CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3765	**Date: May 5, 2017**
	Change Request 9967

SUBJECT: Modifications to the Common Working File (CWF) In Support of the Coordination of Benefits Agreement (COBA) Crossover Process

I. SUMMARY OF CHANGES: The Centers for Medicare & Medicaid Services (CMS) is writing this instruction to separate the Common Working File (CWF) system's exclusion logic for monetary/statistical adjustment claims from its logic for selection of voided/cancelled institutional claims. The CMS is also writing this instruction to ensure that CWF is marking Medicaid Quality Project claims consistently within the Health Insurance Master Record claims history.

EFFECTIVE DATE: October 1, 2017
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 2, 2017

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	27/80.15- Claims Crossover Disposition and Coordination of Benefits Agreement By-Pass 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: 3765	Date: May 5, 2017	Change Request: 9967

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I. GENERAL INFORMATION

A. Background: Through this instruction, the Centers for Medicare & Medicaid Services (CMS) makes two (2) changes to the Coordination of Benefits Agreement (COBA) claims crossover process: Separating the Common Working File (CWF) logic for exclusion of non-monetary/statistical adjustment claims from the logic for selection of void/cancel only claims**;** and modifying CWF so that it will consistently apply the same Medicaid Quality Project crossover disposition indicator to claims posted in the Health Insurance Master Record (HIMR) detailed claims history.

The CWF system currently excludes inpatient hospital (INPL), outpatient hospital (OUTL), home health (HHAL), and hospice (HOSL) void/cancel only claims (Action Code 4) from the COBA crossover process if a COBA trading partner excludes monetary/statistical adjustment claims. Under current logic CWF posts an "I" crossover disposition indicator to the INPL, OUTL, HHAL, and HOSL claims detail screens when a COBA trading partner **excludes** adjustment monetary/statistical claims. CWF takes this same action if that exclusion criterion is met and a Part A or Home Health & Hospice (HH&H) Medicare Administrative Contractor (MAC) takes action to cancel/void an institutional facility claim. The CMS has determined CWF needs to select voided/cancelled institutional facility claims even if a COBA trading partner excludes monetary/statistical adjustment claims under the COBA process. The CMS is addressing this issue through this instruction.

Through this instruction, the CMS re-adds the pre-existing language for crossover disposition indicator "AV" (Void/cancel claim suppressed because the original claim was excluded), which was created through CMS Change Request (CR) 8878 and was erroneously removed from CMS's Internet Only Manual.

With the implementation of CR 6343, CMS made it possible for Medicare to transfer all adjudicated claims for dual Medicare-Medicaid beneficiaries to each State's Medicaid program for coordinated care quality review purposes. This transfer is accomplished using the mechanics of the COBA crossover process. For Medicare-Medicaid coordinated care transfers, CWF should always post an "MQ" disposition indicator (defined as "Claim transferred for Medicaid quality project purposes only") as opposed to an "A" crossover disposition indicator ("Claim was selected to be crossed over") on the HIMR detailed claims history screens. The CMS is correcting this issue through this instruction.

B. Policy: Effective with this instruction, CWF shall modify its "I" crossover disposition logic for INPL, OUTL, HHAL, and HOSL claims. This change in logic will make certain that CWF applies an "I" disposition indicator only when it reads the COBA Insurance File (COIF) and determines the COBA trading partner wants to exclude adjustment claims, non-monetary/statistical. CWF shall make certain that all pre-existing "AV" crossover disposition logic will remain unchanged. The "AV" logic assures that Medicare does not cross over Part A void/cancel claims if CWF previously excluded the associated original claim. When CWF receives an Action Code 4 from a MAC (Part A, HH&H) on a previously processed INPL, OUTL, HHAL, or HOSL claim, it shall select the claim for the Medicare crossover process, unless the COIF specifies exclusion of applicable Type of Bills (TOBs) or Part A claims globally. In selecting the claim for crossover, CWF shall follow its normal processes for posting the "A" crossover disposition indicator on HIMR and returning the Beneficiary Other Insurance (BOI) reply trailer 29 to the MAC (Part A, HHH). All

shared system processes resulting from the receipt of a BOI reply 29 trailer are unchanged.

In the context of the Medicaid Quality Project, when CWF receives a weekly COIF that contains a COBA ID in the range 79000 through 79999, it shall take the following actions as applicable:

- Determine if the COIF contains any exclusion criteria for the COBA ID and then apply the exclusion criteria;
- Select the claim and apply crossover disposition indicator "MQ" when posting the claim to the HIMR detailed claims history if these two (2) conditions are met:
  1) The COBA trading partner has specified no claims exclusions, as per the COIF; and 2) The COBA trading partner is either in test or production mode, as noted by a "T" or "P" Test/Production indicator on the COIF.

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	
9967.1	CWF shall modify its "I" crossover disposition logic for INPL, OUTL, HHAL, and HOSL claims so that the logic is only applied when the COIF tied to a given COBA ID specifies exclusion for adjustment claims, non-monetary/statistical.								X	
9967.1.1	CWF shall make certain that all pre-existing "AV" crossover disposition logic will remain unchanged. (**NOTE:** The "AV" logic assures that Medicare does not cross over Part A void/cancel claims when CWF excluded the associated original claim.)								X	
9967.1.2	When CWF receives an Action Code 4 from a MAC (Part A, HHH) on a previously processed INPL, OUTL, HHAL, or HOSL claim, it shall select the claim for the Medicare crossover process unless the COIF specifies exclusion of applicable TOB claims or Part A claims globally or unless requirement 9967.1.1 applies.								X	
9967.1.3	In selecting the claim for crossover, CWF shall follow its normal processes for posting the "A" crossover disposition indicator on HIMR and returning the BOI reply trailer 29 to the MAC (Part A, HHH).								X	
9967.2	In the context of the Medicaid Quality Project, when CWF receives a weekly COIF that contains a COBA ID in the range 79000 through 79999, it shall take the								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	following actions as applicable: • Determine if the COIF contains any exclusion criteria for the COBA ID and then apply the exclusion criteria; • Select the claim and apply crossover disposition indicator "MQ" when posting the claim to the HIMR detailed claims history if these two (2) conditions are met: 1) The COBA trading partner has specified no claims exclusions, as per the COIF; and 2) The COBA trading partner is either in test or production mode, as noted by a "T" or "P" Test/Production indicator on the COIF.									

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: N/A

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

80.15 - Claims Crossover Disposition and Coordination of Benefits Agreement By-Pass Indicators

(Rev. 3765, Issued: 05-05-17, Effective: 10-01-17, Implementation: 10-02-17)

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 §80.18 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-Pass Indicators

Effective with the October 2008 release, the CWF maintainer shall display COBA bypass 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 by-pass 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 By-pass 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 By-pass indicator on the appropriate claim detail screens (PTBH, DMEH, INPH< OUTH, HHAH, or HOSH) on HIMR.

Claims Crossover By-Pass 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 BX	Submission for Request for Anticipated Payment [RAP] claims (TOB=322 and 332); therefore, the submission is bypassed and not crossed over. Non-compliant ICD DX code on claim; therefore, the claim is by-passed and not crossed over.