared systems of errors returned so that necessary shared system changes to improve HIPAA compliance rates may be realized.*

D. New Date Parameter Logic and Cutover Claims Repair Requirements

To ensure appropriate cutover to the HIPAA 5010 COB flat file format, all shared systems shall develop new date parameter logic to become operational as of January 1, 2012. All shared systems shall ensure that the new logic addresses all of the following scenarios: repairing any errored 4010-A1 claims in the 5010 claim format; converting claims held in suspense from a 4010-A1 format to the 5010 claim format; converting previously adjudicated 4010-A1 claims to the 5010 "skinny" non-SFR COB claim format

in adjustment claim situations; and converting claims held in "provider alert status" from a 4010-A1 (or earlier) format to the 5010 "skinny' non-SFR COB claim format.

For claims repair scenarios involving claims previously sent to the COBC in the 4010-A1 format just prior to January 1, 2012, shared systems shall retransmit repaired claims to the COBC in the 5010 format. To that end, all shared systems shall utilize CMS-issued 5010 mapping and gap-filling guidance provided in chapter 24 §40.4 and chapter 28 §70.6.5 of Pub.100-04 when repairing their originally transmitted 4010-A1 errored crossover claims in the HIPAA 5010 claim format on and after January 1, 2012. In addition, the shared systems shall apply 5010 non-SFR "skinny" logic to claim repair situations where they originally transmitted claims to the COBC prior to January 1, 2012 in the 4010-A1 claim format.

IMPORTANT: *Contractors shall **not** repair errored 4010-A1 claims that they transmitted to the COBC just prior to January 1, 2012 if the errors returned via the COBC Detailed Error Report relate to a field or segment that no longer exists in the 5010 claim format. Instead, contractors shall issue provider notification letters for those errored claims to the affected providers.*

70.6.3 - Coordination of Benefits Agreement (COBA) Eligibility File Claims Recovery Process

(Rev.1727, Issued: 05-01-09, Effective: 10-01-09, Implementation: 10-05-09)

Effective with January 2, 2007, when the CMS or the Coordination of Benefits Contractor (COBC) determines that 1) certain members on a COBA production trading partner's eligibility file were **not** properly loaded to the Common Working File (CWF) Beneficiary Other Insurance (BOI) auxiliary file (see §70.6 of this chapter for more details regarding this file) **or** 2) a COBA production trading partner's claims selections, as conveyed via the COBA Insurance File (COIF), were **not** properly loaded to the CWF, the CMS shall send the Part A or Part B contractor crossover contact(s) a 'COBAProcess' e-mail communication. When the CMS sends a "COBAProcess" e-mail communication to a Medicare contractor to initiate a COBA eligibility file claims recovery process, the contractor shall acknowledge receipt of the communication via return e-mail within 1 business day. The CMS will then contact the contractor's crossover staff via phone to discuss the specific Common Working File (CWF) date span or claim date of service parameters, or both, for the claims recovery process. **(NOTE:** Durable Medical Equipment Regional Carriers, DME Medicare Administrative Contractors, and their shared system shall implement the COBA eligibility file claims recovery process as part of a future systems release.)

During the transitional period from the 4010-A1 to 5010 COB claim format (January 2010 to December 31, 2011), all requirements indicated above and below will remain intact, except that the shared system shall recover claims in the claim format (4010-A1 or 5010) that the COBC specifies to each affected Part A or Part B contractor's crossover contacts. As of January 1, 2012, all contractors shall utilize the 5010 COB claims format in association with claims recovery activities.

Following the telephone discussion between the CMS and the Medicare contractor crossover staff, the COBA eligibility file recovery process will further unfold as detailed below.

1. Receipt and Processing of the COBC COBA Eligibility File and Searching Claims History for the Needed Claims

After the COBC sends the contractor copies of the trading partner's COBA eligibility file(s), which will be prepared in accordance with the CMS proprietary format, the contractor shall initiate recovery of the processed claims within the contractor's claims history that meet the beneficiaries' eligibility dates, as provided on the COBC eligibility file(s), and that fall within the specified CWF date span or date of service parameters, or both, that CMS has provided to the contractor. (**NOTE**: The COBC will transmit the COBA eligibility file to the Medicare contractors through its existing Network Data Mover (NDM) connection with each contractor.)

2. Time Frames for Recovery

The contractor shall complete its claims recovery process, culminating with transmission of the recovered claims to the COBC, within eight (8) work days following the date that it receives the COBC COBA eligibility file.

3. Using Data Elements from the COBA Eligibility File For the Claims Recovery Process and Copying Elements from That File to the Recovered Claims Flat File

Contractors shall perform the following activities related to the COBA eligibility file:

a) Utilize each beneficiary's coverage dates from the COBA eligibility files (field E01.13 for beneficiary supplemental eligibility-from date and field E01.14 for beneficiary supplemental-to date and successive eligibility-from and eligibility-to dates if provided);

b) Apply the specified CWF date span; or

c) Apply the date of service parameters; or

d) Both items b and c above.

Once the Medicare contractor, working with its Data Center, has recovered the specified claims, it shall copy the COBA ID from the COBC COBA eligibility file (field E01.002) and place it within the NM109 segment of the 1000B loop of the flat file containing the recovered Part A and B claims.

4. Scope of the Claims Recovery Effort

Neither the contractor nor its Data Center shall be required to search archived claims history while fulfilling the COBA eligibility file claims recovery process.

The contractor and its Data Center shall not be required to apply the COBA production trading partner's selection criteria before transmitting the recovered claims to the COBC.

The contractor or its Data Center shall not transmit claims that had previously been sent to the COBC as part of the COBA eligibility file claims recovery process, as demonstrated by the claims' crossover location status or the presence of a COBA identification (ID) number accompanied by a 'P' (production) indicator in relation to the processed claims.

5. Populating a Unique BHT-03 Identifier to Designate Recovered Claims

The contractors' systems shall be required to populate an 'R' indicator in the 22nd position of the Beginning of the Hierarchical Transaction (BHT)-03 segment of the 837 flat file when transmitting recovered claims for COBA production trading partners to the COBC. (**NOTE**: The CMS would only consider invoking the COBA eligibility file recovery process for trading partners that are in production mode. Therefore, this

practice does not conflict with previous guidance issued by the CMS, which may be referenced in §70.6.1 of this chapter.)

6. Preparation and Transmission Requirements

The recovered claim files shall be prepared in the same 837 flat file format used for normal, daily transmissions to the COBC, as discussed in §70.6 of this chapter.

Contractor Data Centers shall transmit the recovered claims to the COBC via a separate 837 flat file transmission. Contractors shall transmit the recovered claims to the COBC using the following dataset names:

For Part A recovered files: PCOB.BA.NDM.COBA.Cxxxxx.PARTA.RECV(+1)

For Part B recovered files: PCOB.BA.NDM.COBA.Cxxxxx.PARTB.RECV(+1)

(**NOTE:** Datasets that begin with 'TCOB,' with all else remaining constant, would be used as part of systems release testing. The 'xxxxx' in the dataset names above represents the contractor number.)

Contractor Data Centers shall send no more than 100,000 recovered claims (which equates to 20 ST-SE envelopes per contractor with 5,000 claims per envelope) to the COBC per transmission.

Contractor Data Centers shall transmit recovered claims files to the COBC via the existing Network Data Mover (NDM) connectivity that they have with that entity.

7. Marking Claims History To Assist Customer Service Efforts

When the contractor or its Data Center transmits the recovered claims to the COBC, the contractor shall mark its claims history to indicate that each claim was recovered and transmitted to the COBC to be crossed over to the COBA trading partner.

Contractors shall notify their customer service representatives that they will be able to determine that recovered claims were sent to the COBC by referencing claims history.

8. COBC Detailed Error Report Processes In Relation to the Claims Recovery Process

If contractors receive COBC Detailed Error Reports that contain a 22-byte BHT-03 identifier that ends with an 'R,' they shall suppress generation of provider letters, regardless of the error source code indicated ('111,' '222,' or '333').

When the contractor, or its shared system, receives COBC Detailed Error Reports for recovered COBC Detailed Error Reports for recovered claims that contain '111,' '222,' or '333' errors, it shall mark its claims history to indicate that the recovered claims will not be crossed over.

9. The Possibility of Repairing COBA Recovery Claims

Contractors, and their shared systems, shall assume that recovered claims for COBA production trading partners that exceed established percentage parameters for '111,' '222,' and '333' errors are potential candidates for the COBA repair process, as provided in §70.6.2 of this chapter.

In accordance with the full claim file repair process discussed in 70.6.2 of this chapter, contractors and their shared systems shall populate an '18' Beginning of the Hierarchical Transmission (BHT)-02 transaction set purpose code at the ST-SE envelope level when transmitting the 'repaired' COBA recovery claims.

Unlike the process documented in §70.6.2 of this chapter, contractors shall transmit 'repaired' COBA recovery claims to the COBC via the separate 837 flat file transmission for recovery claims, as described within "Preparation and Transmission Requirements" above.

In addition, unlike the existing full claim file recovery process documented in §70.6. 2 of this chapter, contractors and their shared systems shall include an 'R' in the 22nd position of the BHT-03 identifier when transmitting the 'repaired' COBA recovery claims to the COBC.

Contractors, or their shared systems, shall also **not** generate provider notification letters if they, in conjunction with CMS, determine that the recovered claims that contained severe errors cannot be repaired.

10. COBA Claims Recovery Financial Management Processes

The CMS will reimburse the contractor for individual claims accepted by the trading partner at the per claim rates published in the current Budget and Performance Requirements document. Contractors shall not establish accruals for the recovered claims with BHT-03 identifiers that end with 'R' due to the certainty that numerous claims will be rejected by the COBA trading partner as not meeting its claims selection criteria.

Medicare contractor financial staff shall report reimbursements on recovered claims for the COBA crossover process on the 'COB Credits' line as part of the contractor's monthly Interim Expenditure Report (IER). (**NOTE**: The contractors' systems shall develop a separate report for their associated Medicare contractors to enable them to fulfill the foregoing requirements.)

Contractors shall charge their costs for each individual COBA recovery process to Activity Code 11207 *or include them within any other cost reporting mechanism needed to capture costs incurred in support of the national COBA crossover process*.