CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 4220	**Date: January 25, 2019**
	Change Request 11092

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) directs the Common Working File (CWF) to add a new Coordination of Benefits Agreement (COBA) claims crossover bypass indicator for situations in which a beneficiary once had COBA crossover eligibility but no longer does.

EFFECTIVE DATE: July 1, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 1, 2019

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
R	TOC
R	27/80.5/ Claims Crossover Disposition and Coordination of Benefits Agreement Bypass Indicators

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:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 4220	Date: January 25, 2019	Change Request: 11092

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

EFFECTIVE DATE: July 1, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 1, 2019

I. GENERAL INFORMATION

A. Background: When the Centers for Medicare & Medicaid Services (CMS) designed the national Coordination of Benefits Agreement (COBA) crossover process, it required the Common Working File (CWF) to establish 1 to 2 byte COBA crossover disposition as well as bypass indicators to be used as part of its COBA crossover processing routine. Currently, CWF includes either a COBA crossover disposition indicator or a COBA bypass indicator on each claim that CWF posts to its claims history after reading the details of the Benefits Coordination & Recovery Center (BCRC)-generated COBA Insurance File (COIF). The COIF, which is issued weekly, includes all specifications regarding the types of claims a COBA trading partner wishes to receive or exclude. The presence of any crossover disposition indicator other than "A" (This claim was selected to be crossed over) or "MQ" (Claim was transferred for Medicaid quality project purposes only) indicates that CWF excluded the claim from being crossed over in accordance with the COIF. The presence of a COBA bypass indicator means CWF found a reason to exclude a claim from crossing over before reading all precise line-level details on the claim.

The CMS recently learned that the CWF COBA by-pass indicator "BB" only controls for the lack of a Beneficiary Other Insurance (BOI) record or the BOI auxiliary file contains only BOI records that include a "Y" delete indicator. Therefore, CMS needs to establish a new 2-byte COBA bypass indicator that can be posted when a BOI auxiliary record exists but there are no active BOI entries in place that correspond to a claim's service dates. The CMS is addressing this issue through this instruction.

B. Policy: Effective July 1, 2019, when CWF determines that a beneficiary has one or more BOI auxiliary records that contain an expired termination date that does not correspond to a claim's service dates, it shall create a new 2-byte COBA bypass indicator "BY" to address this situation. CWF shall ensure that the description for the new "BY" COBA bypass indicator reads as follows: BY-- "A BOI record exists, but there are no active BOI entries that correspond to the claim's service dates. Therefore, the claim is bypassed and not crossed over." CWF shall ensure that it displays the new 2-byte COBA bypass indicator within the Health Insurance Master Record (HIMR) on the appropriate claim detail screen (claim detail page 3 or 4, as appropriate). Medicare Administrative Contractors (MACs) shall update their documentation for COBA crossover bypass indicators for provider customer service purposes to include the new "BY" COBA bypass indicator and associated description. The Next Generation Desktop (NGD) contractor shall update its documentation for COBA crossover bypass indicators to include the new "BY" COBA bypass indicator and associated description.

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	
11092.1	Effective July 1, 2019, when CWF determines that a beneficiary has one or more BOI auxiliary records that contain an expired termination date that does not correspond to a claim's service dates, it shall create a new 2-byte COBA bypass indicator "BY" to address this situation.								X	
11092.1.1	CWF shall ensure that the description for the new "BY" COBA bypass indicator reads as follows: BY-- "A BOI record exists, but there are no active BOI entries that correspond to the claim's service dates. Therefore, the claim is bypassed and not crossed over."								X	
11092.2	CWF shall ensure that it displays the new 2-byte COBA bypass indicator within HIMR on the appropriate claim detail screen (claim detail page 3 or 4, as appropriate).								X	
11092.3	MACs shall update their documentation for COBA crossover bypass indicators for provider customer service purposes to include the new "BY" COBA bypass indicator and associated description.	X	X	X	X					RRB-SMAC
11092.3.1	The NGD contractor shall update its documentation for COBA crossover bypass indicators to include the new "BY" COBA by-pass indicator and associated description.									NGD

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, 410-786-2487 or 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

Medicare Claims Processing Manual
Chapter 27 - Contractor Instructions for CWF

Table of Contents
(Rev.4220, Issued: 01-25-19)

80.5 - Claims Crossover Disposition and Coordination of Benefits Agreement Bypass Indicators

(Rev. 4220, Issued: 01-25-19, Effective: 07-01-19, Implementation: 07-01-19)

1. Claims Crossover Disposition Indicators

Effective with the October 2004 systems release, when a COBA trading partner is in production mode (Test/Production Indicator sent via the COIF submission=P), CWF shall annotate each processed claim on detailed history in the HIMR with a claims crossover disposition indicator after it has applied the COBA trading partner's claims selection criteria. (See the table below for a listing of the indicators.) In addition, when a COBA trading partner is in production mode, CWF shall annotate each processed claim with a 10-position COBA ID (5-digit COBA ID preceded by 5 zeroes) to identify the entity to which the claim was crossed or not crossed, in accordance with the terms of the COBA.

Effective with October 2006, the CWF maintainer updated its data elements/documentation to capture the revised descriptor for crossover disposition indicators "E," as reflected below. In addition, the CWF maintainer shall update its data elements/documentation to capture the newly added "R," "S," "T," "U," and "V" crossover disposition indicators, as reflected in the Claims Crossover Disposition Indicators table below.

Effective with July 2007, the CWF maintainer updated its data elements/ documentation to capture the newly added "W," "X," and "Y" crossover disposition indicators, as well as all other changes, reflected in the table directly below.

As reflected in the table below, the CWF maintainer created crossover disposition indicators "Z" and "AA" to be effective October 1, 2007. The CWF maintainer created a new "AC" crossover disposition indicator as part of its COBA claims selection processing effective April 1, 2008.

Effective January 5, 2009, the CWF maintainer created crossover disposition indicators "AD" and "AE," as indicated in the table below. The CWF shall utilize the "AD" indicator when an incoming claim does not meet any of the new adjustment, mass adjustment, or recovery audit contractor (RAC)-initiated adjustment inclusion criteria, as specified in §80.8 of this chapter. The CWF shall utilize the "AE" indicator when the COBA trading partner specifies that it wishes to exclude RAC-initiated adjustments and CWF does **not** otherwise exclude the claim for some other reason identified higher within its crossover exclusion logic hierarchy.

Effective with the July 2009 release, the CWF maintainer shall display all auto-exclude/COBA by-pass events, as detailed below, in association with an adjudicated claim within the COBA bypass field on page 3 of the HIMR intermediary claim detail screen and on page 2 of the HIMR Part B and DMEL detail screen.

The CWF shall, in addition, create and display a new "BT" crossover disposition exclusion indicator on pages 2 and 3 of the HIMR claim detail screens, as appropriate, effective with July 2009.

Additionally, the CWF maintainer shall create additional fields within claim page 3 of the HIMR intermediary claim detail screen and page 2 of the Part B and DMEL claim detail screens to allow for the reporting of crossover disposition indicators in association with "test" COBA crossover claims. The CWF maintainer shall 1) create additional fields for displaying "test" crossover disposition indicators within both the eligibility file-based and claim-based crossover portions of the claim detail screens on HIMR; and 2) display the "test" crossover disposition indicators so that they mirror all such indicators used for "production" claims in association with the following four (4) claim versions: 4010A1, 5010, National Council for Prescription Drug Programs (NCPDP)-5.1, and NCPDP-D.0.

IMPORTANT: If the BCRC transmits a COIF that contains a COBA ID within the range 79000 through 79999 (Medicaid quality project), CWF shall post an "MQ" disposition indicator in association with the claim instead of the traditional "A" indicator when it selects the claim for crossover. (**NOTE:** "MQ" shall designate that Medicare is transferring the claim for Medicaid quality project purposes only.) CWF shall annotate claims whose COBA ID is 79000 through 79999 with "MQ" regardless of the claim version indicator in those instances where it selects the claims for crossover to the BCRC. CWF shall also annotate the claims with MQ if the COBA ID is marked on the COIF as being in test (T) or production (P) mode. If CWF excludes from crossover a claim where the COBA ID equals 79000 through 79999, CWF shall continue to post the crossover disposition indicator that corresponds to the reason for the exclusion on the appropriate HIMR claim detail screen.

Effective January 4, 2010, CWF shall apply the newly developed crossover disposition indicator "AF" (see below) to incoming Part B original and adjustment fully paid claims, without deductible and co-insurance, when those claims contain denied service lines where the beneficiary has no liability.

Claims Crossover Disposition Indicator	**Definition/Description**
A	This claim was selected to be crossed over.
B	This Type of Bill (TOB) excluded.
C	Non-assigned claim excluded.
D	Original Fully Paid Medicare claims without deductible and co-insurance remaining excluded.
E	Original Medicare claims paid at greater than 100% of the submitted charges without deductible or co-insurance remaining excluded (Part A). **Also covers the exclusion of Original Medicare claims paid at greater than 100% of the submitted charges excluded for Part B ambulatory surgical center (ASC) claims, even if deductible or co-insurance applies.
F	100% denied claims, with no additional beneficiary liability excluded.
G	100% denied claims, with additional beneficiary liability excluded.
H	Adjustment claims, monetary, excluded (not representative of mass adjustments).
I	Adjustment claims, non-monetary/statistical, excluded (not representative of mass adjustments).
J	MSP claims excluded.
K	This claim contains a provider identification number (ID) or provider state that is excluded by the COBA trading partner.
L	Claims from this A/B MAC or DME MAC ID excluded.
M	The beneficiary has other insurance (such as Medigap, supplemental, TRICARE, or other) that pays before Medicaid. Claim excluded by Medicaid.
N	NCPDP claims excluded.
O	All Part A claims excluded.
P	All Part B claims excluded.
Q	All DME MAC claims excluded.

R	Adjustment claim excluded because original claim was not crossed over.
S	Adjustment fully paid claims with no deductible or co-Insurance remaining excluded.
T	Adjustment Claims, 100% Denied, with no additional beneficiary liability excluded.
U	Adjustment Claims, 100% Denied, with additional beneficiary liability excluded.
V	MSP cost-avoided claims excluded.
W	Mass Adjustment Claims—Medicare Physician Fee Schedule (MPFS) excluded.
X	Mass Adjustment Claims—Other excluded.
Y	Archived adjustment claim excluded.
Z	Invalid Claim-based Medigap crossover ID included on the claim.
AA	Beneficiary identified on Medigap insurer eligibility file; duplicate Medigap claim-based crossover voided
AB	**Not Used**; already utilized in another current CWF application or process.
AC	All adjustment claims excluded.
AD	Adjustment inclusion criteria not met.
AE	Recovery audit A/B MAC or DME MAC (RAC)-initiated adjustment excluded.
BT	Individual COBA ID did **not** have a matching COIF.
MQ	Claim transferred for Medicaid quality project purposes only.
AF	Fully reimbursable claim containing denied lines with no beneficiary liability excluded.
AV	Void/cancel claim suppressed because the original claim was excluded

2. COBA By*p*ass Indicators

Effective with the October 2008 release, the CWF maintainer shall display COBA b*yp*ass indicators in association with claims posted on HIMR. These indicators will appear on page 2 of the PTBH and DMEH screens and on page 3 of the INPH, OUTH, HHAH, or HOSH screens. The COBA Bypass Indicators appear in the table directly below.

Effective with the July 2009 release, the CWF maintainer shall additionally display bypass indicators BA, BB, BC, BD, BE, BF, BP, and BR on the appropriate detailed screens (PTBH or DMEH; INPH, OUTH, HHAH, or HOSH) on HIMR.

Effective with the October 2010 release, the CWF maintainer shall display the new "BG" COBA *b*ypass indicator on the appropriate claim detail screens (PTBH, DMEH, INPH, OUTH, HHAH, or HOSH) on HIMR.

Effective April 1, 2013, the CWF maintainer shall display the new "BX" COBA *byp*ass indicator on the appropriate claim detail screens (PTBH, DMEH, INPH, OUTH, HHAH, or HOSH) on HIMR.

Effective July 1, 2019, the CWF maintainer shall display the new "BY" COBA bypass indicator on the appropriate claim detail screens (PTBH, DMEH, INPH, OUTH, HHAH, or HOSH) on HIMR.

Claims Crossover Bypass Indicator	Definition/Description
BA	Claim represents an "Add History" only (action code 7 on HUOP claims; entry code 9 on HUBC and HUDC claims). Therefore, the claim is bypassed and not crossed over.
BB	Claim falls into one of two situations: 1) there is no eligibility record (exception: if HUBC or HUDC claim has a Medigap claim-based COBA ID); **or** 2) the only available eligibility record contains a "Y" delete indicator. Therefore, the claim is bypassed and not crossed over.
BC	Claim represents an abbreviated encounter record (TOB=11z; condition code=04 or 69); therefore, the claim is bypassed and not crossed over.
BD	Claim contains a Part B/DME MAC CWF claim disposition code other than 01, 03, or 05; therefore, the claim is bypassed and not crossed over.
BE	Submission of Notice of Elections [NOEs] (Hospice—TOB= 8xA through 8xE on HUHC; CEPP—TOB=11A through 11D on HUIP; Religious Non-Medical Care—TOB=41A, 41B, and 41D on HUIP; Medicare Coordinated Care – TOB=89A and 89B on HUOP). Therefore, the submission is bypassed and not crossed over.
BF	Claim represents an excluded demonstration (DEMO) project; therefore, the claim is bypassed and not crossed over.
BG	CWF auto-excluded the claim because it was adjudicated with an "OA" Claim Adjustment Segment (CAS) Group code for **all** denied lines or services.
BN	CWF auto-excluded the claim because it contained a placeholder provider value.
BP	Sanctioned provider claim during service dates indicated; therefore, the claim is bypassed and not crossed over.
BQ	CWF auto-excluded the claim because it contained only PQRS codes.
BR	Submission for Request for Anticipated Payment [RAP] claims (TOB=322 and 332); therefore, the submission is bypassed and not crossed over.
BX	Non-compliant ICD DX code on claim; therefore, the claim is by-passed and not crossed over.
BY	*A BOI record exists, but there are no active BOI entries that correspond to the claim's service dates. Therefore, the claim is bypassed and not crossed over.*