5010 COBC ISSUES LOG

Loop and Item #	Issue	Shared System	Contractor Number/File Creation Date	Date First Identified	GHI Comments	DMBP Comments (formerly DDIS)	X12	Status: N, O, FS, C, D	Maintainer Comments	Fix Resp: M, C, G, T	Prob #	Prob Fix Date	CMS and Contractor Comments	Contractor Fix Date	Trading Partner Information
2300-001a	**H60401:** 'Patient's Reason for Visit' (2300 HI-01=PR) is required on all outpatient visits.	FISS	21027300340008 ORA 00326 102740000350T	10/13/10	**02/23/11**: The HIPAA validation software was updated on 02/20/11 , adding Error code H60401:'Patient's Reason For Visit' (2300 HI-01 = PR) is required on all outpatient visits. Given the "disagree" ruling, the error is being bypassed **11/12/10**: For the example provided, except for the bill type, none of the other condidions seems to be met. The segments from within the claim are included CLM*PL4DGRE3710204*404.2***85:A:I**A*Y*Y~ CL1**1*01~ SV2*0260*HC:96372*59.4*UN*2~ SV2*0300*HC:36415*16.5*UN*1~ SV2*0301*HC:84443*74.3*UN*1~ SV2*0636*HC:J1650*254*UN*2~ Please see the Trading Partner's comments in the "issue" column. Please review and determine (Agree/Disagree) whether this is a valid HIPAA error. The example is for TOB 85:A:I, and there was no HI*PR present. The data in the claim is as follows: CLM*PL4DGRE3710204*404.2***85:A:I**A*Y*Y~ HI*BK:V1251~ HI*BF:7295*BF:2449*BF:V5869~ HI*BE:A2:::6268~ HI*BG:D1*BG:M0~	**11-15-10**: **DISAGREE**. Claim does not contain revenue code 045X, 0616, 0526, 0r 0762 per the NUBC's definition of unscheduled outpatient visits. **11-09-10:** More information is needed. Patient Reason for Visit is required only per the NUBC's definition of unscheduled outpatient visits. That is Bill type 013X or 085X, together with Form Locator 14 (Priority of Visit/Type of Admission) codes 1, 2, or 5 and revenue codes 045X, 0516, 0526, or 0762 (observation). Were codes 1, 2, or 5 and revenue codes 045X, 0516, 0526, or 0762 submitted?		C								
2300-002b	**H45209:** 'Rendering Provider Name' was not found, but was expected because both the Billing and Pay-To Providers are present (2010AA and 2010AB) and the Billing/Pay-To Provider Specialty Information (2000A PRV) is not present, so the Rendering Provider must be identified.	MCS	2210280650110 04402 102930000450T	10/25/10	**11/19/10:** Claims are rejecting to the Medicare contractors with the error indicated in the "Issue" column. Please see the comments from the medicare contractor, in the "CMS and Contractor Comments" column, and advise if this is a valid HIPAA error (Agree) or if it should be bypassed (Disagree).	**11/22/2010: DISAGREE**: There is no TR3 rule requiring the rendering provider when the billing and pay to providers are submitted AND the taxonomy code is not submitted. In fact, taxonomy is situational and has no bearing whether present or not. BSR		C					Trailblazer: The ICNs I looked at do have the 2010AA and 2010AB loops because of different addresses but the Billing Provider is a laboratory and there is no other Rendering Provider. I don't see any notes in the 5010 IG that say the Rendering Provider loop must be present if the 2010AA and 2010AB loops are present. The 2000A PRV is not required either.		

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2300-003b	**H46210**:The Accident Date is required when CLM11-1 or CLM11-2 has a value of 'EM' and this claim is the result of an accident.	MCS	2210333084350 04102 103440003650T	12/16/10	**12/16/10**: Claims are rejecting to the Medicare contractors with the error indicated in the "Issue" column. Please see the comments from the medicare contractor, in the "CMS and Contractor Comments " column, and advise if this is a valid HIPAA error or if it should be bypassed. The data in the 2300 loop are as follows: CLM*SFI00104120201*138***11:B:1*Y*A*Y*Y*P*EM~ REF*F5*N~ HI*BK:7224*BF:73730~	**12-20-10: DISAGREE**. The requirement for accident date (when value is EM) only applies "if" there is an accident. CEM does not currently have an edit to require the accident date for EM. Bsr		C					Trailblazer: ICN 2210333084350 for contractor 04102 was rejected with H46210 because there was no 2300 DTP for an accident date when the value of EM was present in the CLM11-1. Based on the TR3 there should not be an edit requiring the Accident DTP when the CLM11-1 or -2 has a value of EM as the note indicates it should only be submitted when the Related Cause is Employment (EM) and is Accident Related. If the Related Cause is Employment, it does not necessarily mean there was an accident. For example, someone who develops carpal tunnel, the visit would be Employment related but there would not be an accident date. I think a ruling will be required for this issue before any MCS system change can be considered.		
2300-009a	The occurrence code has been used more than once	FISS	211082003145O4V AA 00453 110950006750TO	05/09/11	**05/20/11**: Please see the comments in the"issue" column, as submitted by two partners. Please advise if this is a valid (Agree) error or not (Disagree). In the example provided, the data is presented as follows: CLM*18783*5671.54***21:A:2**A*Y*Y~ HI*BH:50:D8:20110215*BH:50:D8:20110221~	**05/24/11**: **DISAGREE**. There is nothing in the TR3 or NUBC manual that prohibits this. MAK		C							

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2300-010b	Segment CRC (Homebound Indicator) is used.	MCS	0211161063100	11/02/11	**11/02/11**: Please see the comments in the "Issue" column, as submitted by a COBA Partner. Please advise whether you "agree" - the claim is not compliant or "disagree" the claim is compliant. The partner provided the following X12 data from the claims in question, with justification from the TR3. ***X12 segments for the claim example provided:*** *SBR*U*18*******MC* *<<<<<(Medicaid)* *NM1*IL*1*DOE*BETTY*M***MI*99993028664* *N3*32 MAIN AVE* *N4*LURAY*VA*228351750* *DMG*D8*19370806*F* *NM1*PR*2*BUREAU OF TENNCARE*****PI*70043* *N3*310 GREAT CIRCLE RD.* *N4*NASHVILLE*TN*37243* *CLM*W1605379*49***21:B:1*Y*A*Y*Y*P* *DTP*435*D8*20110527* *REF*F5*N* ***CRC*75*Y*IH*** *<<<<ERROR HERE* **TR3** *Situational Rule: Required for Medicare claims when an independent laboratory renders an EKG tracing or obtains a specimen from a homebound or institutionalized patient. If not required by this implementation guide, do not send.*	11-16-11 **Disagree,** though this reallys is not a simple AGREE or DISAGREE. This claim was a 100% compliant claim when it arrived at Medicare. COB trading partners must be willing to concede that by virtue of the crossover process, Medicare could be forwarding them data which only applies to Medicare. bsr		C							
2300-014b	CLIA (Clinical Laboratory Improvement Amendment) number is invalid for CLIA Number. Value of element REF02 (CLIA Number) is incorrect. Expected value is CLIA number (format is 10 characters where the third character is 'D'.	MCS	3211276131970 00954 112870006250TO 5810327180220 15102 112870020250TP	10/27/11	11/14/11: Please see the comments in the "Issue" Column as submitted by a COBA partner. They have provided citation as follows: Medicare Claims Processing Manual Chapter 16 - Laboratory Services Table of Contents (Rev. 2136, 01-21-11)70.4 - CLIA Numbers (Rev. 1, 10-01-03) A3-3628.2.D The structure of the CLIA number follows: Positions 1 and 2 contain the State code (based on the laboratory"s physical location at time of registration); Position 3 contains the letter "D"; and Positions 4-10 contain the unique CLIA system assigned number that identifies the laboratory. (No other laboratory in the country has this number.) Data on the claim edxamles: ICN 3211276131970: REF*X4***XA**~ ICN 5810327180220: REF*X4***187073**~ Please advise if you "agree" - the claim is not compliant, or "disagree" - the claim is compliant	12-20-11 **DISAGREE**. CLIA number formatting is not defined by X12, nor referenced as a codeset within the TR3. The IOM has no jurisdiction regarding HIPAA regulation and therefore it's reference has no merit. bsr		C							

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2300-015b	Anesthesia Related Procedure Code (HI*BP) segment at Loop 2300 has issues, per X12 guide if HI*BP is passed then HI.02 = BO should be passed too.	MCS	2911287002770 12202 113010019550TO	12/02/11	**12/09/11**: Please see the comments in the "Issue" column, as submitted by a COBA Partner, stating that the claim is non-compliant. Please advise whether you "agree" (the claim is not compliant) or "disagree" (the claim is compliant). The partner provided TR3 citation as follows: *see page 239 and 240 of the TR3 Below is an excerpt REQUIRED HI02 – 1 BO Health Care Financing Administration Common Procedural Coding System CODE SOURCE 130: Healthcare Common Procedural Coding System REQUIRED HI02 - 2 1271 Industry Code M AN 1/30 Code indicating a code from a specific industry code list SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.If C022-08 is use For the claim example provided, the data in the 2300 HI is as follows Claim Information (2300) *CLM*416547110*1795.5***21:B:1*Y*A*Y*Y~* *HI*BK:71595*BF:4019*BF:53081*BF:7245~* *HI*BP:27130~*	12-12-11 **DISAGREE** The subsequent Anesthesia Related Procedure (BO) is only submitted if there is an additional procedure to submit after the principal Anesthesia Related Procedure (BP). bsr		C							

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2300-016a	Admitting diagnosis (HI01-BJ) required when the the admission date (DTP*435) is on the claims, reported after the 12/05/11 FISS change to populate the admission date on Home Health and Hospice date	FISS	211327015970051LR 11001 113400016650TA	12/15/11	**12/16/11**: With the 12/05/11 FISS fix that now populates the admission date (2300 DTP*435) on Home Health and Hospice claims (reference issue 2300-004a). The partner is indicating that because the admission date is populated, the admitting diagnosis is required. Please advise if this is an "agree" - the claim is not compliant or "disagree" - the claim is compliant. They've cited the following: *2300, DTP (Admission Date/hour) Segment language: "Required on inpatient claims. If not required by this implementation guide, do not send".* *2300 HI (Admitting Diagnosis) Segment language: "Required when a claim involves an inpatient admission."* *Our compliance maps interpretation the TR3 language: Since the TR3 directs an admit date to only be included on inpatient claims, if an admit date is receive received, the claim is considered to involve an inpatient admission, hence an admitting diagnosis is required.* For the example provided, the 2300 was polulated as follows. **Claim Information (2300)** CLM*XXXXXXXXXXXXXXX*3808.1***33:A:9**A*Y*Y~ DTP*434*RD8*20111004-20111110~ DTP*435*DT*201106060001~ CL1*9*1*01~ REF*F8*211292023276O5ILR~ HI*BK:99883~ HI*BF:25000*BF:49320*BF:4019*BF:4168*BF:29650*BF:V462~ HI*BE:61:::44100~	12/19/11: **disagree**. MAK The NUBC manual on pg 17 does not list the admitting diagnonis as being required for HH and hospice claims. So, the admitting diagnosis is not required on HH or hospice claims. The trading partner is not interpreting the requirement correctly since the TR3 defers to the NUBC to determine inpatient and outpatient direction.		C							
2330A-001a	**H45153**:'Other Subscriber City/State/ZIP Code' was not found, but was expected because the Other Insured Address Line (N3-01) is present	FISS	211151000032025 CA; 00380 111530000850TO 211151000018025 CA; 00380 111530000850TO	03/17/11	**03/22/11**: During STC testing for CR7202, COBC is rejecting claims with the error identified in the "Issue" column. For the ICN being reviewed, this is occurring on the 2330A of Medicare's 2320 loop. When translated, the 2330A is as follows NM1*IL*1*Vxxxxxxxxx*Lxxxxxxxx****MI*xxxxxxxxxD~ N3*111 PARK ST~ Please advise if this is a valid error, or if the COBC should be bypassing this error for the 2330A loop on 5010 errata claims.	**03/22/11**: **DISAGREE**. The N4 errata situational rule does not require N4 when N3 is present.		C							

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2400-001b	**H40480**:The Place of Service Code at Service Line level is the same as the Place of Service Code at Claim level (CLM-05-1).	MCS VMS	MCS - 0210287001450 00880 102890000150T VMS - 10013856092000 44410 102790000150P	08/30/10	As we process the 5010 test claims with the STC, we've noticed 837P claims rejecting with the message identified in the "issue" column. Please verify whether this is a valid HIPAA error For ICN 0210287001450 - MCS, the data is CLM*814940011A-5010*50***11:B:1*Y*A*Y*Y*P~ SV1*HC:99214:::::NOT OTHERWISE CLASSIFIED*50*UN*1*11**1~ For ICN 10013856092000 - VMS, the data is CLM*WRIWINKG00223861*100***12:B:1*Y*A*Y*Y~ SV1*HC:A4256:KX*100*UN*2*12**1~	**8-31-2010** : **DISAGREE**. Per section 1.12.5 of the TR3, transactions cannot be rejected for containing uneeded information. bsr		C							
2400-003b	Value of sub-element HI02-02 cannot be verified because there were no pointers to this code. In this claim, two diagnosis codes were reported, but no associated pointer was listed for diagnosis code 7840. Diagnosis Code Pointers are located in 2400 SV107-1, SV107-2, SV107-3, SV107-4. The 5010 professional TR3 indicates (page 356) for SV107-1: "This first pointer designates the primary diagnosis for this service lilne. Remaining diagnosis pointers indicate declining level of importance to service line. Acceptable values are 1 through 12, and correspond to Composite Data Elements 01 through 12 in the Health Care Diagnosis Code HI segment in the Claim Loop ID-2300." SV107-2 (page 356 of the TR3) explains: "Required when it is necessary to point to a second diagnosis related to this service line. Acceptable values are the same as SV107-1. If not required by this implementation guide, do not send." In the questioned claim, two diagnosis codes were reported in 2300 HI. The service line(s) pointed only to the first diagnosis code (2300 HI01) using SV107-1. There was no pointer to the second diagnosis code (2300 HI02), therefore, the payer could not identify why the second diagnosis code was reported in the claim. The TR3 indicates (page 227) for HI02 "If not required by this implementation guide, do not send."	MCS	4810067050100 11402 112340012850TP	10/4/11	Please see the comments in the "Issue" column, as presented by a COBA partner, and advise whether you "agree" - the claim is not compliant or "disagree" the claim is compliant. X12 segments for the claim example provided: ***2300*** CLM*xxxxxx-xx xxx*75***11:B:7*Y*A*Y*Y*P HI*BK:4659*BF:7840~ ***2400*** SV1*HC:99212:::::NOT OTHERWISE CLASSIFIED*75*UN*1*11**1~	10-12-11 **DISAGREE**. There are no requirements in the TR3 that every submitted diagnosis code must be "pointed to" somewhere in the claim.		C							

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2400-004b	Value of sub-element SV107-02* has been already used. Diagnosis Code Pointers are expected to be unique within SV107.	MCS	0211188702980 10102 112010018750TO	11/2/11	**11/02/11**: Please see the comments in the "Issue" column, as submitted by a COBA Partner. Please advise whether you "agree" - the claim is not compliant or "disagree" the claim is compliant. X12 segments for the claim example provided: **The partner provided the following from the TR3**. *REQUIRED SV107 - 1 1328 Diagnosis Code Pointer M N0 1/2* *A pointer to the diagnosis code in the order of importance to this service* *SEMANTIC:* *C004-01 identifies the primary diagnosis code for this service line. 851 This first pointer designates the primary diagnosis for this service line. Remaining diagnosis pointers indicate declining level of importance to service line. Acceptable values are 1 through 12, and correspond to Composite Data Elements 01 through 12 in the Health Care Diagnosis Code HI segment in the Claim Loop ID-2300.* And the following for SV107-2, SV107-3, SV107-4 *SITUATIONAL SV107 - 2 1328 Diagnosis Code Pointer O N0 1/2* *A pointer to the diagnosis code in the order of importance to this service* *SEMANTIC:* *C004-02 identifies the second diagnosis code for this service line. 852 SITUATIONAL RULE: Required when it is necessary to point to a second diagnosis related to this service line. Acceptable values are the same as SV107-1. If not required by this implementation guide, do not send.*	11-16-11 **DISAGREE** While we see the logic, there is no requirement in the TR3 which requires that each dx pointer be "unique". Bsr		C							
2430-001b	The COBA trading partner is indicating that that it is receiving non-compliant claims and not accepting them based on the following: "The contractor is sending two CO (Contractual Obligation) adjustments using the same CARC (e.g., 45) in the same segment at positions CAS02 and CAS05.	FISS MCS	1111021045140 12502 110350023940P 21127200011502 COM 04901 112770020050TO 21127200093202 ORA 00326 112770017650TO	03/08/11	Please see the comments in the "Issue" column from the COBA trading partner. This issue has been reported by two State Medicaids (DE and PA). The contractor's rationale for allowing this is the 4010A1 Guide and CR 7050. For the ICN example provided, the 2430 CAS is populated as follows: CAS*CO*45*707.25**45*141.07~ CAS*CO*45*890.19**45*49.6~ 837I (21127200011502COM) CAS*PR*2*22.55**2*176.58 21127200093202ORA CAS*PR*2*26.14**2*224.78~ CAS*PR*2*5.36**2*62.94~ CAS*PR*2*15.01**2*170.85~ Please advise.	10/18/11 - MAK (via email) - it also applies to 5010 ("**disagree**"). The ruling has not changed 6-14-11 DISAGREE. We can find no language in the 837 which precludes the same reason code from being used on the same detail line. bsr		C							

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