CMS Manual System

Pub. 100-20 One-Time Notification

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 83 **Date: MAY 14, 2004**

CHANGE REQUEST 3255

I. SUMMARY OF CHANGES: FIs, carriers, and durable medical equipment regional carriers must notify their trading partners of the attached coordination of benefits companion documents.

NEW/REVISED MATERIAL - EFFECTIVE DATE: June 14, 2004
***IMPLEMENTATION DATE: June 14, 2004**

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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 not updated.***)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
N/A	

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

	Business Requirements
	Manual Instruction
	Confidential Requirements
X	One-Time Notification
	Recurring Update Notification

***Medicare contractors only**

One-Time Notification

Pub. 100-20	Transmittal: 83	Date: May 14, 2004	Change Request 3255

SUBJECT: Additional Health Insurance Health Insurance Portability and Accountability Act (HIPAA) Coordination of Benefits (COB) Information for Trading Partners

I. GENERAL INFORMATION

A. Background: Trading partners need to know how the CMS will develop the HIPAA COB transaction.

B. Policy: The CMS, under HIPAA, is required to develop compliant COB transactions. The Part A and Part B COB, as well as the National Council on Prescription Drug Program (NCPDP) companion documents have been developed to convey CMS's processing intentions where the HIPAA 837 and NCPDP implementation guides are not specific. The CMS desires to clarify to its trading partners what data they may expect from CMS when the conditions listed in the attachments occur. These documents will be referenced in the COB trading partner users guide, and will be available on CMS's HIPAA Medicare Web site (www.cms.hhs.gov/providers/edi/hipaadoc1.asp). The information included in these guides describes the COB record that CMS will produce as of July 2004 (with the exception of the Part B invalid ICD-9 change which will be changed as of January 3, 2005). In addition, further changes may be made with each quarterly release. When changes are made, CMS will send out another notification and update the companion documents on the website and in the COB trading partners user guide. Note that CMS is making changes effective July 2004. However, non-compliant data may still remain on the claims that are already in process. In most cases, CMS will gap fill at the point when the COB transaction is created. However, there are some instances where CMS cannot make such changes (i.e., CMS cannot make a non-compliant code into a compliant code).

C. Provider Education: None

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement #	Requirements	Responsibility
3255.1	Contractors shall communicate these COB companion documents to your COB trading partners during your next scheduled notification process or within the next 30 days, whichever is sooner.	FIs, carriers, and durable medical equipment regional carriers (DMERCs)
3255.2	Contractors shall communicate to your COB trading partners that the COB companion	FIs, carriers, and DMERCs

	documents describe CMS's processing intentions where the HIPAA 837 and NCPDP IGs are not specific or where data may not be available to generate HIPAA-compliant outbound COB transactions.	
3255.3	Contractors should add specific items not contained in this companion document. However, these items must not contradict any other items in the companion document or the IGs.	FIs, carriers, and DMERCs

III. SUPPORTING INFORMATION & POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: June 14, 2004 **Implementation Date:** June 14, 2004 **Pre-Implementation Contact(s):** Matt Klischer, mklischer@cms.hhs.gov, 410-786-7488 **Post-Implementation Contact(s):** Matt Klischer, mklischer@cms.hhs.gov, 410-786-7488	**These instructions should be implemented within your current operating budget.**

3 Attachments

Attachment: National Council for Prescription Drug Program (NCPDP) Coordination of Benefits (COB) Companion Document

Issue	CMS COB Information
Capitalized data	The CMS will format COB data in upper case.
Gap Fill Data	The CMS uses gap fill data that complies with the IG syntax requirements with the understanding that the data may not appear valid. An inbound claim could lack data elements, or contain data that do not meet the data attribute (alpha-numeric, numeric, minimum and maximum lengths, etc.) requirements needed to prepare a HIPAA-compliant outbound NCPDP transaction. The "gap fill" data meets the data element minimum length requirement of an outbound NCPDP transaction if insufficient data are available for entry in a required data element. The selected values will not include any special characters, low values, high values, or "all spaces" and will be useable with every type of data where this situation could occur (decimal (R), identifier (ID), date (DT), etc.) except for alphanumeric (string) or numeric (Nn). The CMS will use "UNKNOWN" to gap fill alphanumeric data and zeros to gap fill numeric data to meet minimum length requirements. The CMS shall not gap fill data elements with pre-defined implementation guide values such as qualifiers and data elements that refer to a valid code source.
Medical Code Set Grace Period	The CMS will continue to allow a 90-day grace period for medical code sets for a limited time. The 90-day grace period for ICD9 will end for: - inpatient claims with a discharge date on or after October 1, 2004. - outpatient claims with date of service on or after October 1, 2004. The 90-day grace period for the HCPCS code set will end for claims with dates of service on or after January 1, 2005.
Medicaid	The following field must be submitted in order to allow Medicare to determine that a beneficiary has claim based Medicaid coverage and to specify where the coverage is: - The Group Id (301-C1) on the Insurance segment is not blank. - The two position state alpha code followed by the word "MEDICAID" must be submitted in the Group Id (301- C1) in the Insurance segment. **EXAMPLE: "XXMEDICAID"** such as NYMEDICAID or FLMEDICAID
Medigap	The following fields must be submitted in order to allow Medicare to determine that a beneficiary has Medigap coverage: - The Group Id (301-C1) on the insurance segment is not blank. - For Coordination of Benefits (COB) related to Medigap, the Patients Medigap Plan Id Number will be submitted in the Alternate Id (330-CW) in the Claim segment. - The Medigap Insurer Id (OCNA number) will be submitted in the Group Id (301- C1) in the Insurance segment. **NOTE:** Medigap takes priority when there is dual Medigap and Medicaid in a claim based situation.
Other Payer Amount Paid qualifier field	The NCPDP has approved the following use of qualifiers for reporting Medicare COB amounts: "07" = Medicare Allowed Amount "08" = Medicare Paid Amount "99" = Deductible Amount "99" = Coinsurance Amount "99" = Co-Payment Amount

	NOTE: The first occurrence of "99" will indicate the Deductible Amount. The second occurrence of "99" will indicate the Coinsurance Amount. The third occurrence "99" will indicate the Co-Payment Amount.
NCPDP Data	CMS will send out on NCPDP COB, all data that is received on the inbound NCPDP claim regardless as whether Medicare needs the data to process the claim. Any extraneous non-Medicare data will be edited for syntax, but not data content.
Narrative Segment	The NCPDP standard contains a 500-position field in the Prior Authorization Segment that supports one occurrence of narrative information. Medicare COB may contain the following: - Certificate of Medical Necessity (CMN) or DMERC Information Form (DIF) - Narrative Supporting Documentation - Facility Name and Address - Modifiers for compound drugs Values for the narrative field that is being used to submit any of the information are as follows. CMN - Indicates that the supporting documentation that follows is Medicare required CMN or DIF information. CNA - Indicates that the supporting documentation that follows is Medicare required CMN or DIF and narrative information. CFA - Indicates that the supporting documentation that follows is Medicare required CMN or DIF information and Facility Name and Address. CNF - Indicates that the supporting documentation that follows is Medicare required CMN or DIF information, narrative information, and Facility Name and Address. FAC - Indicates that the supporting documentation that follows is Medicare required Facility Name and address. FAN - Indicates that the supporting documentation that follows is Medicare required Facility Name and Address and narrative information. NAR - Indicates that the supporting documentation that follows is Medicare required Narrative Information. MMN - Indicates that the supporting documentation that follows is Medicare modifier information and CMN or DIF information. MNA - Indicates that the supporting documentation that follows is Medicare modifier information, CMN or DIF information and narrative information. MFA - Indicates that the supporting documentation that follows is Medicare modifier information, CMN or DIF information and Facility Name and Address. MNF - Indicates that the supporting documentation that follows is Medicare modifier information, CMN or DIF information, narrative information and Facility Name and Address. MAC - Indicates that the supporting documentation that follows is Medicare modifier information and Facility Name and Address. MAN - Indicates that the supporting documentation that follows is Medicare modifier information, narrative information and Facility Name and Address. MAR - Indicates that the supporting documentation that follows is Medicare modifier information and narrative information. MOD - Indicates that the supporting documentation that follows is Medicare modifier information.

Attachment: Institutional Coordination of Benefits (COB) Companion Document

Issue	CMS's Implementation Guide Interpretation/Resolution
Capitalized data	The CMS will format COB data in upper case.
Value, Occurrence, Occurrence Span, and Condition Codes	Some Codes are defined in the National Code Set as 'payer use only'. The CMS generates these codes via its adjudication process and will allow for these codes to be passed on to the COB even though these codes were not submitted on the inbound claim.
Gap Fill Data	The CMS uses gap fill data that complies with the IG syntax requirements with the understanding that the data may not appear valid. An inbound claim could lack data elements, or contain data that do not meet the data attribute (alpha-numeric, numeric, minimum and maximum lengths, etc.) requirements needed to prepare a HIPAA-compliant outbound X12N 837 COB transaction. The "gap fill" data meets the data element minimum length requirement of an outbound X12N 837 COB transaction if insufficient data are available for entry in a required data element. The selected values will not include any special characters, low values, high values, or "all spaces" and will be useable with every type of data where this situation could occur (decimal (R), identifier (ID), date (DT), etc.) except for alphanumeric (string) or numeric (Nn). The CMS will use Xs to gap fill alphanumeric data and 9s to gap fill numeric data. When inbound claims do not contain a required telephone number to create a HIPAA compliant outbound X12N 837 HIPAA COB transaction, the CMS will gap fill the phone number data element with "8009999999". The CMS shall not gap fill data elements with pre-defined implementation guide values such as qualifiers and data elements that refer to a valid code source.
Medical Code Set Grace Period	The CMS will continue to allow a 90-day grace period for medical code sets for a limited time. The 90-day grace period for ICD9 will end for: - inpatient claims with a discharge date on or after October 1, 2004. - outpatient claims with date of service on or after October 1, 2004. The 90-day grace period for the HCPCS code set will end for claims with dates of service on or after January 1, 2005.
Should Verses Must Issues	In most instances the CMS interprets the IG 'required when' language to not mean 'reject if submitted when not required'. The CMS interprets the IG to mean the data is allowed even if not required.
Destination Payer verses Other Payer	COB transactions are to contain the payer receiving the claim (the destination payer) in loops 2000B and 2010BC. If the "destination" payer is the same as the "other" payer, the CMS will not populate the 2320 loop. However, there may be instances where the formatting of the payer name is different, even if both payers are actually the same. In these instances the 2320 loop may be created. This issue will be corrected with the implementation of the National PlanID.
Provider/Physician Data	The CMS will allow Attending, Operating, or Other Provider/Physician data to be sent on COB claims whenever it is received on an inbound claim regardless of bill type.
Patient Status Code	The CMS will allow a patient status code to be sent on COB claims whenever it is received on an inbound claim regardless of bill type.
Admitting Diagnosis	The CMS will allow an admitting diagnosis to be sent on COB claims whenever it is received on an inbound claim regardless of bill type.

Admission Source Code	The CMS will allow an admission source code to be sent on COB claims whenever it is received on an inbound claim regardless of bill type.
Admission Type Code	The CMS will allow an admission type code to be sent on COB claims whenever it is received on an inbound claim regardless of bill type.
Discharge Hour	The CMS will allow a discharge hour to be sent on COB claims whenever it is received on an inbound claim regardless of bill type.
X12N 997 Acknowledgement	The CMS will not process an incoming X12 997. The CMS contractor may create and use its own proprietary report(s) for feedback purposes.
Health Insurance Prospective Payment System (HIPPS) Rate Codes	The CMS will allow any HIPPS Rate Code (not just skilled nursing facility HIPPS Rate Codes) to be sent on COB claims.
Admission Date/Hour	The CMS will allow admission date/hour data to be sent on COB claims whenever it is received on an inbound claim regardless of bill type.
Admission Hour/Minute	The CMS will send a default value of "0001" for admission hour/minute for home health claims if the hour/minute is unknown.
CR6 (Home Health)	CMS does not require the CR6 data elements for adjudication of home health claims. Home health claims will be accepted without the CR6 and COB may also be sent without the CR6 for home health claims.
Outpatient Claims	In general, the following bill types are considered outpatient: 13x, 14x – Outpatient Hospital 23x, 24x – SNF 32x, 33x, 34x – Home Health (HHA) 71x – Rural Health Clinic (RHC) 72x – Renal Dialysis Facility (RDF) 73x – Federally Qualified Health Center (FQHC) 74x – Outpatient Rehabilitation Facility (ORF) 75x – Comprehensive Outpatient Rehabilitation Facility (CORF) 76x – Community Mental Health Center (CMHC) 81x, 82x, – Hospice 83x - Hospital Outpatient Surgery Subject to Ambulatory Surgery (ASC) Center Payment Limits 85x – Critical Access Hospital (CAH)
Inpatient Claims	In general, the following bill types are considered inpatient: 11x – Hospital 12x – Inpatient Part B Hospital 18x – Swing Bed 21x – Skilled Nursing Facility (SNF) 22x – Inpatient Part B SNF 41x – Religious Non-Medical Health Care Institution (RNHCI)
ICD-9	The ICD-9-CM procedure codes were named as the HIPAA standard code set for inpatient hospital procedures. The HCPCS/CPT codes were named as the HIPAA standard code set for physician services and other

	health care services. The Office of HIPAA Standards (OHS) posted an FAQ stating that "…health plans must realize that reporting hospital outpatient services with ICD-9-CM procedure codes on standard claim transactions is not compliant, and that their good faith efforts to come into compliance must include steps being taken to change this requirement." Based on provider and payer input regarding this issue, the CMS has decided not to begin rejecting outpatient claims with ICD-9-CM procedure codes at this time. However, the CMS plans to begin rejecting outpatient claims with ICD-9-CM procedure codes in an upcoming systems release.
TaxID/SSN	When non-HIPAA inbound claims do not contain a required TaxID or SSN, and the CMS does not have a number on file, the CMS will populate the NM109 (Identification Code) with syntactically compliant (all 9s if NM108 = '24' and '199999999' if NM108 = '34') data to be sent on COB claims.
Provider Address Information	The CMS will populate the outbound COB files with the provider's first name, last name, middle initial, address, city, state and zip code that is present on CMS's provider files.
E-Code Validation	The CMS currently only validates E-codes for claims received via the HIPAA 837 format. E-codes received in other formats (paper, direct data entry, etc.) will be validated in a subsequent CMS release.

Attachment: Professional Coordination of Benefits (COB) Companion Document

Issue	**CMS COB Information**
Capitalized data	The CMS will format COB data in upper case.
Gap Fill Data	The CMS uses gap fill data that complies with the IG syntax requirements with the understanding that the data may not appear valid. An inbound claim could lack data elements, or contain data that do not meet the data attribute (alpha-numeric, numeric, minimum and maximum lengths, etc.) requirements needed to prepare a HIPAA-compliant outbound X12N 837 COB transaction. The "gap fill" data meets the data element minimum length requirement of an outbound X12N 837 COB transaction if insufficient data are available for entry in a required data element. The selected values will not include any special characters, low values, high values, or "all spaces" and will be useable with every type of data where this situation could occur (decimal (R), identifier (ID), date (DT), etc.) except for alphanumeric (string) or numeric (Nn). The CMS will use Xs to gap fill alphanumeric data and 9s to gap fill numeric data. When inbound claims do not contain a required telephone number to create a HIPAA compliant outbound X12N 837 HIPAA COB transaction, the CMS will gap fill the phone number data element with "8009999999". The CMS shall not gap fill data elements with pre-defined implementation guide values such as qualifiers and data elements that refer to a valid code source.
Admission Date	Admission Date - The admission date is required for all inpatient medical visits. Non-HIPAA claims do not capture this date. For COB purposes, the admission date will be gap-filled with the earliest date of service in loop 2400 when the inbound claim is non-HIPAA.
Accident Date	The accident date is required when the related causes code (CLM11) is equal to "AA" (auto accident), "AB" (abuse), "AP" (another party responsible)" or "OA" (other accident). Non-HIPAA claims do not capture this date. For COB purposes, the accident date will be gap-filled with the earliest date of service in loop 2400 when the inbound claim is non-HIPAA.
Ambulance Certification	Ambulance claims require ambulance certification data elements. Non-HIPAA claims do not have ambulance certification information. For COB purposes, these elements will be gap-filled with the following values when the inbound claim is non-HIPAA: CR103 = I, CR104 = A, CR105 = DH, CR106 = 1, CRC01 = 07, CRC02 = Y, CRC03 = 09
Medical Code Set Grace Period	The CMS will continue to allow a 90-day grace period for medical code sets for a limited time. The 90-day grace period for ICD9 will end for: - inpatient claims with a discharge date on or after October 1, 2004. - outpatient claims with date of service on or after October 1, 2004. The 90-day grace period for the HCPCS code set will end for claims with dates of service on or after January 1, 2005.

Should Verses Must Issues	In most instances the CMS interprets the IG 'required when' language to not mean 'reject if submitted when not required'. The CMS interprets the IG to mean the data is allowed even if not required.
Home Health Treatment Plan Certification (CR7)	Home Health Plan of Treatment (CR7) does not pertain to Medicare Part B. COB transactions being built from non-HIPAA claims will not contain the CR7 segment because the Medicare carrier does not have the information to populate the CR7 segment.
X12N 997 Acknowledgement	The CMS will not process an incoming X12 997. The CMS contractor may create and use its own proprietary report(s) for feedback purposes.
Destination Payer verses Other Payer	COB transactions are to contain the payer receiving the claim (the destination payer) in loops 2000B and 2010BB. If the "destination" payer is the same as the "other" payer, the CMS will not populate the 2320 loop. However, there may be instances where the formatting of the payer name is different, even if both payers are actually the same. In these instances the 2320 loop may be created. This issue will be corrected with the implementation of the National PlanID.
TaxID/SSN	When non-HIPAA inbound claims do not contain a required TaxID or SSN, and the CMS does not have a number on file, the CMS will populate the NM109 (Identification Code) with syntactically compliant (all 9s if NM108 = '24' and '199999999' if NM108 = '34') data to be sent on COB claims.
Provider Address Information	The CMS will populate the outbound COB files with the provider's first name, last name, middle initial, address, city, state and zip code that is present on CMS's provider files.
ICD9 Diagnosis Codes	COB transactions may contain invalid diagnosis codes until October 1, 2004. **NOTE:** There may be claims pending in the system with invalid diagnosis codes which were submitted prior to the new diagnosis edit. If those claims are flagged to cross over, they may contain invalid diagnosis codes after 10/1/2004.