COBC ISSUES LOG

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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
1000A-001	Invalid email address format (8005551212) at (PER06).	VMS			TP's agree they can live with this	Disagree 10/24/05 - DDIS re-view: Concur with previous comment, but edit should be put in place to check for the @ sign. Disagree. This format is a phone number, however, there are no examples of what a standard email address should look like in the guide. This should not be considered an error.	pg 70; expects email address	C 09/07 /04							
2000A-003	CUR02, 'USA' does not appear to be a valid Currency Code..	FISS	00230/12/28 /04 (204348013 41602, 2043480129 6102, 2043480129 6702, 2043440091 6002)	01/05/05	'USA' found in inbound file.	Disagree 10/24/05 - DDIS re-view: Concur with previous comment Disagree: The IG refers to code source 5 which is codes for countries not currencies. As long as "USA" exists in the code source, its use is compliant.		C 01/18 /05							Horizon Aetna
2000B-002	I have a couple examples of an 'extra' SBR segment being used. Two SBR*S being used which indicate two secondary insurances. Value of element SBR01 has been already used in loops 2000B/2300. Elements SBR01 are expected to be different from SBR01 specified in loop 2000B and to have unique values within loop 2300 excluding 'T' value.	VMS			Trading Partner that reported this (IPN), can live with it. (If data is exact we need to change, but there could be > 1 for each line of business). IPN needed examples of 2 Primary or 2 Secondary Payer, to be able to make changes internally.	Disagree 10/24/05 - DDIS re-view: Concur with previous comment Disagree. There can be 2 secondary payers. Likewise, there can be 2 primary payers. The guide doesn't note that SBR01 can't be the same as the second SBR01	pg 101	C 09/07 /04							
2000B-005	SBR09 claim filing code is an invalid code	FISS	0363	08/05/05	SBR09 on the inbound file is CI. Trading Partner is expecting to see ZZ.	Disagree 8/10/05 - CI is a valid code (Since the Individual Identifier has not been implemented, ZZ is not valid).		**C 09/30 /05**							BCBS Michigan

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2000B-006a (Closed 9/13/07)	SBR09 claim filing code is an invalid code	FISS	General	01/20/06	**08/29/07 - Trading Partners are currently receiving these claims. There is no error code associated with this.** Trading Partner is expecting to see MA in this field 2/1/06 We are seeing "ZZ" mostly and sometimes "CI".	Disagree 2/8/06 2000B contains the subscriber info for the destination payer. In this case, the destination payer is the COB trading partner, so there would not be MA or MB there. 01/24/06 - what value is being submitted?		C 9/13/07							BCBS Michigan
2000B-006b (Closed 9/13/07)	SBR09 claim filing code is an invalid code	MCS	General	01/20/06	**08/29/07 - Trading Partners are currently receiving these claims. There is no error code associated with this.** Trading Partner is expecting to see MB in this field 2/1/06 We are seeing "ZZ" mostly and sometimes "CI".	Disagree 2/8/06 2000B contains the subscriber info for the destination payer. In this case, the destination payer is the COB trading partner, so there would not be MA or MB there. 01/24/06 - what value is being submitted?		C 9/13/07	4/27 - MCS - The ZZ qualifier is used in this field.						BCBS Michigan
2010AA-003	If the Billing Provider Loop (2010AA) and Pay-to-Provider Loop (2010AB) are supplied, then the secondary information is required for both loops; the loops are missing REF*1C segment. If the REF*1D segment is available, it should also be on the file.	B				Disagree 10/24/05 - DDIS re-view: Concur with previous comment. Edit should be created to make sure REF 1C is present. Disagree. Although the guide does not require the REF, agree that the Medicare provider number should always be submitted in the REF.		C 09/29/04							

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2010AA-005	It looks like the title suffix is simply being appended to the end of the surname field. The implementation guide indicates its should be in the name suffix field, NM107. NM1*85*2*ESRA SAMLI-ONAT MD*****24*223649784~	MCS	00751-12/20-0304327105280, 0304327200430; 00650-12/21-0434180942 3000; 00805-08/10	09/10/04	01/18 - This was discussed with the Trading Partners on 01/18, the claim will pass their translator, but may cause lookup issues in their claims process. 01/03 - File information updated. Data in inbound file has the suffix appended to the name (NM103) 12/21 GHI to take issue back to the TPs and do more research. 12/07 - Will revert back to the TP as to whether this will still be an issue based on DDIS comments. The suffix is part of the NM103 on the inbound file	Disagree 10/24/05 - DDIS re-review: Concur with previous comment Disagree 1/28. There is no clear cut way to differentiate MD (as Medical Doctor suffix) from MD (letters of a name). The data is syntactically correct and therefore must be accepted. Agree. Since the qualifier in NM102 is 2 (non person) only the NM103 is to be used. This may be the name of the organization. If this is was is on the provider file. Follow up comment: The NM1 is syntactically correct.		C 02/01/05	01/11 MCS Based on the qualifier the loop is syntactically correct. Based on the provider file set up the surname is included as part of the name that is mapped to NM103 when NM102 is a 2. MCS believes this should be moved to the closed tab or disagree tab based on the DDIS comment. 12/20 MCS - The example is from 8/10 if this still needs a review we need a more current example. Also based on DDIS comment I believe this should be closed. 12/7 MCS - The example is from 8/10 if this still needs a review we need a more current example. Also based on DDIS comment I believe this should be closed. The NM1 is syntactically correct. 10/27/04 - This is a carrier set up issue.	G			2/1 CMS: COBA/TP conference call, agreed to close. 1/27 CC Notes: DDIS indicated that they would change their opinion from agree to disagree. 11/4 Conference call notes: Determined to be a Claredi issue.		
2010AA-008	N301 can't have a :	MCS	00901-10/22	11/08/04	01/10 - A fix was put in at COBC (VIPS), to strip delimeters from the flat file. 1/4 GHI to update issue as to reason closed	Disagree 10/24/05 - DDIS re-review: Concur with previous comment Disagree 11/16: colon is part of the basic character set. Although not adviseable, it is allowed as long it was not defined as a deliminter in the ISA. N301 has an "AN" attribute which is a "string" data element. A "string" data element contains any characters from the basic or extended character set.		C 12/21/04							MD(00901)	

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2010AA-009b	H40416: The REF-01 (Identification code Qualifier) Cannot equal "EI" when NM1-08 equals 24" because both refer to employer ID number	MCS	00512 - 07/12/07 - 02071830238 20, 02071831717 90 00865 - 07/12/07 - 18071803205 10, 18071803196 80 17003 - 07/12/07 - 07187844347 000, 07187844329 000 18003 - 07/12/07 - 07156811344 000, 07184921464 000 00520 - 04/26/07 - 02071032090 80 00511 - 04/26/07 - 11071028011 10		07/17/07 - Recent examples provided. 05/25/07 - Trading partners are now seeing the Part B files with the same values in the NM109 and REF02 of the 2010AA loop and sometimes in the 2310A loop. Please advise whether the values can be the same for Part B. This issue is originally reported as a FISS issue (Agree/Closed log-2010AA-009a), FISS implemented the fix so that the values in the NM109 are not the same as the REF02. Since the Faciledi error was based on the presence of the 24 and EI qualifier respectively, the error was bypassed, with the Trading Partner receiving the claims. None of the Trading partners questioned receiving these values until recently. The Part A files seem to have the different values correctly.	6-19-07 EI and 24 can be used when the values are different. When the values are the same, you cannot have 24 and EI. 5-30-07 Agree		C 7/19/07		G ~~M~~	~~FS4459S2~~	~~Prod 2/17, Test 1/27~~	7/19/07 - On the 07/19/07 contractor call, Donna K. indicated that DDIS disagreed with this error, it should be re-added to the exclusion list for the claims to go back to the Trading Partners. Error removed on 07/19/07 for files processed that evening. 7/5/07 - CMS gave COBC permission to lift the bypass on 7/9/07 based on DMBP updated comments 4/14 CC Notes: This issue is no longer a problem. (Opened 5/30/07 contractor 00511 is the lead) 3/17 CC Notes: Still is an error because only looking at qualifier, even when the IDs are different. GHI will make changes to Claredi edits. No action needed by FISS.		MassHealth (00181, 00270)
2010AA-010	N404 - The 'Country Code' should only be used when not US	FISS	00090-11/09; 00390-11/10	11/11/04	The value in the contractor's file - US	Disagree 10/24/05 - DDIS re-view: Concur with previous comment Disagree - Per CR3255 (already distributed to CMS's COB trading partners), 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.		C 12/21/04					12/21 CMS moved issue from agree tab to disagree tab.	Horizon(00090, 00390)	

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2010AA-011	In loop 2010AA. Element PER07 is used. It is expected to be used only when element PER05 is used	VMS	00630-10/30-0427843589 8000	11/24/04	Input and output file - blank in PER 05 but PER 07 has fax number	Disagree 10/24/05 - DDIS review: Concur with previous comment Disagree: The 4010A1 IG doesn't specify that repeating elements must appear in a specific order. This position was confirmed by X12N. However, this was addressed and the 5010 IG does specify the ordering for the future.		C 01/18 /05							Horizon(00630)
2010AA-013b	Data contains invalid character(s) from neither the basic, nor the extended character set.	VMS	00803/11/30 /04(86) (043206459 63000)	12/10/04	In Billing Provider Name (2010AA) nm1 contains "NM1*85*1*PORTNOI'*V ALERIE*A***34*1085825 22~	Disagree 10/24/05 - DDIS re-view: Concur with previous comment. Disagree 12/21. The apostrophe is part of the basic character set.		C 01/18 /05							
2010AA-015b (Closed 9/13/07)	H20622 - REF02 does not match the format for UPIN	MCS	00522 - 02/02/05 - 2206030088 330	02/15/06	**08/29/07 - Trading Partners are currently receiving these claims. The error code (H20622) is currently being bypassed.** Value in inbound file is NPP000 with a 1G qualifier	Disagree 3/6/06 - The format of the UPIN is correct. The UPIN itself is invalid and there should be a prepass to reject the claim in the shared system.	**H20622 is bypassed for both A and B**	C 09/13 /07	4/27 - MCS - We do not currently edit the validity of the UPIN, we do make sure it is a valid formt. If the system is suppose to validate the UPIN we would need a CR to enhance the system to validate the UPIN.						Horizon

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2010AA-016	The same 'Provider ID Number' (REF-01) MAY NOT BE REPEATED.	VMS	14330-01/21/05, ICN - 05006900851000	01/20/05	"REF 0001 1C 02281" Data repeated on inbound file	Disagree 10/24/05 - DDIS re-view: Here is a situation where the CLAREDI edit is based on logical thinking. Why tell us your provider number twice in the same claim? While I can understand that it is ridiculous to so, the IG doesn't prohibit it. Unless the TP can produce the specific language in the IG that prohibits duplicate reporting, we have to hold to the DISAGREE. Concur with previous comment, but editing would help clean up the data. 9/21/05 Disagree - There is nothing in the guide that states you can't repeat the same qualifier and the same ID number. X12 said "should" not "must". Disagree 2/10. The IG doesn't state that the same qualifier and ID can't be repeated.		C 02/15/05					10/13 CC Notes: o GHI commented the purpose of the IG was to eliminate redundant data, but we are interpreting redundant data to be OK. CMS indicated that this particular question was sent to the workgroup as a for interpretation clarification and the workgroup agreed that there is nothing in the IG to prohibit the duplicate information between the two elements.	GHI	

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2010AA-016a	REF 01, The same 'Provider ID Number' (REF-01) may not be repeated.	FISS	00011-02/01/05, ICN - 20501901106302, 20501901106602 00390 - 02/01/05, ICN - 20501806107502 00363 - 01/31/05, ICN - 20501803954301	02/08/05	Both IDs appear in the inbound file with the same qualifier.	10/25/2005 - DDIS review: Here is a situation where the CLAREDI edit is based on logical thinking. Why tell us your provider number twice in the same claim? While I can understand that it is ridiculous to so, the IG doesn't prohibit it. Unless the TP can produce the specific language in the IG that prohibits duplicate reporting, we have to hold to the DISAGREE. Concur with previous comment, but editing would help clean up the data. 9/21/05 Disagree - There is nothing in the guide that states you can't repeat the same qualifier and the same ID number. X12 said "should" not "must". Disagree 2/10. There is nothing in the guide that states you can't repeat the same qualifier and the same ID number.		C 02/15/05					10/13 CC Notes: o GHI commented the purpose of the IG was to eliminate redundant data, but we are interpreting redundant data to be OK. CMS indicated that this particular question was sent to the workgroup as a for interpretation clarification and the workgroup agreed that there is nothing in the IG to prohibit the duplicate information between the two elements.		
2010AA-22	REF02 - he value '23980115' at 'REF02' does not match the format for a 'Federal Tax Identification Number'.	FISS	00160 - 03/07/05, ICN - 20505500323502, 20505500323302 00308 - 03/07/05, ICN - 20505404172001	03/09/05	Data in inbound file with a EI qualifier. For 00308 the value was '282N00000'	Disagree 10/24/05 - DDIS re-view: Concur with previous comment Disagree 3/16. Since there is no external code source listed in the IG, any value meeting the IG syntax is acceptable.		C 03/22/05							

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2010AA-025	**H40415** (~~H51108~~) - A Social Security number (REF01|SY) cannot be used when the Patient or Insured Name Segment contain a Social Security number.	MCS	00910 - Regence	7/21/05	This issue was submitted directly to CMS/DDIS from the Contractors	Disagree 7/27 - Technically, once Medicare crosses over the claim, it is no longer a "Medicare" claim. Therefore, one of the iterations could contain "SY". CMS disagrees with the Claredi edit.		**C 09/30 /05**							
2010AA-026 (Closed 9/13/07)	H54217 - REF 02, dashes in the SSN - HGSA is receiving COBC reject H54217 for dashes appearing in the social security number in error. Since the dashes may be reported on the incoming files and they are permissible on outbound, the errors should not be generated.	MCS	00801- HealthNow Part B 00865 - 06/19/2006 - 11061666587 90, 11061666587 70 00865 - ICN 11061181657 60, 11061816580 0, 11061181658 40, 11061077072 20, 11061770735 0.	5/1/2006 5/17/06 and 5/05/06	**08/29/07 - Trading Partners are currently receiving these claims. H54223 (Social Security Numbers should not contain dashes) is now the error code associated with this issue.** This issue was submitted by the contractor to CMS. Their comments are noted in the DDIS columm. The SSN in the file contained dashes (999-99-9999). Please confirm that this is a disagree by DDIS	10/29/07 - CMS agrees that NNN NN NNNN, NNN-NN-NNNN, or NNNNNNNNN would be compliant, in the absence of an external code source reference. In general spaces are not to be submitted, but unless there's something to preclude them, they can be sent. If a CMS COB trading partner is rejecting claims with an SSN formatted as NNN NN NNNN, I would like to see the IG note supporting such rejection. Disagree 02/26/07 - It appears that the issue was logged by Medicare contractor (HGSA) and not by a TP. DDIS "agrees" with HGSA's comment that dashes are allowed. We "disagree" with the trading partner's rejection of the claim due to the presence of dashes in the SSN. 6/22/06 Still agree. As per the e-mail from Kathleen S. to Linda S. : I agree with HGSA and also		C 9/13/ 07		G		05/08/07			

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2010AB-001	**H40425** - Billing Provider and Pay-To Provider must be different.	MCS, ~~VMS~~	05440 - 04/29 - ICN 1105117022870 00900 - 04/29 - ICN 2205108738600, 2805108006090 14330 - 0501191258 6000; 05535 - 5012788031000; 00811-10/09-0427184295 8000; 00630-11/16-0430771567 0000		09/12/05 - Based on DDIS' 08/17 Disagree, this error code was added to the Faciledi Exclusion list on 09/12/05. 08/23 - Should DDIS review this again? 07/25 - Additional examples provided 05/09 - This error is now occurring from MCS, see examples 03/09 - This issue is no longer occurring from VMS 01/18 - See updated file information sent to VMS on 01/18 01/03 - As of files received the week of 12/27, this error is still occurring. The data appears in both loops of the contractor's file	Disagree 8-17-05, For consistency purposes, DDIS will change this to a disgree. The lack of the word "only" indicates that they can be the same in both loops. PRIOR RESPONSE- Agree, they must be different entities. Is all of the information in both loops?	pg 95; 2010AB(Pay to provider) is required if the billing provider (2010AA) is different. Pay To provider has 87 qualifier in NM1, Billing provider has 85 qualifier in NM1	**C 09/29/05 O Reopened 5/9/05 ~~C 03/09/05~~**	9/29 MCS - With the DDIS updated comment, should this be moved to the disagree tab? 06/30 MCS - We disagrees with the DDIS agree. The IG does not prohibit the 2010AB when it is the same as the 2010AA. 3/06/05 VMS - Could GHI (COBC) confirm if this issue is no longer occurring. 01/24/05 VMS - Carrier 14330 (GHI) has the VMS standard edits turned off which would have rejected the claim because of the presence of the NPI qualifier of 'XX' in the 2010AB NM108. As for the 5535 (Cigna) carrier, no 2010AB REF was sent so the new edit going in on 2/3/05 would not catch this error. Question: should we put in an edit to require the 2010AB REF01=1C as we have for 2010AA	M	PS3205 PL 3092 front end edit Ps2946 - Back end only	3205 2/3/05 3092 - 2/3/05 PS2946 - 12/23/04	9/29 CC Notes: GHI - This issue will be closed. 9/8 CC Notes: Neil: For 2010AB-001, at the time it was an agree, now it is a disagree. The edit will be turned off since it is a disagree. 8/11 CC Notes: On 6/30 EDS replied in the log that we disagreed with the error because the IG does not prohibit the 2010AB when it is the same as the 2010AA. Currently there is not a DDIS comment in the log. 2/18 CMS response: No, you should not create that edit. 2/3 CC Notes: ViPs submitted a question to CMS asking for comments on how to address possible gaps in their solution to this issue, they are still waiting on the response. 12/13 CIGNA - COBC issue log # 2010AB-001		
2010AB-004	NM109 - The value '0752674712' at 'NM109' does not match the format for a 'Federal Tax Identification Number'.	FISS	00380 - 03/08/05, ICN - 2050540305 5005 03	03/09/05	Data in inbound file with a 24 qualifier	Disagree 10/24/05 - DDIS re-view: Concur with previous comment Disagree 3/16. Since there is no external code source listed in the IG, any value meeting the IG syntax is acceptable.		C 03/22/05							
2010AB-005	The value '23980115' at 'REF02' does not match the format for a 'Federal Tax Identification Number'.	FISS	00160 - 03/07/05, ICN - 2050550032 3502, 2050550032 3302	03/09/05	Data in inbound file with a EI qualifier	Disagree 10/24/05 - DDIS re-view: Concur with previous comment Disagree 3/16. Since there is no external code source listed in the IG, any value meeting the IG syntax is acceptable.		C 03/22/05							

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2010AB-007 (Closed 9/13/07)	Pay-To provider in production (NSF) is different to the Pay-To provider from COBC	MCS	00630 - 1105311041280 - 11/21/05	1/13/06	**08/29/07 - Trading Partners are currently receiving these claims. There is no error code associated with this.** Trading Partner is questioning why the Pay-To provider in their production file, NSF format, is different than the Pay-To provider received in the COBC file The NSF file has 'Memorial Health System' as the pay-to provider; the COBC file has 'Memorial Health System' as the Billing provider and Vincent Henderson as the pay-to provider	1/24/06 This is not a DDIS issue to address. Any changes to the COB file output would need to be addressed by either the shared systems maintainers, GHI, or central office COB staff.		C 9/13/07	4/27 - MCS - The mapping logic between NSF and HIPAA are different. Is the information being passed in the 2010AB incorrect?						
2010BA-003	Medicaid Recipient ID number missing	B			The Medicaid Recipient ID number will now be in the REF segment, where REF01 = IG. This is being pulled from 2010BA/NM109, where NM108 = MI	Disagree 10/24/05 - DDIS re-view: Concur with previous comment. Disagree. Medicaid populates the REF with the IDs on the COB eligibility files.		C 09/16/04							
2010BC-003	REF02 - The value '0777000201' at 'REF02' does not match the format for a 'Federal Tax Identification Number'.	FISS	00011 - 03/07/05, ICN - 20505300736002, 20505301066602	03/09/05	Data (10-digit EIN) in inbound file with a TJ qualifier	Disagree 10/24/05 - DDIS re-view: Concur with previous comment. Disagree 3/16. Since there is no external code source listed in the IG, any value meeting the IG syntax is acceptable.		C 03/22/05							

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2010BC-004 (Closed 9/13/07)	NM103 = X	MCS	00650 - 07/27/06 - 11061940251 30	8/16/06	**08/29/07 - Trading Partners are currently receiving these claims. There is no error code associated with this.** The Trading Partner is questioning whether 'X' is a valid value for NM103 NM1*QD*2*X~ N3*2013 W 50TH ST~ N4*MISSION*KS*662052025~	Disagree 9/14/06 - While the value of X may not provide anything, the IG allows for 1/35 AN. The X is compliant.		C 9/13/07								
2300 - REF02 (Closed 9/13/07)	H51132 - 'N' is not a valid Service Authorization Exception Code	MCS	00951, 00952, 00953, 00954	6/23/06	**08/29/07 - Not sure if DDIS commented on this issue**	Disagree-SFR Submitting a "4" on the inbound claim correctly. Contractor is sending the COBC with an identifier of "4" in the COBC output file.	**Pg. 222 & 223**	C 9/13/07							CIGNA
2300-003	Patient Signature Source Code' was not expected because the Release of Information Code (CLM-09) is 'N-Provider is Not Allowed to Release Data'	B	00811/REF*F8*04261847784000~		Trading Partner that reported this (Regence), can live with it. GHI note: The Part B guide has CLM10 NOT USED.	Disagree 10/24/05 - DDIS re-view: Concur with previous comment. Disagree. CLM10 does not indicate that you can't have data in the field. It notes that the element is required except if CLM09 = "A". This does not mean you must not enter data if CLM09 = "N"	pg 166 - CLM10 - 'Patient Signature Source Code' is required, except in cases where CLM09 = N	C 09/09/04							

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2300-005	ICD9 Code data at '2300.HI' is not found in ICD9 database	B			Trading Partner that reported this (Cigna), can live with it. Should be 3 characters then decimal followed by 2 places. Ex. 739.12; E-codes have an exception E + 3 digits followed by decimal and 1 digit ex. E987.1 (Source ICD-9-CM 2004 Vol. 1 and 2).	11-1-05 Unless there is any new information, the issue will remain closed. Disagree 10/24/05 - DDIS re-review: Linda and I discussed this today and I provided her with CR3260, released Oct 2004, which requires the Part B, DMERC, and NCPDP shared system maintainers to implement diagnosis code editing to prevent processing claims that contain invalid dx codes whether pointed to or not. I would expect that this error is no longer an issue. However, trading partners MUST understand that if they choose to receive denied claims in their crossovers, then they must not be surprised to receive non-compliant claims that would fail CLAREDI. We would consider changing this to an AGREE under two conditions a) if it can be	Not X12 - see Analysis Comments	C 09/01/04							

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2300-006	ICD9 Code '4140' is not valid, must be coded to the highest number of digits possible (4th or 5th digit).	MCS	00952/REF* F8*0204261 179000~ - ICD9 Code = 5640		Trading Partner that reported this (Cigna), can live with it. Should be 3 characters then decimal followed by 2 places. Ex. 739.12; E-codes have an exception E + 3 digits followed by decimal and 1 digit ex. E987.1 (Source ICD-9-CM 2004 Vol. 1 and 2)	11-1-05 Unless there is any new information, the issue will remain closed. Disagree 10/24/05 - DDIS re-review: Linda and I discussed this today and I provided her with CR3260, released Oct 2004, which requires the Part B, DMERC, and NCPDP shared system maintainers to implement diagnosis code editing to prevent processing claims that contain invalid dx codes whether pointed to or not. I would expect that this error is no longer an issue. However, trading partners MUST understand that if they choose to receive denied claims in their crossovers, then they must not be surprised to receive non-compliant claims that would fail CLAREDI. Iwe would consider changing this to an AGREE under two conditions a) if it can be	Not X12 - see Analysis Comments	C 09/01 /04								
2300-019	Value of element REF02 (CLIA Number) is incorrect. Expected value is CLIA number (format is '10 characters where the third character is 'D").	MCS	00902-10/27	11/10/04	Value in contractor's file is 01W2F1000413	Disagree 10/24/05 - DDIS re-view: Concur with previous comment Disagree 11/16: there is no code set for CLIA, therefore, the structure of CLIA number is not defined by the IG		C 01/18 /05					12/21 CMS - GHI to do more research.	Horizon(00902)	

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2300-020a	Service Facility Name' was not found, but was expected because both the Billing and the Pay-To Providers are present (2010AA and 2010AB) and the Billing/Pay-To Provider (PRV) is not present, so the Service Facility must be identified.	FISS	00390-12/03/04 (204286018 94602) 00363-12/02/04 (204323003 31701) 00453-12/03/04 (204324005 40402, 2043240054 1802) 00350-12/02/04 (204324008 73702, 2043240087 4302)	12/06/04	No 2310E loop in the inbound file (00390, 00363, 00453, 00350). Note:- The Service Facility Name should be in 2310E	Disagree 10/24/05 - DDIS re-view: Concur with previous comment. Disagree 1/13 - Per Doug Renshaw (an 837 workgroup co-chair). The PRV and 2310E can be 'not present' for Medicare claims per the first part of the PRV segment note. Although our COB trading partner(s) may require either the PRV or 2310E segment, the IG allows us not to require one or the other. Disagree 12/10 - the 2310E usage notes do not support the requirement suggested in the issue column.		C 01/18 /05								Horizon(00390,0036 3,00453) & Regence(00350)
2300-033	**H40358 -**The 'Acute Manifestation Date' cannot be used unless the Patient Condition Code in CR2-08 is 'A' or 'M'.	MCS/ VMS	00900 - 07/18 - 2205186879 990. 00510 - 07/18 - 2205181609 820 Seen from several contractors	7/12/2005	The inbound file contained the date in the 2300 loop, with a 453 qualifier. The CR208 contained 'F'	Disagree 8/8/05, the IG states "required when", not "required only when".		**C 09/30 /05**								Contractor Trailblazers, based on errors received for July release testing

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2300-038 (closed 4/09/07	DTP03 (qualifier 435) - Gap Fill date = 177607040001, causing rejects in Trading Partner's process	FISS	Seen from several contractors Example 00011, 00090, 00101, 00130, 00180, 00332, 00363 00380, 00450, 00454	8/29/2005	04/09/07 - The 1776 gap fill date is no longer being seen. Since this is a compliant value, the TP identifies this error. Since this has not been reported recently, please close. 03/27/06 - Preliminary evaluation of the fix indicate the value in now 196607010001 This issue was reported by WPS in May and previously discussed on the COBC/Contractor Thursday call	Disagree 10/24/05 - DDIS re-view: With the end of the inbound claim contingency, contractors are no longer accepting non-HIPAA electronic claims. However, paper claims are allowed under limited ASCA exceptions. Because this error is an FISS error and typically the volume of paper claims going to intermediaries is small, this should not be a major problem for the trading partner. We still hold to the DISAGREE as there is no requirement on what consitutes a valid date. Disagree 9/7/05. The date is HIPAA compliant per the IG. The IG has no conditional notes affecting the age of the date. This is a "gap-fill" date because CMS did not receive the date on the non-HIPAA inbound claim.		**C 04/09/07 Re-opened 11/08 ~~C 09/30/05~~**	5/17/06 FISS - FS4652 corrected this. 11/4/05 - the date used to gap fill all dates will be changed to 7/1/1996 in FS4652, scheduled for production 3/6/06.	FS	FS4652	P-3/6/06	11/08 CMS: Even though DDIS disagreed with the compliance issue FISS has agreed to fix the gap filled date. 10/13 CC Notes: o Would like to have this considered as a system issue. Trading Partners have trouble processing 1776 because of Y2K processing. Agreement was made that a default date of 07/01/1966 would be used instead of 1776.		Reported by Trading Partner - WPS

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2300-049 (closed 9/13/07)	The trading partner, TN Medicaid, received 837 Professional claims for chiropractic services that did not contain a CR2 segment. TN Medicaid alleges this makes the claim non-compliant. Per CMS' Center for Medicare Management claims processing staff, the elements within this segment are not necessary for/do not impact Medicare's adjudication processes. Carriers use other information, such as ICD-9 code, to assess the chronic nature of a beneficiary's condition in relation to MR/UR.	MCS	00650 - 09/12/06 - 14062230101 00, 09/14/06 - 14062280056 10 00510 - 09/14/06 - 24062290090 50	11/01/06	**08/29/07 - Trading Partners are currently receiving these claims. There is no error code associated with this**. Submitted for DDIS' analysis. Please see CMS/OFM comments in the 'Issue' column	Disagree 2-13-07 - The usage note in the IG states "required when known to impact payer's adjudication process". Since the policy area is stating that we don't need this info to adjudicate the Medicare claim, then it is not required. The crossover claim is compliant.		C 9/13/ 07							

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2300-051 (Closed 9/13/07)	Trading Partner (Missouri Medicaid) contends that 2300 loop DTP*435 (date of admission) & DTP*096 (date of discharge) must be present on 837 professional claims when the beneficiary is an inpatient w/in the hospital. **Per the Part B claims operations staff, the dates of admission & discharge are not necessary for Medicare adjudication. However, the notes within the IG read: "Required on all ambulance claims/encounters when the patient was known to be admitted to the hospital. Also required on inpatient medical visits claims/encounters." (For the example provided, the place of service is '56'—inpatient psychiatric facility.)	MCS	ICN#4906244 024118	02/14/07	**08/29/07 - Trading Partners are currently receiving these claims. I'm not sure if there is an error code associated with this, I would have to look at a recent example, which the TP would have to identify.** 02/14/07 - Please see the comment submitted in the 'Issue' column. Issue 2300-007 (VMS) is on the log for date of admission. This issue includes both admission and discharge date.	2-28-07 Two part response: AGREE that the admission date is required, but DISAGREE that discharge is required. Discharge date is "required" when the patient HAS been discharged and the discharge date is KNOWN.		C9/13/07							
2300-55 Closed 8/28/08	A State Medicaid Agency maintains that the 2300 CLM07 (Provider Accept Assignment Code) is required on Medicare crossover claims. Does DMBP agree with the Medicaid agency?	FISS		8/18/08	Please see the issue as stated in the Issue column. This was submitted by Mass medicaid.	8-21-08 Disagree. The 837I implementation guide indicates that CLM07 is SITUATIONAL.		**C 8/28/08**							Mass Medicaid

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2310A-005	Referring Povider name was not found, but was expected because there is a 'Referral Number'	VMS	01/10 - 00803 - 435165949200, 043516594930000803/0928	10/01/04	01/10 - See updated file information provided to VMS on 01/05. 11/10/04 - TP question - If there is a 2310A then it is required to have a NM1 segment. Page 269 of the IG # 3 and 4. 2310A did not appear in the inbound file	Disagree 10/24/05 - DDIS re-review: Concur with previous comment. Disagree 1/28. After more research, this referral number segment is mainly used to capture data for a managed care setting. For Medicare, referral numbers are not used. Therefore, a link cannot be made between the referral number and referral name. Medicare claims that require referral information will require the name only. No edit will be implemented. Agree 12/20/04 (changed) Originally Disagree. 11/16/04 We agree that if 2310A is present NM1 must be present. However, that is not the error that was reported. The error reported was that they expected 2310A because there was a referral number. Disagree 10/00/04 IG		C 02/25/05	01/24/05 VMS - What level edit whould we implement (IG or VMS)? 01/17/05 VMS - Is DDIS saying that the 2310A must be present if a 2300 REF01 = 9F is present? 01/10/05 VMS looking into adding a new inbound edit. Estimate and date TBD.				2/8 CMS: DDIS changed the opinion from agree to disagree. Discussed with the TPs on Tuesday, 2/8 and agreed to close. 1/27 CC Notes: Brian – we are going to reverse our decision on that. I've looked in the 4010 and also looking in the 5010 to get an ideal of what's expected. It seems that the referral number is not a Medicare issue. It's typically involved in Managed Care arrangements where a referral is needed to be seen by another physician. We should not be getting a referral number in. So we are thinking we should not be making any changes because of this		
2310A-009	NM103, The value '101ST AVENUE FOOT CARE PC' at 'NM103' does not match the format for a 'Person name, must be at least one letter'.	VMS	14330-01/27/05-ICN-500691098400 0	01/31/05	Value in inbound file '101ST AVENUE FOOT CARE PC' with NM102 = 2	Disagree 10/24/05 - DDIS re-view: Concur with previous comment. Disagree. According to GHI, the value of 2 is in NM102. If so, the value in NM103 is correct.		C 01/31/05							
2310A-011	INCORRECT ELEMENT IN NM103	FISS	00450-02-12-05 ICN, 205027022392 02	3/29/05	" - " FOUND ON INBOUND FILE. Error reported by Mass Health.	10/20/2005 - DDIS review: Concur with previous comment. Disagree 3/31. The data is HIPAA compliant. CMS does not edit for valid names in the 2330B loop except to verify the data are syntactically compliant.		C 04/18/05							

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2310A-017 (closed 9/13/07	**H40415**:A Social Security Number (REF01=SY) cannot be used with the 'Referring Provider Secondary Identification' when the Primary ID contains a Social Security Number (NM108=34).	MCS	00952 - 06/14/07 - 02071522230 10 (for loop 2010AA and 2010AB) 00900 - 12/11/06 - 22063325017 70	02/12/07	08/29/07 - Trading partners are receiving some of these claims (if the error occurs in the 2010AA). They would have to be notified that they should be prepared to receive the claims if the error occurrs in any of the other provider loops. (i.e. H40415 is currently being bypassed for 2010AA,) 06/25/07 - Resubmitted for clarification on the 'dup'. Please advise if the duplicate refers to issue 2010AA-025 which was a disagree, and confirm whether this issue would have the same decision. Would the same decision apply to other loops, 2010AB for example 02/12/07 - This error is on the log under 2010AA-025. The contractor is questioning whether this is a valid error. Please see their comments. The claim contained the 2310A NM108 = 34 with NM109 as the 9 digit SSN and ~~REF02~~ REF01 = SY with ~~REF03~~ REF02 = the SSN in	7-3-07 Yes, this would be a disagree in any loop. There is not a note which precludes the use of sy when 34 is previously used. Bsr 2-28-07 This a dup.		C 9/13/07					06/27/07 - Comments from 00952: The social security number is not used for Medicare, however we do require the provider send it. If the proivder sends the NPI in the 2010AA NM1we require a tax ID in the 2010AA REF or we will reject the claim. If they do not have an EIN they have to send the SSN. This particular provider did not send an NPI, they have the SSN in both the NM1 and the REF, but there is nothing at this point to stop this kind of billing. These errors are going to increase as we continue to implement NPI. Comments from 00900 - "The 4010A1 IG does have a note that says "the social security number may not be used for Medicare" but this note does not prohibit it from being sent if it is a Medicare claim so we have no edit that will reject these claims . Also, as with the 2010AA situation for this error, this would no longer be a Medicare claim once		
2310B-001	Leading spaces are not allowed (NM103).	11/22/04 - MCS	11/22/04 - 00590(G90-11/17)-1004310446020, 0904288670410; 00865(G85-11/17)-1104309855410, 1104309855210		12/21 GHI turned off the edits. 11/22/04 - This is still happening as of 11/17	Disagree 10/24/05 - DDIS re-view: Issue fixed by ViPS 11/2004. Disagree 12/13 DDIS changed their opinion. 10/00 Agree this is an error. Does the GHI translator check for mandatory fields prior to building the 837 COB?		C 01/18/05	11/12 CMS - GHI needs to validate if this problem is continuing. 11/08/04 VMS - corrected outbound July release under CR3100.	G					

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2310B-006	'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 ide	MCS	910 - 02/14/05, ICN - 1105038131 4260 902 - 02/14/05, ICN - 2205026046 000	02/15/2005	If (2010AA & 2010AB) are present and 2000A PRV is not present 2310B NM1 is expected. (if PRV is present 2310B is not expected.) In this case 2310B and 2000A are not present.	Disagree 10/24/05 - DDIS re-view: Concur with previous comment. Disagree 2/28 - the issue description doesn't say that the data is the same, it just says they are present. If that is the case, we change the response to disagree. Agree 2/16.		C 03/15/05	MCS 2/18 - EDS disagrees with the DDIS agree. In these cases the Billing provider was the same as the rendering provider, therefore, the 2310B is not created. The 2310B is only required when it is different thanthe billing provider. The 2000A/PRV was not created because it was not submitted in the inbound record and maintainers are not to crosswalk the taxonomy code. Per CMS CR2437 for paper/NSF claims neither the 2000A or the 2310B PRV is created since Medicare does not need or require the taxonomy code and the CR instructed maintainer to discontinue crosswalking. Also with CR2437 the prepass only requires 2000A or 2310B PRV to be present on 4010 format. Therefore, a 4010A1						
2310B-007	NM104, First Name is populated with a dash (" - ")	MCS	31141 - 02/01/05 - ICN, 0105005019 450, 0105006033 550	02/01/05	Data found in inbound file.	Disagree 10/24/05 - DDIS re-view: Concur with previous comment. Disagree 6/1. The dash is a valid character		C 08/02/05							
2310B-008 (Closed 9/13/07)	H54213 - '436003377' is not a valid SSN.	MCS	00523 - 09/29/05 - ICN 1105259356 970 00523 - 10/03/05 - ICN 1105262510 720	10/4/05	08/29/07 - Trading partners are receiving some of these claims. H54213 is being bypassed for 2310B based on 2310B-008 in the 'disagree' log on the website).	Disagree 11-01-05. If there is a code source description of what a valid SSN is, then we would consider changing to an agree.	This is currently occurring	C 9/13/07							

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2310B-009 (Closed 9/13/07)	Service Address (Rendering Provider) is received in the production file, (NSF), but not from COBC	MCS	00630 - 1105311041280 - 11/21/05	1/13/06	**08/29/07 - Trading Partners are currently receiving these claims. There is no error code associated with this.** Trading Partner is questioning why the service address for the rendering provider is seen in their NSF file, but not in the file from COBC	1/24/06 This is not a DDIS issue to address. Any changes to the COB file output would need to be addressed by either the shared systems maintainers, GHI, or central office COB staff.		C 9/13/07	4/27/06 MCS - The mapping logic of the rendering provider is different between NSF and HIPAA. For HIPAA the 2310B will only be mapped IF the ID is different than the ID in 2010AA. This is not a problem with the file, it is just a difference in file mapping.						
2310C-001	Purchased Service Provider (2310C NM1) not found, but was expectect because 'Total Purchased Service Amount' (AMT-01=NE) is present.	VMS	00512 - 04/27 - ICN 02051020501100900 - 04/27 - ICN 22051013514 70	04/29/05	The 2310C Loop is missing in the inbound file	Disagree 10/24/05 - DDIS re-view: Concur with previous comment. Disagree 6/1. The IG doesn't require the 2310C just because the AMT is populated.		C 08/02/05							
2310D-001	Billing Provider and Service Facility must be different.	B			Trading Partner that reported this (Regence), can live with it. 09/07/2004 - Neil requested feedback from TPs, since this can become a big issue. Wellmark and Horizon has a workaround. Question was posed to Mass Health, since they're using Sybase (as does Wellmark). They will get back to us with the answer. As of 09/21 no feedback received.	Disagree 10/24/05 - DDIS re-view: Concur with previous comment. Disagree. The guide notes that the service facility is required if different than the billing or pay to provider location. The guide doesn't note that they can't be the same. The only instance where you can't use the 2310D is when the service was at the patient's home.		C 09/21/04					12/13 CIGNA - was this closed for the same reason as indicsted in 2010AB-001.		

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2310D-003	Leading spaces are not allowed (N302).	B			12/21 GHI turned off the edits.	Disagree 10/24/05 - DDIS re-view: Issue corrected 11/2004. Disagree 12/13 - DDIS changed their opinion. Agree this is an error. Does the GHI translator check for mandatory fields prior to building the 837 COB?		C 01/18/05	11/12 CMS - GHI needs to validate if this problem is continuing. 11/08/04 VMS - corrected outbound July release under CR3100.	G					
2310D-004	o Service Facility in 2310D – what does it mean when they have NM1*FA*2 with a REF*1C of 'SUBMITTED BUT NOT FORWARD'?	MCS				Disagree 10/24/05 - DDIS re-view: Concur with previous comment. Disagree. Gap filling		C 12/21/04							
2310D-007	The value '190064 at REF02 does not match the format for a UPIN	MCS	00528-10/07-1104229237840	11/02/04	Value of 190064 appears in the contractor's file. Must be 1 alpha + 5 numeric	Disagree 10/24/05 - DDIS re-view: Concur with previous comment. Disagree 11/23 - DDIS agrees with the MCS response. The 2310D facility loop would not be populated with a UPIN, so the "190064" value was appropriate in this situation. Please note that the DDIS response may be applicable in other situations, just not this particular one. Agree. 10/00 - I believe this was reported sometime ago and MCS was mapping from the SFR and not the finalized claim screen. I believe the claim screen will have the UPIN, but the SFR will have whatever was submitted (which is not edited against the provider file). MCS needs to map from the claim screen. I understand they did this prior to HIPAA.		C 12/21/04	11/23/04 MCS- The 2310D/REF01 was a 1C which is for the Medicare Number. Based on the REF01 qualifier the UPIN should not have been expected. FYI, the MCS system uses the provider number for this field not the UPIN number, therefore, when the claim screen is used a 1C qualifier is sent with the Medicare Provider number. We do not see this as an error and need further direction from CMS. 11/10/04 MCS - What is the qualifier in the 2310D/REF01 where the non UPIN REF02 was identified? Is the REF01 = to 1G or 1C? The MCS claim would have the provider number of the Facility Provider not the UPIN and on paper claims the 2310D/REF01 of 1C is used with the facility provider number, not UPIN in the REF02.						Cigna(00528)

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2310D-008	The REF-01 (Identification code Qualifier) Cannot equal "TJ" when NM1-08 equals 24" because both refer to employer ID number	MCS	00904-07/16; 11/02		01/31 - Correcting this error in our translator will require additional I/O. Not sure how we should proceed. Its occurrence has reduced recently. 11/02 - Originally reported as 2310B-004, but should be 2310D, will re-submit to OIS for review. Output file has a 'TJ' qualifier, which isn't a valid value. The contractor's (Trailblazer(00904)) file had a value of 'TJ'	Disagree 10/24/05 - DDIS re-view: Concur with previous comment. Disagree 2/8 - The IG does not state that you can't have the same numbers in NM109 and the REF. Prior response: Agree. The qualifier is "TJ" is valid for Tax ID. The guide does not note that you can't have both numbers in NM109 and the REF. Although agree that they should be different. The REF should have the Medicare provider ID.	pg-295 Qualifier values FOR 2310D (0B, 1A, 1B, 1C, 1D, 1G, 1H, G2, LU, N5, TJ, X4, X5)	C 02/15/05	01/24 MCS - EDS is not moving forward with this CR due to conversations in last weeks meeting. GHI was going to see what they could do with the file. 01/11 MCS Not sure what to do with this. Found that the claim was submitted with REF01 of TJ and no other REF loops. According to the IG, page 310, the REF is only Required when a secondary identification number is necessary to identify the entity. The prmary identification number should be carried in the NM109. The IG does not prohit the submission of the TJ REF when it is the only REF. Based on this the submission was IG compliant. It was also compliant with Medicare editing because the Facility Provider is not needed to process the claim. Not sure what to	M	17114	NS	2/3 CC Notes: DDIS indicated that they disagreed with the issue of the TJ being submitted with the NM108 of 24 as an error because the IG does not prohibit the duplication of information. The originally agreed with the error because they thought the true error was that the 1C was not also submitted on the file.		
2320-003	Segments in Loop 2320 are out of order. Payor Paid Amount is first, then Approved Amount, then Allowed-Actual Amount, then Patient Responsibility - Actual Amount. SBR*P*18*574051793D6**MB****MB~ AMT*D*65.51~ AMT*B6*81.88~ AMT*F2*44.73~ AMT*AAE*81.88~	VMS			Trading Partner that reported this (IPN), can live with it.	Disagree 10/24/05 - DDIS re-view: Concur with previous comment. Disagree. This is not an error. The AMT segments within a loop do not need to occur in a particular order. The qualifier is all you need to identify what the segment represents.	pg 315-325 Order listed in guide as follows: D, AAE, B6, F2, AU, D8, DY, F5, T, T2	C 09/07/04							

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2320-004	'Medicare Outpatient Adjudication Information' was not expected because this Claim is for Inpatient services	A				Disagree 10/24/05 - DDIS re-view: Concur with previous comment. Disagree. What is the bill type? Medicare processed some inpatient as outpatient. CR 3031 provided a list oh how CMS defines bill types	pg 391 - 2320/MOA - To convey claim level data related to the adjudication of Medicare claims, not related to an inpatient setting.	C 09/03/04	Per GHI, this error occurred on type of bill 22. TOBs 12 and 22 are inpatient for HIPAA, but are processed by Medicare as outpatient. An MOA (Medicare Outpatient Adjudication information) is valid for these TOBs.						
2320-010	SBR*S*21***MI****ZZ~ DMG*D8*19010101*M~ OI***Y*S**Y~ NM1*IL*1*GRIFFIN*JOHN*N***MI*111111111A~ NM1*PR*2*PIPE TRADERS HEALTH WEL*****PI*99999~ Questioning whether the entire second iteration of Pipe Trades should be present at all. *The COBA ID was sent at 99999, this is not valid. *The same subscriber is listed in both iterations of Pipe Trades - if maybe his wife was listed as the subscriber in the second one, it would mean he has double coverage with Pipe Trades. However, John is	VMS	00630-09/25-0425771142 7000	10/15	The data appears in the contractor's file. The Payer in 2010BB is Pipe Trades, COBA 00001, as secondary. Pipe trates appear again in 2330/2330B as Secondary with an ID of 99999. Note:- This is not the same issue as 2000B-002. In that instance they were questioning why there were two 'S' in the SBR01. The original thought was that there would be a 'P', 'S', 'T'. Not 'P', 'S', 'S'.	Disagree 10/24/05 - DDIS re-view: Concur with previous comment. Disagree 12/2 - This problem will go away when the TP goes live in production. Agree. The second iteration of Pipe Traders is not required.		C 12/21/04	12/3 VMS - This issue describes an insurer being listed twice owing to being crossed both directly to the trading partner and in a test mode to the same TP through the COBC. On 12/2 ViPS was advised that the DDIS has moved this to the Disagree list and no further action is required. 11/12 VMS - has the same insurer listed twice. This is due to the fact that this claim is crossed to the COBC and to the trading partner directly via an eligibility record. VMS has no way to know that these are the same TPA. 11/08/04 VMS - Note that the second iteration is for the eligibility record the trading partner sent to the carrier. Once they go live with COBC, the trading partner should be informing the carrier that the eligibility records are	G					

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2320-016	Currently our (Trading Partner) program expects AMT*C4 in the 2320 loop. This tells us that medicare has made a payment. We're not seeing "C4" in the Part A files.	FISS	00011 - 03/09 - 20435537505304 00021 - 03/09 - 20504800073202	05/10	09/26/05 In the past I have commented on HIPAA compliance balancing issues. We have determined the our compliance validator is expecting the PAID amount in the 2320 loop and where AMT01 = C4 in the Payer Prior Payment segment. I have read the issues log and closed issues on this very issue. The CMS response was that CMS will repond with the Medicare paid amount with the 2320 loop and where AMT01 = N1. We are concerned with this and would like CMS to review the WEDI white paper on COB Balancing. http://www.wedi.org/cmsUploads/pdfUpload/WhitePaper/pub/COBWhitePaper200412.pdf Specifically, the white paper states, "Although	Disagree 10/27. CMS uses the AMT segment with N1. Need to confirm from the trading partner that the AMT with N1 (IG page 376) is not present. If N1 is present, trading partner needs to process the data from N1. If the data is in N1 and the trading partner processes teh data and the data does not balance, then CMS will address the balancing issue. Disagree 9/7. This segment is not required. Segment note 2 allows for this segment to not be present (no paid amount). The Medicare amount is in the AMT*N1 segment (IG pages 376-377). Disagree 10/24/05 - DDIS re-view: Concur with previous comment. Disagree 6/1. This AMT segment is not required. The amount (if needed by the trading partner) ca		C 08/02/05								

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2320-016 - Duplicate	Currently our (Trading Partner) program expects AMT*C4 in the 2320 loop. This tells us that medicare has made a payment. We're not seeing "C4" in the Part A files.	FISS	00011 - 03/09 - 20435537505304 00021 - 03/09 - 20504800073202	05/10	**08/26/05** Based on the response on 08/15, the Trading Partner has additional questions: 1. Can you clarify how the value codes would be used to identify other paid amount? The Implementation Guide states the definition of BE is a "VALUE". 2. How do we identify the other payer paid amount at the claim level? Additional information: For ICN 20435537505304 the codes are as follows: HI*BK:V583~ HI*BF:99851*BF:99883*BF:2384*BF:496*BF:V103*BF:4019~ HI*BE:61:::9927~ For ICN 20504800073202 the codes are as follows: HI*BK:41071*BJ:41401~ HI*DR:121~ HI*BF:4280*BF:41401*BF:4660*BF:78039*BF:43	Disagree 9/7. This segment is not required. Segment note 2 allows for this segment to not be present (no paid amount). The Medicare amount is in the AMT*N1 segment (IG pages 376-377). 8/15 - CMS uses value codes 12-16 or 41-43 for these amounts. These codes are more specific. Mass Health needs to let CMS know if none of these values are populated. Disagree 6/1. This AMT segment is not required. The amount (if needed by the trading partner) can be derived from SVD segment and CAS segment data.		**C 09/30/05**								

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2320-020 (Closed 9/13/07)	Leading spaces in the 2320 SBR03	FISS	00322 - 05/04/06 - 20611000024002	06/19/06	**08/29/07 - Trading Partners are currently receiving these claims. The error code (H10016:Leading spaces are not allowed in '%si - %i'. The X12 syntax requires the suppression of leading and trailing spaces) is currently being bypassed.** Ruling from DDIS already received via email. Submitted to be added to the Main Issues Log	Disagree - Based on a 06/19/06 email from CMS/0IS to CMS/OFM. The following comments were made: Leading spaces are allowed. SBR-03 is classified as AN (string) in the IG. The definition from the IG for a string data element is "a sequence of any characters from the basic or extended character sets. The significant characters shall be left justified. Leading spaces, when they occur, are presumed to be significant characters. Trailing spaces should be suppressed unless they are necessary to satisfy a minimum length."		C 9/13/07							

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2320-022 (Closed 9/13/07)	Claims were submitted as type of bill 210 or 13G, and the contractors (Cahaba Iowa & Riverbend) adjudicated the claim to deny with beneficiary liability (PR*50 or PR*96). However, the fully denied 837I COB claim contained CAS*CO*A1, with no CAS*PR. **This represents a problem with the 837 flat file creation process and needs to be corrected as soon as possible.**	FISS	00011 - 20635628400 004 - 01/17/07 (TOB 210) 00390 - 20700200514 202 - 01/29/07 (TOB 210) 00011 - 20700821336 102U - 01/15/07 (TOB 13G)	03/19/07	**08/29/07 - Trading Partners are currently receiving these claims.** 03/21/07 - Please see comments in the 'Issue' column, the examples submitted are for TOB 21 and 13. Depending on your response, please identify whether the same should apply for other bill types.	3/27/2007 Disagree. 210 and 13G are both HIPAA compliant bill types. The other codes contained in the issue are HIPAA compliant codes. The HIPAA 837i IG 2320 CAS note does not say the codes used on the 837i must come from the 835 but rather that they should come from the 835 (the 837i 5010 says the codes must). The 2430 CAS also does not say the codes must come from the 835. Therefore, the 837i is HIPAA compliant (the issue language does not claim the 837i is not HIPAA compliant). This is a COB policy issue. CMS can instruct FISS to ensure the 837i COB codes must come from the 835. That would require a CR from the COB folks as the busines owners of COB.		C 9/13/07								
2330A-002	NM109 - Populated with what seems to be the Supplemental ID, but in one instance it took the HICN. Also being truncated to 10 characters.	AB			01/10 - 2330A NM109 will contain the HICN; 2010BA NM109 will contain the supplemental ID, if in the elig. file, otherwise the HICN. This is no longer and issue for the TP, since the Policy number (suppl. ID) will now be in the 2010BA REF segment, where REF01 = IG. This is currently being pulled from 2010BA/NM109, where NM108 = MI. VIPS has a PROB in to pass the supplemental to the REF02, the NM109 will have the HICN	Disagree 10/24/05 - DDIS re-view: Concur with previous comment. Disagree. This should be the HICN from the eligibility file. The other policy number would be reported in the REF. (Comment taken from 2010BA)		C 10/08/04								

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2330A-005	The Social Security Number may not be used as identifier for Medicare	MCS	803 - 02/15/05, ICN - 05040824802000, 05031629129000, 05040608871000, 05031834359000 883 - 02/15/05, ICN - 09050312523 90(2010AA REF01)	02/15/05	in contractor 803 REF*SY*076288208~ was found in 2330A REF01, and in 883 REF*SY*168408298~ was found in 2010AA REF01.	Disagree 10/24/05 - DDIS re-review: Concur with previous comment. Disagree 2/28 - the issue description doesn't say which 2330A it's in. If the SY is in the non-Medicare 2330A then we will change this to a disagree. Agree 2/16.		C 03/22/05	MCS 2/18 - EDS disagrees with the DDIS agree. I agree that the SY may not be used as an identifier for Medicare. However, in these cases, the SY is being sent to a non-Medicare entity, therefore, EDS believes it should be considered valid. The SY is not being sent in the Medicare 2330A it is with an other payer 2330A and in the 2010AA, the record is for the the other insurer not Medicare.						
2330A-006	2330A - REF 01 cannot = 1W when NM108=MI	MCS	05440/03-03-05 (020504575 7670)	03/15/05	Data in inbound contractor file. NM109 and REF02 contained the same value - YVB54022868701; with the MI and 1W qualifier respectively.	Disagree 10/24/05 - DDIS re-review: Concur with previous comment. Disagree 6/1. There is no IG note prohibiting this.		C 08/02/05							
2330B-006	The REF-01 (Identification Code Qualifier) cannot equal "2U" when NM1-08 equals "PI" because both refer to Payer Number	VMS	00803/0928	10/04/04	REF02 = 2U in inbound file	Disagree 10/24/05 - DDIS re-review: Concur with previous comment. Disagree. IG doesn't state that 2U can't be used.		C 12/21/04					12/21 CMS - Sent note to DDIS for review		

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2330B-008	12/2 - Is anything being done to determine if the NAIC code is valid and contained in the external code source? The Payer ID is not a valid NAIC code, so why is it being sent as the Payer's Secondary ID? NM1*PR*2*SAGAMORE*****PI*35164~ REF*NF*35164~ 12/2 - It looks as though the Payer's Payer ID is being put in the 2330B REF segment with a qualifier of 'NF'.	VMS	00630-10/26-04286706571000	11/03/04	The value in the contractor's file - REF01 = NF; REF02 = 35164	Disagree 10/24/05 - DDIS re-review: Concur with previous comment. Disagree 12/2 - that until NPlan ID is implemented we are unable to edit payer ID's for validity. Agree 12/2 - that NF is not a valid qualifier and cannot be used		C 01/18/05	12/01/04 VMS - Segment is situational. Also, the "NF" qualifier may not be used by Medicare but can be sent as informational.	C			12/9 Confernce Call Notes - VMS disagrees with the DDIS agree. The qualifier used is valid per the IG. Brian reviewed the error and reported that this is valid and this error should be removed from the agree and moved to disagree.	IPN(00630)	
2330B-009	Adjudication (EOMB) date on COBA parallel test Claim file is different than the Adjudication date on production claims file DTP*573*D8*20041015~	MCS	00901/(0104261012060)	12/29/2004		Disagree 10/24/05 - DDIS re-review: Concur with previous comment. Disagree 12/30. This isn't related to the implementation guide. Seems like a problem with parallel testing.		C 01/18/05							MARYLAND MEDICAID
2330B-013	INCORRECT ELEMENT IN NM103	FISS	181-2-14-05, ICN - 20502100207402	3/28/05	" . " FOUND ON INBOUND FILE. Error reported by Mass Health.	Disagree 10/24/05 - DDIS re-review: Concur with previous comment. Disagree 3/31. The data is HIPAA compliant. CMS does not edit for valid names in the 2330B loop except to verify the data are syntactically compliant.		C 04/18/05							

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2330B-015	**H10012** - NM103 - Special character '[' in the Tertiary Payer , record type 590 pos 7-41, suggest Fiss 'scrub' the flat file data after created	FISS	00363 - 08/05/05 - 2052160088 0008	8/1/05	09/12/05 - Based on DDIS' 09/08 Disagree, this error code was added to the Faciledi Exclusion list on 09/12/05. 08/26/05 Data appears as '[ABCW' (First char is Hex BA) on the mainframe and 'ABCW' (first char s Hex 8D) when viewed in Faciledi. ABCW appears when viewing the inbound data in faciledi.	Disagree 9/7. This appers to be a Faciledi issue. A "[" (hex BA) is a valid character in the extended character set. 8/25 - We do not understand. GHI's comments say ABCW appears in the field, whereas the issue says a "[" is in the field. Please clarify.		**C 09/30 /05**			Tar #44155		record type 590 pos 7-41, suggest Fiss 'scrub' the flat file data after created		
2330E-003 (Closed 9/13/07)	Trading Partner (Wisconsin Medicaid) has advised its providers to place the Medicaid provider ID within loop 2330-E of the 837 claim to ensure that this information is received on the crossover claim. Per MCS & VMS, this information is not mapped to the 837 flat file, since it falls below the loops in which Medicare is designated as the 'destination payer.' **Apparently, the 2330E (Other Payer Rendering Provider Secondary Identification) is where the Medicaid rendering/performing provider information may be notated. **We surveyed Medicaids to determine what they tell their providers in terms of billing of their provider information. It appears that 99% of those that have	MCS/VMS	to be provided	02/14/07	**08/29/07 - Trading Partners are currently receiving these claims.** 02/14/07 - Please see the comment submitted in the 'Issue' column	2-28-07 DISAGREE - placing the Medicaid data in the 2330E is not compliant and could be considered an abuse of the intent of the transaction.		C 9/13/07	3/09/2007 - VMS: Is it correct to assume you are referring to the Medicare created 2320/2330 loops? If you are referring to the Medicaid 2320/2330 loops, those loops should be removed if Medicaid is the destination payer and the submitter correctly sent the COBA-ID in the 2330B NM109 field.							

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2330G-002	**H45211** - 'Entity Identifier Code' was not expected because the Service Facility Identifier Code (2310D-NM1-01) is not 'FA-Facility' and the Other Payer Service Facility Identifier Code (2330G-NM1-01) is 'FA-Facility'	MCS -	00865_ 08/19 - 4705193613 120	8/19/05	09/12/05 - Based on DDIS' 09/08 Disagree, this error code was added to the Faciledi Exclusion list on 09/12/05. 08/26/05 Spoke to the Claredi contact who explained the error as follows: Faciledi does not expect the 2330G NM101 to be 'FA', because 2310D NM101 was not FA. i.e. both 2310D NM101 and 2330G NM101 should be 'FA' In the inbound file, the 2310D NM101 has a value of 77. 2330G NM101 has a value of FA. Same error as 2420C-003 - see follow-up tab	Disagree 9-8-05. Nowhere in the IG does it state that the value in the 2310D NM1must equal the value in 2330G NM1. 8/25/05 Neither this explanation nor the other is clear. I do not understand what the problem is. Are you saying that the 2330G/2420C loop was not expected because the qualifier is FA? Are you saying that 2330G can't be FA if 2310D is not FA? I do not see any notes in the IG that link or prohibit use of service location qualifiers in other loops. Please be specific in the explanation and cite the IG references/usage notes that make these loops "not expected".		**C 09/30 /05**					The 2330G NM101 and 102 populated correctly. However NM103 thru 111 should not be used per IG. Therefore HGSA feels this error should be excluded.		
2400-004	Hospice Employee Indicator' (CRC 02) was not expected because the Facility Type (CLM-05-1) is not '34-Hospice' and the Place of Service (SV1-05) is not '34-Hospice'	B			Trading Partners that reported this (Cigna, GHI HMO, Regence), can live with it.	Disagree 10/24/05 - DDIS re-review: Concur with previous comment. Disagree. The guide notes this is required on all Medicare claims involving physician services to Hospice patients. It does not note that the data can't be present if the place of service is not hospice. The hospice patient could have been temporarily moved to another facility or visiting home.	pg 411, pg163; Hospice employee indicator present, when facility is office(CLM) and ESRD facility (SV1)	C 09/05 /04							

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2400-009	The 'Ambulance Certification' in Loop 2400 must be different than the 'Ambulance Certification' in Loop 2300	B			09/07/2004 - Discussion with Wellmark and Horizon. Provider # will reject if same for header and lower level?????.	Disagree 10/24/05 - DDIS re-review: Concur with previous comment. Disagree. The guide notes that 2400 is required if it is different than reported at 2300. It does not state that you can't submit 2400 if it is the same.	pg 233 - The CR1 segment in Loop 2300 applies to the entire claim unless the exception is reported in the CR1 segment in Loop 2400	C 09/07/04							
2400-010	Unrecognized segment ID, the service line should be SV2 but the file has SV1	VMS			The Trading Partner reported this as Part A. Further research at GHI determine it to be Part B. TP agreed until it happens again, this error can be ignored. (email of 9/9/04).	Disagree 10/24/05 - DDIS re-review: Concur with previous comment. Disagree. SVD2 is not on the Part B 837 COB. It is on the institutional claim, SV1 is part B.		C 09/09/04							
2400-018	Service Through Date is in the future. DTP*472*RD8*20041007-20041124~	MCS	00885-10/26	11/03/04	Value in contractor's file is 2004100720041124	Disagree 10/24/05 - DDIS re-review: Concur with previous comment. Disagree 11/16: some services (DME) are billed with future dates		C 12/21/04						IPN(00885)	
2400-019	Value of element REF02 (Oxygen Flow Rate) is incorrect. Valid values are '1' - '999' and 'X'.	VMS	00811-10/30	11/10/04	Value in contractor's file 002	Disagree 10/24/05 - DDIS re-review: Concur with previous comment. Disagree 11/16: AN (string) doesn't prohibit leading zeroes		C 12/21/04						Horizon(00811)	
2400-021	Missing mandatory SV202-1, SV202-2	FISS	00400/12/15/04 (20105200805001R(93))	12/17/04	2/10 The Type of Bill type = 11. 02/07 - Additional info sent to DDIS on 01/26. Data missing in the inbound file	Disagree 10/24/05 - DDIS re-review: Concur with previous comment. Disagree 2/10 Update 2/10/05 If SV2 segment is used, then SV202-1 is required. However, since the type of bill is 11 (inpatient) SV202-2 is not required. 1/20 Need more info. Elements are required on outpatient claims. Was this an outpatient claim?		C 02/15/05	2/3/05 - IG says situational, "required for outpatient claims when an appropriate HCPCS exists for the service line item."						Aetna

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2400-022	Value of sub-element SV101-04 has already been used. Procedure modifier codes are expected to be unique for every product/service	MCS	00805 12/22/04 (020434411 0190)	01/05/05	Value in inbound file is 26 for SV101-03 and SV101-04. SV1*HC:93307:26:26*1 08.2*UN*10*21**1~	Disagree 10/24/05 - DDIS re-review: Concur with previous comment. Disagree: The IG doesn't preclude the same modifier from being repeated.		C 01/18 /05							Horizon
2400-024	2400 SV105 Optional facility code ('13', '14' and '49) is not a value in table.	MCS	31141-2/9/2005 ICN 0205027499 410, ICN 0105014016 080 2/15/2005 ICN 0205033577 840	2/9/2005		Disagree 6/28/05 - The IG clearly states that the list is subject to change and that Code Source 237 takes prececedence over the list in the IG. 13 is Assisted Living and 49 is Independent Clinic.		**C 09/30 /05**							
2400-027	**H31000 -** The 'Date - Date Last Seen ' cannot be after the Transaction Set Creation Date BHT04	MCS	00865 - 08/30/05 - ICN 1105227217 050	9/6/05	BHT04 date 08/31/2005. Date last seen 2400 DTP 06/23/2050 (304 qualifier)	9-22-05 Disagree. The IG doesn't specify when the date must be (< or >). This appears to be a typo.		**C 11/02 /05**					HGSA (00865) comments: BHT04 date 08/30/2005. Date last seen 2400 DTP 06/23/2005 and 07/22/2005		
2400-029 (Closed 9/13/07)	H61066:Date - Last X-ray was not expected because the Procedure Code (SV1-01-2) is not between '98940' and '98942'	MCS	00953 - 01/26/06 - 1106023853 630	2/15/06	**08/29/07 - Trading Partners are currently receiving these claims. The error code (H61066) is currently being bypassed.** Trading Partner is not expecting to see the last x-ray date. Data i the file as follows SV1*HC:99213*72*UN*1 *11**1~ DTP*472*D8*20060106~ DTP*455*D8*20050718~ REF*6R*M153873T9670 T1~ 64 AMT*AAE*54.42~	Disagree 3/6/06 - The IG states "required when…", not "required only when…" Trading partner should move extraneous data to repository, if not needed.		C 9/13/ 07							

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2400-032 (Closed 9/13/07)	SV202 - the Trading Partner is stating - required data was missing - The claims were for outpatient services but the procedure code in SV202 was missing. On page 446 the implementation guide states "This data element is required for all Outpatient claims. CLM segment = CLM*HC0017*65.21***71:A:1*Y*A*Y*Y*********Y~ SV2 segment = SV2*0521**65.21*UN*1*0~DTP*472*D8*20060411~ This claim is a rural health clinic, from the CLM05-1 of 71, and the required procedure code in SV202 is missing.	FISS	00400 - 05/16/06 - 20612403401501	6/9/06	**08/29/07 - Trading Partners are currently receiving these claims.** The Trading Partner is stating that the SV202 is missing and is required for all outpatient claims. They have been in contact with CMS staff and still thinks this is an issue. This is being submitted for DDIS' ruling. Comments previously sent to the Trading Partner from CMS: As of April 1, 2005, RHCs and FQHCs are no longer required to report HCPCS codes when billing for RHC and FQHC services they provided. However, RHCs/FQHCs may use HCPCS codes if they wish. No HCPCS code exist that accurately represents the bundle of RHC/FQHC services. In the past FQHCs reported HCPCS codes that were used to sort services into groupings of services, but the codes reported did not accurately represent the services provided. Payment for	08/29/07 - Trading Partners are currently receiving these claims. 06/28/06 Disagree. Per the 4010A1 HIPAA 837i IG, the note for SV202 states: This data element is required for outpatient claims when an appropriate HCPCS exists for the service line item. HCPCS are not required for all outpatient claims. This note is also in the latest draft of version 5010.		C 9/13/07								

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2400-033 (Closed 9/13/07)	Trading Partner is questioning the receipt of claims with multiple diagnosis in the HI segments but then the service line segments always indicate a diagnosis pointer pointing to '1'. They've indicated that this is causing a benefit payment/service issue for their claims processing. They are stating that this information is needed for accurate claims processing in their system. Their comment: "The problem is that we never receive more than one pointer per line, when we have confirmed that more than one pointer applies to the line and should have been transmitted."	MCS	05440 - 11/07/06 - 11062981193 30	2/5/07	**08/29/07 - Trading Partners are currently receiving these claims.** For the ICN example: 2300 HI contains HI*BK:4659*BF:7862*BF:7867*BF:7962~ 2400 SV1 contains SV1*HC:99214*124*UN*1*11**1~ MCS has indicated that they are only sending the SV107-1, and it will remain this way until a user enhancement CR is written and installed.	Disagree 2/13/07 - The IG does not require that multiple pointers be present to adjudicate the claim. However, we recognize that having all diagnosis codes is critical to proper claims adjudication both by Medicare and the COB TPs. Therefore, our processing systems are currenty being modified to indicate that more than 1 diagnosis code was used to adjudicate a line.		C 9/13/07								

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2400-037 Closed 3/27/08	**H60300**:The 'OG-Original Starting Dosage' is only valid for measurement of 'R3-Epoetin Starting Dosage' (MEA-02)	VMS	18003 - 03/12/08 - 08060760890000, 08060761448000	3/17/08	Please see the comments from the Medicare contractor in the "CCMS and Contractor Comments " column, the claims are rejecting back to this and other contractors. Please indicate whether this is a valid error. The value in the two examples provided are as follows: MEA*OG*HT*68~ MEA*OG*HT*64~	3-24-08 **Disagree.** The IG does not stipulate that. bsr		C 03/27/08					**8/27/08 - CMS - Send to disagree closed log. COBVA will be issued. Comments from contractor 18003**: I can see that the OG measurement identifier is not the best choice when you are submitting the height of the patient, but I don't see in the ANSI Guide that the OG can only be used with the R3-Epoetin Starting Dosage qualifier. I think CMS will have to clarify this. If the OG can only be used when the qualifier is R3, then I think we will have to have a new front end critical error and reject the claim from the beginning.		
2420B-001	'Purchased Service Provider Name' was not expected because the Purchased Service Provider Identifier (PS1-01) is not present	MCS	836/0427 ICN 1105103334160	04/29/05	The inbound file contained the 2420B NM1 segment with NM101, NM102, NM108 and NM109 populated. The 2400 PS1 segment was missing	Disagree 10/24/05 - DDIS re-review: Concur with previous comment. Disagree 6/1. There is no IG note prohibiting this.		C 08/02/05							
2420C-001	o Service Facility in 2420C – what does it mean when they have NM1*FA*2* SUBMITTED BUT NOT FORWARD N3* SUBMITTED BUT NOT FORWARD N4* SUBMITTED BUT NOT FORWARD*Subscriber ST*Subscriber ZIP	MCS				Disagree 10/24/05 - DDIS re-review: Concur with previous comment. Disagree. Gap filling		C 12/21/04							

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2420C-003	**H45211** - 'Entity Identifier Code' was not expected because the Service Facility Identifier Code (NM1-01) is not FA and other payer ID is FA.	MCS	00910 - Regence	7/21/05	09/12/05 - Based on DDIS' 09/08 Disagree, this error code was added to the Faciledi Exclusion list on 09/12/05. 08/26/05 Spoke to the Claredi contact who explained the error as follows: Faciledi does not expect the 2420C NM101 to be 'FA', because 2310D NM101 was not FA. i.e. both 2310D NM101 and 2420C NM101 should be 'FA' 08/24 - In the inbound file, the 2310D NM101 has a value of 77. 2330G NM101 has a value of FA. Trying to get better clarification from Claredi. This issue was submitted directly to CMS/DDIS from the Contractors	Disagree 9-8-05. Nowhere in the IG does it state that the value in the 2310D NM1must equal the value in 2420C NM1. 8-25-05 Neither this explanation nor the other is clear. I do not understand what the problem is. Are you saying that the 2330G/2420C loop was not expected because the qualifier is FA? Are you saying that 2330G can't be FA if 2310D is not FA? I do not see any notes in the IG that link or prohibit use of service location qualifiers in other loops. Please be specific in the explanation and cite the IG references/usage notes that make these loops "not expected". 8/05 The issue is not clear as worded. Please clarify further.		**C 09/30 /05**	9/8 - MCS My understanding is that this error was set because the 2330G/NM101 value was FA and the 2420C/NM101 value was LI. The IG does not require these values to be the same. That is why Regence disagrees with the error.						

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2420E-001	Ordering Provider Contact Information' was not expected because neither the Arterial Blood Gas Quantity (CR5-10) nor the Oxygen Saturation Quantity (CR5-11) are present	VMS	00811-10/14; 00635-10/29		11/12/04 - In the contractor files received, the PER is present, even though the Arterial Blood Gas Quantity (CR5-10) and the Oxygen Saturation Quantity (CR5-11) are not there	Disagree 10/24/05 - DDIS re-review: Concur with previous comment. Disagree 11/17: We agree with the interpretation from VMS. The presence of the PER is not an error. 10/00 Agree this is an error.	X-pg538; Required when services involving an oxygen therapy certificate of medical necessity (CMN) is being billed	C 01/18/05	11/12 VMS - describes a PER segment when one was not expected. Our analysis shows that this segment is required under certain circumstances and situational otherwise, but not proscribed. If this is not the case and a front-end edit is required, please advise. 11/08 VMS - The IG states that the PER segment is only required when Arterial Blood Gas Quantity (CR5-10) or the Oxygen Saturation Quantity (CR5-11) are present. Otherwise this is a situational loop and can be sent whenever. If CMS disagrees, VMS can add a front-end edit to only allow the 2420E PER loop when either of the 2 situations are present on the claim.						
2420E-002	There are cases where we are receiving what looks like gap fill in situational loops	VMS	05655 - 08/03/05 - 0520650103 3000 00811 - 08/04/05 - 0519511202 8000 00635 - 08/04/05 - 0516425076 9000 00885 - 08/04/05 - 0518931095 7000	08/04/05	The data in the outbound is a direct translation of the inbound data. NM1*DK*1*XXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXX*XXXXXXX XXXXXXXXXXXXXXXXX X~ N3*XXXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXX~ N4*XXXXXXXXXXXXX XXXXXXXXXXXXXXX*I A*505013909~ REF*1G*U31760~	Disagree 8/11/05 - There is no reason why the contractor would gap fill the "ordering provider" loop. This data was likely submitted to Medicare this way and is compliant per the IG requirements of AN.		**C 09/30 /05**							Highmark(Trading Partner)

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2420E-002a	There are cases where we are receiving what looks like gap fill in situational loops	VMS	05655 - 08/03/05 - 05206501033 000 00811 - 08/04/05 - 05195112028 000 00635 - 08/04/05 - 05164250769 000 00885 - 08/04/05 - 05189310957 000	08/04/05	03/21/07 - Please advise if the 'disagree' decision applies to paper claims only or all claims. The data in the outbound is a direct translation of the inbound data. NM1*DK*1*XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX*XXXXXXXXXXXXXXXXXXXXXXXXX~ N3*XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX~ N4*XXXXXXXXXXXXXXXXXXXXXXXXXXXXX*IA*505013909~ REF*1G*U31760~	3-27-07 We only gap fill for paper claims. Disagree 8/11/05 - There is no reason why the contractor would gap fill the "ordering provider" loop. This data was likely submitted to Medicare this way and is compliant per the IG requirements of AN.		C 09/30/05			CR3255	May 2004			Highmark(Trading Partner)
2420E-003 (Closed 9/13/07	H45233:'Ordering Provider City/State/ZIP Code' was not found, but was expected because the Ordering Provider Address Line (N3-01) is present	MCS	000900 - 10/13/05 - ICN 2205273797 270, 2205273792 920	10/21/05	**08/29/07 - Trading Partners are currently receiving these claims. The error code (H45233) is currently being bypassed for the 2420E loop.** City, state and zip (N4 segment) missing in inbound file. In both cases the N3 segment contained phone and/or fax information. See comment from contractor 00900.	Disagree 11-1-05. The IG does not specify that an N4 segment must be created if an N3 segment is present. The TP needs to relax this edit. In response to comments from 00900…AGREE The IG does not specify how to differentiate an address from a phone number.	**H45233 currently bypassed for Part B**	C 9/13/07					Comments from 000900 - According to the 4010A1 IG, the N4 is not a required segment in the 2420E loop. We do have providers submitting the 2420E loop with an N3 but no N4. It does seem that if an N3 is being submitted, then the N4 would also be sent but that's not the always the case and since neither segment is required according to the IG, we have no edit in place to reject claims that are submitted to us this way. It appears that these providers are using the N3 to submit their telephone numbers which is not correct either but the data they are sending in the N3 is not non-compliant so we can't reject their claims.		

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2420E-003a (Closed 9/13/07)	H45233:'Ordering Provider City/State/ZIP Code' was not found, but was expected because the Ordering Provider Address Line (N3-01) is present	MCS	00952 - 02/02/06 - ICN 2206030088330 00900 - 10/13/05 - ICN 2205273797270, 2205273792920	10/21/05	**08/29/07 - Trading Partners are currently receiving these claims. The error code (H45233) is currently being bypassed for the 2420E loop.** 02/22/05 - Based on discussions in a confrence call with the Trading Partner, COBC and CMS, this is submitted for another review - Trading Partners expects to receive a complete address (street, city, state, zip), if street address is present. In the new example for ICN the data appears as follows. NM1*DK*1*DOWLER*DONALD***MD*24*371206525~ N3*SKILLED NURSING GOOD SAMARITAN~ REF*1G*C37301~ City, state and zip (N4 segment) missing in	Disagree 3/6/06 Absent any new information, this will remain a disagree. Disagree 11-1-05. The IG does not specify that an N4 segment must be created if an N3 segment is present. The TP needs to relax this edit. In response to comments from 00900…AGREE The IG does not specify how to differentiate an address from a phone number.	**H45233 currently bypassed for Part B**	C 9/13/07						Comments from 000900 - According to the 4010A1 IG, the N4 is not a required segment in the 2420E loop. We do have providers submitting the 2420E loop with an N3 but no N4. It does seem that if an N3 is being submitted, then the N4 would also be sent but that's not the always the case and since neither segment is required according to the IG, we have no edit in place to reject claims that are submitted to us this way. It appears that these providers are using the N3 to submit their telephone numbers which is not correct either but the data they are sending in the N3 is not non-compliant so we can't reject their claims.		
2430-005	The Procedure Code '85024' is not a valid CPT or HCPCS Code.	B			Trading Partner that reported this (Cigna, Regence), can live with it. '85024 has been deleted. To report use '85025' (Source - CPT 2003 Prof. Edition)	Disagree 10/24/05 - DDIS re-review: Concur with previous comment. Disagree. Is there a CAS reason code that notes the procedure code is invalid? There are times when an invalid code will be on the COB and the Trading Partner wants all types of claims (rejected, paid, etc)	Not X12 - see Analysis Comments	C 09/09/04							

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2430-006 Updated 3/30/07 disagree closed	The Service Line Paid amounts (2430/SVD-02) and all Service Line Adjustment amounts (2430/CAS) do not equal the 'Line Item Charge' for this Service Line (Loop 2400).	MCS; VMS	16003 - 01/11/07 - 06362972493000 8/16 00590 - 08/04 - 97052009018 60 (MCS); 00910 - 08/05 11052030354 80 (MCS); 00635 - 08/05 52067514850 00 (VMS); 31141-10/04-08042510001 10		01/24/07 - This issue was discussed on conference call with CMS, DDIS, COBC and VMS. It was discussed that H30201 - should not be applied to the following claims - unbundled, bundled. Based on this, this issue is re-submitted for a formal decision by DDIS, with any additional comments.	2-1-07 Disagree. Based on the discussions with OFM and ViPS, we are now aware that the issue involves bundling and unbundling of lines.		C	03/09/07 VMS - Bundling correction going live 3/22/2007	M	VMS: PS6820	VMS: 3/22/07	Bundling Unbundling will not balance and system fix was to identify the bundling and unbundling claims in order to cross claims appropriately.		
2430-008	If the file creation date is 20040909 (see GS04), why would the adjudication date be after (DTP*573*D8*20040913). How could the file be created on Sept 9 and the claims within the file be adjudicated on Sept 13?	FISS	11/22/04 - 00130-11/09-2043021109 0904	09/20/04	The value was in the contractor's file. Note: The ICN was in the contractor's file, but not in the Claims file.	Disagree 10/24/05 - DDIS re-review: Concur with previous comment. Disagree 12/01 - There is nothing in the IG to prohibit the use of a future date for this scenario. Agree 10/00 - that the file creation date would not be before the adjudication date.		C 12/21 /04	MO0066 was created to correct. However, this PAR will most likely be returned due to the fact that this cannot be corrected without major reconstruction to how FISS processes COB/COBC. 11/2 - Still needs to be discussed on HIPAA wrkgrp.						
2430-010	The code 'ZZ-Mutually Defined' is not valid for HIPAA	VMS	05655-01/21/05, ICN-0501382339 3000 00811-01/21/05, ICN-0436387169 8000	01/20/05	ZZ found on inbound file 'SVD*00811*00003159F *ZZ:WW006**150~	Disagree 10/24/05 - DDIS re-review: Concur with previous comment. Disagree 2/10. ZZ is a valid qualifier indicating "workers comp procedures and supply codes". This loop reflects data from a previous other payer. However, the other payer for this iteration of 2430 would should not be Medicare.		C 02/15 /05							

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COBC ISSUES LOG

Yellow = new issue
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2430-011	Claim contains coinsurance at both the line level and the claim level. Is the coinsurance equal to total of both claim and line level coins or was it reported twice? It should be reported at either the line level or claim level.	FISS	52280 - 06/04 - 20514314135004	07/14/05	The values were received in the inbound file.	Disagree 8/8/05. The IG notes on pg 306 do not indicate any overriding line level information. Pg 494 CAS segment has no note about line and claim level info being mutually exclusive.		**C 09/30 /05**							Maryland Medicaid
2430-012	Claim contains incorrect (as we think) coinsurance amount. Medicare paid amount = 1361.20 on line level Line item 9 has coinsurance of 890.57 and that seems too much for coinsurance	FISS	52280 - 06/04 - 20514302639802	07/14/05	The values were received in the inbound file.	Disagree 8/8/05. The IG notes do not indicate that the values must appear to be correct. This is an issue for FISS to review how this value is calculated. This is not a HIPAA error.		**C 09/30 /05**							Maryland Medicaid
GEN-002	We should only receive 5,000 claims per ST-SE but we're receiving up to 9,999 claims			09/16/04	03/09 - Additional validation needs to be done	Disagree 10/24/05 - DDIS re-review: Issue corrected 3/2004. Disagree. The IG recommends limiting the size to 5000 claims, but it is not a requirement. The maximum number of claims segments is agreed to with the trading partner. Is GHI limiting the number claims to what the trading partners wants?		C 04/06 /05	1/13 - This should be corrected with FS4459S2. 12/13 FISS - TAR will be released to the user sites on 2/3/05 with an expected production date of 3/7/05. We also plan to include the EIN issue that has been recently identified as a FISS system problem. 10/00 FISS - The We need to ask GHI how they are handling claims within the ST-SE. A CR will be required to correct this issue.	M	FS4459S2	Prod 2/17, Test 1/27	3/31 CC Notes: Yes, this is no longer a problem		

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GEN-011 Closed 3/27/08	Trading partner is alleging that the Federal TAX ID/EIN when present in the "REF" segment must be 9 digits and conform to the format 999999999 or 99-99999999, as per Internal Revenue Service (IRS) requlations. (NOTE: This conforms to the manner in which the Medicare shared systems edited the 2010AA & 2010AB NM109 segment when the EIN was present there, prior to NPI usage.) Do you agree that the Federal TAX ID/EIN in the "REF" segments, qualified by "EI," must conform to the format specified in the IRS regulations?	FISS MCS VMS	00380 - 12/12/07 - 20733403164 605 03	03/17/08	Because of previous 'Disagree' items (2010AA-022, 2010AB-004, 2010AB-005, 2010BC-003), Trading Partners are currently receiving claims that do not conform to the indicated format. With the upcoming implementation of NPI, an increasing numbere of partners are questioning the receipt of claims in which the EIN/TAX ID does not meet the format indicated in the "Issue" column	3-24-08 Disagree. Formatting of the EIN/SSN is not stipulated in the 837 transactions. Therefore, any data that satisfies the attributes is acceptable. bsr		C 3/27/08						8/27/08 - CMS - Send to disagree closed log. COBVA will be issued.		C. L. Frates

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