CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 99 | **Date: FEBRUARY 9, 2004**

CHANGE REQUEST 3100

I. SUMMARY OF CHANGES: Contractors and shared systems maintainers must make necessary changes to implement the HIPAA X12N 837 coordination of benefits transaction.

NEW/REVISED MATERIAL - EFFECTIVE DATE: July 1, 2004
IMPLEMENTATION DATE: July 6, 2004

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.

II. CHANGES IN MANUAL INSTRUCTIONS:
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	24/70/Crossover Claims Requirements

***III. FUNDING: These instructions should be implemented within your current operating budget.**

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification

***Medicare contractors only**

Business Requirements

Pub. 100-04	Transmittal: 99	Date: February 9, 2004	Change Request 3100

SUBJECT: Health Insurance Portability and Accountability Act (HIPAA) X12N 837 Coordination of Benefits (COB) Gap Fill Additional Instruction

I. GENERAL INFORMATION

A. Background: Shared systems changes are needed to standardize gap filling values on the HIPAA X12N 837 COB transaction in order that the COB trading partners may receive the COB which contains the same gap fill values from each of their CMS trading partners.

B. Policy: The CMS is committed to implementing the 837 COB per the HIPAA implementation guide (IG). This CR does not override CR 2021 and CR 2361 (Part B only), it standardizes the gap fill values of general fields in the 837 COB.

C. Provider Education: N/A

II. BUSINESS REQUIREMENTS

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

Requirement #	Requirements	Responsibility
3100.1	When non-HIPAA inbound claims do not contain data necessary to create a HIPAA compliant outbound X12N 837 HIPAA COB transaction, contractors shall gap fill alphanumeric data elements with Xs and numeric data elements with 9s. For example, a 5-character alphanumeric data element would contain "XXXXX" and a 5-character numeric data element would contain "99999".	Shared systems maintainers (except for MCS) and MCS Carriers
3100.2	When non-HIPAA inbound claims do not contain a required telephone number to create a HIPAA compliant outbound X12N 837 HIPAA COB transaction, contractors shall gap fill the phone number data element with "8009999999".	Shared systems maintainers (except for MCS) and MCS Carriers
3100.3	Contractors shall not gap fill data elements that have pre-defined implementation guide (IG) values such as qualifiers and data elements that refer to a valid code source.	Shared systems maintainers (except for MCS) and MCS Carriers
3100.4	Within 30 days after publication of this transmittal, contractor shall notify your COB trading partners of the requirements 1 and 2 above.	Carriers and Intermediaries

III. SUPPORTING INFORMATION AND 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: July 1, 2004 **Implementation Date:** July 6, 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.**

70 - Crossover Claims Requirements

A3-3602.3

(Rev. 99, 02-09-04)

Prior to HIPAA, each supplemental insurer specified criteria related to the claims it wanted the carrier or FI to transfer. Examples of claims most frequently excluded from the crossover process are:

- Totally denied claims;
- Claims denied as duplicates or for missing information;
- Adjustment claims;
- Claims reimbursed at 100 percent; and
- Claims for dates of services outside the supplemental policy's effective and end dates.

The supplemental insurer will provide an eligibility file no less frequently than monthly, preferably weekly.

The carrier or FI will provide the claim payment information in either the UB-92 or NSF COB flat file or ANSI X12N COB format. This information will be transferred no less frequently than weekly.

Under HIPAA the carrier or FI will provide only the ANSI X12N COB format.

When non-HIPAA inbound claims do not contain data necessary to create a HIPAA compliant outbound X12N 837 HIPAA COB transaction, the shared systems maintainers (except for MCS) and MCS Carriers shall gap fill alphanumeric data elements with Xs and numeric data elements with 9s. For example, a 5-character alphanumeric data element would contain "XXXXX" and a 5-character numeric data element would contain "99999".

When non-HIPAA inbound claims do not contain a required telephone number to create a HIPAA compliant outbound X12N 837 HIPAA COB transaction, the shared systems maintainers (except for MCS) and MCS Carriers shall gap fill the phone number data element with "8009999999".

Data elements with pre-defined implementation guide values such as qualifiers and data elements that refer to a valid code source shall not be gap filled.