CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2022	**Date: January 25, 2018**
	Change Request 10292

Transmittal 1971, dated November 9, 2017, is being rescinded and replaced by Transmittal 2022, dated, January 25, 2018 to modify requirement 10292.2.1 to change "Allowed Amount" to "Allow"; to remove "RARC"; and to remove all spaces. Additionally, CMS is modifying 10292.2.1 to explain the priority order of N699, N700, and N701. Lastly, CMS is modifying 10292.4 to ensure that MCS will not output zero dollar monetary amounts when CARC 237-related RARCs do not apply.

SUBJECT: Modifications to the National Coordination of Benefits Agreement (COBA) Crossover Process

I. SUMMARY OF CHANGES: Through this change request, the Centers for Medicare & Medicaid Services (CMS) creates requirements so that the Part B shared system will suppress the inclusion of a duplicate diagnosis code pointer on outbound 837 professional coordination of benefits claims. Additionally, CMS creates requirements so that two of the shared systems will create a workaround solution for Claim Adjustment Reason Code 237 for the benefit of CMS's COBA trading partners.

EFFECTIVE DATE: April 1, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 2, 2018

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

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

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One Time Notification

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 2022	Date: January 25, 2018	Change Request: 10292

Transmittal 1971, dated November 9, 2017, is being rescinded and replaced by Transmittal 2022, dated, January 25, 2018 to modify requirement 10292.2.1 to change "Allowed Amount" to "Allow"; to remove "RARC"; and to remove all spaces. Additionally, CMS is modifying 10292.2.1 to explain the priority order of N699, N700, and N701. Lastly, CMS is modifying 10292.4 to ensure that MCS will not output zero dollar monetary amounts when CARC 237-related RARCs do not apply.

SUBJECT: Modifications to the National Coordination of Benefits Agreement (COBA) Crossover Process

EFFECTIVE DATE: April 1, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 2, 2018

I. GENERAL INFORMATION

A. Background: This instruction addresses two (2) issues affecting the COBA Medicare crossover process: 1) Making certain that diagnosis code pointers are not duplicated on outbound 837 professional coordination of benefits (COB) claims; and 2) providing COBA trading partners with a workaround strategy for easily determining each negative payment adjustment amount (e.g., Electronic Health Records (EHR), Physician Quality Reporting System (PQRS), and Value-based Payment Modifier (VBM) represented at the claim's service line level.

Billing vendors representing physicians and non-physician practitioners submit Health Insurance Portability and Accountability Act (HIPAA) Accredited Standards Committee (ASC) X12N 837 professional claims to Medicare that include multiple diagnosis codes. Within the HIPAA ASC X12N 837 professional claims format, physicians and non-physician practitioners make a reference to which specific diagnosis code is relevant for the service detail line through diagnosis code pointers. Diagnosis code pointers are included within the SV107 composite of the 2400 loop of 837 professional claims. Many HIPAA edit validators interpret a repeated instance of a diagnosis code pointer as violating the "if not required, do not send" guidance provided in the Technical Report Type 3 (TR-3) Implementation Guide. CMS will address this problem within the Multi-carrier System (MCS)-created 837 professional coordination of benefits (COB) claims through this instruction.

Currently, COBA trading partners are realizing difficulty in calculating Medicare's allowed amount on HIPAA ASC X12N 837 COB/crossover claims. The biggest obstacle has been that Claim Adjustment Reason Code (CARC) 237 is included at the service detail line as a consolidated amount. This occurs because current HIPAA ASC X12 TR-3 Guide requirements specify that CARCs may not be broken out separately at the service line level on 837 claims transactions or on 835 Electronic Remittance Advices. Also, currently, the associated Remittance Advice Remark Codes (RARCs) that identify each negative adjustment amount are only available in the Medicare Outpatient Adjudication information segment within 837 COB/crossover claims. CMS identifies a workaround solution for this CARC 237 issue through this instruction.

B. Policy: The MCS shared system shall suppress any instances of duplicated diagnosis code pointers when creating the 2400 SV107 composite within outbound HIPAA ASC X12N 837 professional crossover claims. (**Note:** This applies to 837 professional COB claims created both from incoming hard copy CMS-1500 and electronically-submitted Part B claims.)

In creating its outbound 837 professional COB claims for COBA crossover purposes, MCS shall create a 2400 NTE ("Third Party Organization Notes") segment for each associated service detail line when a CARC 237 is included in the Claim Adjustment Segment (CAS) for the service line. In creating the 2400 NTE02, MCS shall include the following information in association with each service detail line:

- The service line number (e.g., SX1);
- "Allow=" (where Allow represents Allowed Amount sent to the provider);
- The dollar amount representative of the allowed amount that is sent to the provider for the detail line; and
- All CARC 237-related RARCs shown followed by associated monetary amounts. (Important Note: RARCs N699, N700, and N701 shall always be listed in priority order before all other CARC 237-related RARCs and associated monetary amounts.)

So, for example, 2400 NTE02 shall be formatted as follows: SX1**;** Allow=350.00**;**N700=5.25**;**N699=6.75**;**N701=11.50 (Please note: no spaces shall be included as shown.)

The Fiscal Intermediary Shared System (FISS) shall create a 2400 NTE (Third Party Organization Notes) segment for each associated service detail line when a CARC 237 is included in the CAS for each service line on 85x Type of Bill (TOB) 837 institutional COB claims. In creating the 2400 NTE02 on outbound TOB 85x (Critical Access Hospital) COB claims, FISS shall include the following information in association with each service detail line to the extent applicable:

- The service line number (e.g., SX1);
- RARC N700 followed by the monetary amount representing an EHR negative adjustment; and
- RARC N699 followed by the monetary amount representing a PQRS negative adjustment.

So, for example, 2400 NTE02 shall be formatted as follows: SX1**;** RARC N700= 5.25**;** RARC N699= 6.75 (Please note: spaces shall be included as shown.)

(**Note:** FISS does not produce a VBM-related CARC 237 adjustment on 85x TOB claims.)

When certain CARC 237 RARCs (e.g., E.H.R., PQRS, or VBM) do not apply to the service detail line, MCS shall not create a zero monetary amount in 2400 NTE02 for these RARCs. FISS shall not create a zero monetary amount in 2400 NTE02 for either RARC N700 or N699 when it does not apply to the service detail line.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10292.1	The MCS shared system shall suppress any instances of duplicated diagnosis code pointers when creating the 2400 SV107 composite within outbound HIPAA ASC X12N 837 professional crossover claims.						X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	(**Note:** This applies to 837 professional COB claims created both from incoming hard copy CMS-1500 and electronically-submitted Part B claims.)									
10292.2	In creating its outbound 837 professional COB claims for COBA crossover purposes, MCS shall create a 2400 NTE (Third Party Organization NOTEs) for each associated service detail line when a CARC 237 is included in the Claim Adjustment Segment (CAS) for the service line.						X			
10292.2.1	In creating its outbound 837 professional COB claims for COBA crossover purposes, MCS shall create a 2400 NTE ("Third Party Organization Notes") segment for each associated service detail line when a CARC 237 is included in the Claim Adjustment Segment (CAS) for the service line. In creating the 2400 NTE02, MCS shall include the following information in association with each service detail line: • The service line number (e.g., SX1); • "Allow=" (where Allow represents the Allowed Amount sent to the provider); • The dollar amount representative of the allowed amount that is sent to the provider for the detail line; and • All CARC 237-related RARCs followed by associated monetary amounts. (Important Note: RARCs N699, N700, and N701 shall always be listed in priority order before all other CARC 237-related RARCs and associated monetary amounts.) So, for example, 2400 NTE02 shall be formatted as follows: SX1**;** Allow=350.00**;**N700=5.25**;**N699=6.75**;**N701=11.50 (Please note: no spaces shall be included as shown.)						X			
10292.3	In creating its outbound 837 institutional COB claims for COBA crossover purposes, FISS shall create a 2400 NTE (Third Party Organization Notes) for each associated service detail line when a CARC 237 is included in the CAS for each service line on 85x TOB					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	claims.									
10292.3.1	10292.3.1 In creating the 2400 NTE02 on outbound TOB 85x (Critical Access Hospital) COB claims, FISS shall include the following information in association with each service detail line to the extent applicable: • The service line number (e.g., SX1); • RARC N700 followed by the monetary amount representing an EHR adjustment; and • RARC N699 followed by the monetary amount representing a PQRS adjustment. So, for example, 2400 NTE02 shall be formatted as follows: SX1**;** RARC N700=5.25**;** RARC N699= 6.75 (Please note: spaces shall be included as shown.) (**Note:** FISS does not produce a VBM-related CARC 237 adjustment on 85x TOB claims.)					X				
10292.4	When certain CARC 237 RARCs (e.g., E.H.R., PQRS, or VBM) do not apply to the service detail line, MCS shall not create a zero monetary amount in 2400 NTE02 for these RARCs.						X			
10292.4.1	FISS shall not create a **zero monetary** amount in the 2400 NTE02 for either RARC N700 or N699 when it does not apply to the service detail line.					X				
10292.5	The shared systems shall implement the requirements in this instruction based upon outbound COB files created with a date of April 1, 2018, and after.					X	X			

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	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

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: 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.

ATTACHMENTS: 0