CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1296	**Date: JULY 18, 2007**
	Change Request 5569

NOTE: Transmittal 1232 dated April 27, 2007 is being rescinded and replaced by Transmittal 1296 dated July 18, 2007. Chapter 28, Section 70.6 has been revised to include updated information from CR 5656 that implements August 6, 2007. All other information remains the same.

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

I. SUMMARY OF CHANGES: Through this instruction, CMS is modifying its Common Working File (CWF) exclusion logic for 100 percent denied claims for COBA crossover purposes; updating a portion of its full claim file repair requirements; and modifying its special provider notification letters. Finally, CMS is changing the CWF logic that is applied to exclude home health prospective payment system (HHPPS) types of bills 329 and 339, and to reject non-assigned supplier claims when the beneficiary has both Medicare and Medicaid entitlement.

New / Revised Material
Effective Date: October 1, 2007
Implementation Date: October 1, 2007

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	27/80.14/ Consolidated Claims Crossover Process
R	28/70.6/ Consolidation of the Claims Crossover Process
R	28/70.6.1/Coordination of Benefits Agreement (COBA) Detailed Error Report Notification Process
R	28/70.6.2/Coordination of Benefits Agreement (COBA) Full Claim File Repair Process

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1296	Date: April 27, 2007	Change Request: 5569

NOTE: Transmittal 1232 dated April 27, 2007 is being rescinded and replaced by Transmittal 1296 dated July 18, 2007. Chapter 28, Section 70.6 has been revised to include updated information from CR 5656 that implements August 6, 2007. All other information remains the same.

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

Effective Date: October 1, 2007

Implementation Date: October 1, 2007

I. GENERAL INFORMATION

A. Background: Currently, the Common Working File (CWF) reads one of three non-payment indicators (N, R, or B) that each contractor includes on its HUIP, HUOP, HUHH, or HUHC claim transmission for purposes of excluding fully denied claims with or without beneficiary liability. The CMS has determined that this exclusion logic is **not** resulting in the suppression of fully denied Part A claims with or without beneficiary liability. Therefore, CMS is modifying CWF's exclusion logic for fully denied claims with and without beneficiary liability through this instruction.

In accordance with Transmittals 138 (CR 3218) and 533 (CR 3842), the CWF currently rejects non-assigned supplier claims back to Durable Medical Equipment Regional Medicare Administrative Contractors (DMACs) when it determines that beneficiary's claim has been identified for crossover to a State Medicaid Agency that is currently in COBA production. In such situations, CWF not only rejects the claim with edit 5248 but also sends a Medicaid reply trailer (36) to the DMAC. The latter action prompts the DMAC's system to change the provider assignment code and retransmit the claim to CWF. These systematic actions shall be discontinued effective with this instruction.

Effective with October 1, 2007, CWF shall cease by-passing its logic to exclude Part A adjustment claims, fully (100 percent) paid, in association with home health prospective payment system (HHPPS) types of bills 329 and 339. The CWF shall also exclude such claims if the COBA Insurance File (COIF) designates that the trading partner wishes to exclude either 'original claims fully paid without deductible or co-insurance remaining' or 'adjustment claims fully paid without deductible or co-insurance remaining.'

With the implementation of Transmittal 1189 (CR 5472), contractors are now required to include the specific error rejection code and accompanying description on the special letters they generate to providers when the COBC does not cross claims over due to errors relating to Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X-12N 837 compliance and other data content difficulties. The CMS will further modify the language included within those letters through the issuance of this communication.

Finally, through this instruction, CMS is modifying a portion of its full claim file repair requirements, as found in Transmittal 837, CR 4277.

B. Policy: Effective with this instruction, the CWF maintainer shall create a 1-byte beneficiary liability indicator field within the header of its HUIP, HUOP, HUHH, and HUHC Part A claims transactions (valid values= "L," "N," or space). As Part A contractors adjudicate claims and determine that the beneficiary has

payment liability for any part of the fully denied services or service lines, they shall set an "L" indicator within the newly created beneficiary liability field in the header of their HUIP, HUOP, HUHH, and HUHC claims that they transmit to CWF. As Part A contractors adjudicate claims and determine that the beneficiary has no payment liability for any of the fully denied services or service lines—that is, the provider must absorb all costs for the fully denied claims—they shall include an "N" indicator within the newly designated beneficiary liability field in the header of their HUIP, HUOP, HUHH, and HUHC claims that they transmit to CWF. NOTE: Part A contractors shall not set the "L" or "N" indicator on partially denied/partially paid claims.

Upon receipt of an HUIP, HUOP, HUHH, or HUHC claim that contains an "L" or "N" beneficiary liability indicator, CWF shall read the COIF to determine whether the COBA trading partner wishes to receive 'original' fully denied claims with beneficiary liability (crossover indicator "G") or without beneficiary liability (crossover indicator "F") or 'adjustment' fully denied claims with beneficiary liability (crossover indicator "U") or without beneficiary liability (crossover indicator "T"). If CWF determines that the COBA trading partner wishes to exclude the claim, as per the COIF, it shall suppress the claim from the crossover process and shall post the appropriate crossover disposition indicator in association with the adjudicated claim on the Health Insurance Master Record (HIMR) detailed history screen. In addition, the CWF maintainer shall create and display the new 1-byte beneficiary liability indicator field within the INPL, OUTL, HHAL, and HOSL detailed history screens, to illustrate the indicator ("L" or "N") that appeared on the incoming HUIP, HUOP, HUHH, or HUHC claim transaction.

The CWF shall no longer apply edit 5248 to HUDC non-assigned claims nor return a Medicaid reply trailer 36 to the DMAC to prompt a modification of the provider assignment indicator when it determines that the affected beneficiaries are identified for crossover to a State Medicaid Agency that is in COBA production mode. Instead, if CWF receives a non-assigned HUDC claim for which there is a corresponding COBA identification number (ID) in the "Medicaid" range (70000-77999), it shall now only return a Beneficiary Other Insurance (BOI) reply trailer (29) to the DMAC for the claim if the COIF specifies that the State Medicaid Agency wishes to receive a non-assigned crossover claim. Otherwise, the CWF shall exclude the claim for crossover, as per the COIF, and post the appropriate crossover disposition exclusion indicator for the claim (crossover indicator "C") within the appropriate HIMR detailed history screen. Additionally, DMACs shall no longer modify the provider assignment indicator on incoming non-assigned claims for durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) for which there is a corresponding COBA ID in the "Medicaid" range (70000-77999). (NOTE: The foregoing policy does not apply to claims that Part B contractors, including carriers and MACs, adjudicate using pricing from the Medicare Physician Fee Schedule [MPFS].)

Effective with this instruction, CMS is developing modified standard language that contractors shall use within their special provider notification letters that are generated following their receipt of the COBC Detailed Error Report. CMS also clarifies one of its requirements relating to the full claim file repair process, as outlined in CR 4277, to address situations where CMS would authorize a claims repair process for claims whose "222" and "333" error percentages fall below established parameters.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)							
		A/B MAC	DME MAC	FI	CAL DMERC	DME MAC	RHHI	Shared-System Maintainers	OTHER

								FISS	MCS	VMS	CWF	
5569.1	The CWF maintainer shall create a 1-byte beneficiary liability indicator field within the header of its HUIP, HUOP, HUHH, and HUHC Part A claims transactions (valid values= "L," "N," or space).										X	
5569.1.1	As Part A contractors adjudicate claims and determine that the beneficiary has payment liability for any part of the fully denied services or service lines, they shall set an "L" indicator within the newly created beneficiary liability field in the header of their HUIP, HUOP, HUHH, and HUHC claims that they transmit to CWF.	X		X			X	X				
5569.1.2	As Part A contractors adjudicate claims and determine that the beneficiary has no payment liability for any of the fully denied services or service lines—that is, the provider must absorb all costs for the fully denied claims—they shall include an "N" beneficiary indicator within the designated field in the header of their HUIP, HUOP, HUHH, and HUHC claims that they transmit to CWF.	X		X			X	X				
5569.1.3	Part A contractors shall not set the "L" or "N" indicator on partially denied/partially paid claims.	X		X			X	X				
5569.2.1	Upon receipt of an HUIP, HUOP, HUHH, or HUHC claim that contains an "L" or "N" beneficiary liability indicator, CWF shall read the COIF to determine whether the COBA trading partner wishes to receive "original" fully denied claims with beneficiary liability (crossover indicator "G") or without beneficiary liability (crossover indicator "F") or "adjustment" fully denied claims with beneficiary liability (crossover indicator "U") or without beneficiary liability (crossover indicator "T").										X	
5569.2.2	CWF shall deploy the same logic for excluding Part A fully denied "original" and "adjustment" claims with or without beneficiary liability as it now utilizes to exclude fully denied 'original' and 'adjustment' Part B and DMAC claims with and without beneficiary liability, as specified in CR 5094.										X	
5569.2.3	If CWF determines that the COBA trading partner wishes to exclude the claim, as per the COIF, it shall suppress the claim from the crossover process.										X	
5569.2.3.1	CWF shall post the appropriate crossover										X	

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMAC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	disposition indicator in association with the adjudicated claim on the Health Insurance Master Record (HIMR) detailed history screen.											
5569.2.3.2	In addition, the CWF maintainer shall create and display the new 1-byte beneficiary liability indicator field within the HIMR detailed history screens (INPL, OUTL, HHAL, and HOSL), to illustrate the indicator ("L" or "N") that appeared on the incoming HUIP, HUOP, HUHH, or HUHC claim transaction.										X	
5569.2.4	If a Part A contractor sends values other than "L," "N," or space in the newly defined beneficiary liability field in the header of its HUIP, HUOP, HUHH, or HUHC claim, CWF shall reject the claim back to the Part A contractor for correction.										X	
5569.2.4.1	The Part A contractor shall change the incorrect value placed within the newly defined beneficiary liability field and retransmit the claim to CWF.	X		X			X	X				
5569.3	When CWF receives a non-assigned HUDC claim for which there is a corresponding COBA ID in the "Medicaid" range (70000-77999), and the State Medicaid Agency is determined to be in COBA production, it shall no longer reject the claim with edit 5248 and return a Medicaid reply trailer (36) to the DMAC.										X	
5569.3.1	In lieu of this procedure, CWF shall only return a BOI reply trailer (29) to the DMAC for the claim if the COIF for the State Medicaid Agency indicates that the entity wishes to receive non-assigned claims. **NOTE**: Most Medicaid agencies will not accept such claims for crossover purposes.										X	
5569.3.2	If CWF determines via the corresponding COIF that the State Medicaid Agency does not wish to receive non-assigned claims, it shall exclude the claim for crossover, as per CR 3218.										X	
5569.3.2.1	In addition, CWF shall mark the excluded claim with its appropriate claims crossover disposition indicator (crossover indicator "C") and store the claim with that information within the appropriate HIMR detailed history screen.										X	
5569.3.3	The DMACs shall no longer modify the provider assignment indicator on incoming non-assigned		X			X				X		

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMAC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	supplier claims for which there is a corresponding COBA ID in the "Medicaid" range (70000-77999).											
5569.3.4	If CWF erroneously returns an edit 5248 or Medicaid reply trailer 36 from CWF, the DMACs shall take no action to modify the claim's provider assignment indicator.		X			X				X		
5569.4	CWF shall cease by-passing its logic to exclude Part A adjustments claims, fully (100 percent) paid, in association with home health prospective payment system (HHPPS) types of bills 329 and 339 (final bills).										X	
5569.4.1	The CWF shall also exclude such claims if the COIF designates that the trading partner wishes to exclude either 'original claims fully paid without deductible or co-insurance remaining' or 'adjustment claims fully paid without deductible or co-insurance remaining.'										X	
5569.5	All contractors shall modify their provider notification letters generated for "111," "222," and "333" error situations to include the following standard language within the opening paragraph of their letters: "The claim(s) noted below was/were not crossed over due to claim data errors or was/were rejected by the supplemental insurer."	X	X	X	X	X	X	X	X	X		
5569.5.1	Contractors shall reformat their provider notification letters to ensure that, in addition to the newly revised standard language in requirement 5569.5, they continue to include the rejection code and accompanying description, as derived from the COBC Detailed Error Report, for "222" or "333" errors in association with each errored claim.	X	X	X	X	X	X	X	X	X		
5569.5.2	Contractors shall cease including the language provided in CR 5472, requirement 7.5 in association within their provider notification letters that are created for "111" error situations.	X	X	X	X	X	X	X	X	X		
5569.6	With respect to the full claims file repair process (see CR 4277), contractors and their systems shall have the capability to initiate a claims repair process, internally or at CMS direction, for situations in which they encounter high volume "222" or "333" error rejections that do not meet	X	X	X	X	X	X	X	X	X		

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMAC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	or exceed the established error threshold parameters.											
5569.6.1	Before initiating a claims repair for error situations that fall below the established percentage parameters, contractors shall first contact a member of the CMS COBA team to obtain clearance for that process.	X	X	X	X	X	X					
5569.6.2	Contractors shall have the capability to suppress their provider notification letters for a timeframe of up to 14 work days, or longer at CMS direction, where they initiate a claims repair process when claims with "222" or "333" errors fall below the "normally established" four (4) percent threshold.	X	X	X	X	X	X	X	X	X		

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMAC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	None.	X	X	X	X	X	X					

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements:
"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

B. For all other recommendations and supporting information:

V. CONTACTS

Pre-Implementation Contact(s): Brian Pabst (brian.pabst@cms.hhs.gov; 410-786-2487)

Post-Implementation Contact(s): Brian Pabst (brian.pabst@cms.hhs.gov; 410-786-2487)

VI. FUNDING

A. ***For Fiscal Intermediaries, Carriers, and the Durable Medical Equipment Regional Carrier (DMAC)*****:**
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

B. ***For Medicare Administrative Contractors (MAC)*****:**

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). 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.

80.14 - Consolidated Claims Crossover Process

(Rev.1296, Issued: 07-18-07, Effective: 10-01-07, Implementation: 10-01-07)

A. The Mechanics of the CWF Claims Selection Process and BOI and Claim-based Reply Trailers

1. CWF Receipt and Processing of the Coordination of Benefits Agreement Insurance File (COIF)

Effective July 6, 2004, the COBC will begin to send copies of the Coordination of Benefits Agreement Insurance File (COIF) to the nine CWF host sites on a weekly basis. The COIF will contain specific information that will identify the COBA trading partner, including name, COBA ID, address, and tax identification number (TIN). It will also contain each trading partner's claims selection criteria exclusions (claim or bill types that the trading partner does not want to receive via the crossover process) along with an indicator (Y=Yes; N=No) regarding whether the trading partner wishes its name to be printed on the Medicare Summary Notice (MSN). During the COBA parallel production period, which is estimated to run from July 6, 2004, to October 1, 2004, CWF will exclusively return an "N" MSN indicator to the Medicare contractor.

The CWF shall load the initial COIF submission from COBC as well as all future weekly updates.

Upon receipt of a claim, the CWF shall take the following actions:

a. Search for a COBA eligibility record on the BOI auxiliary record for each beneficiary and obtain the associated COBA ID(s) [NOTE: There may be multiple COBA IDs];

b. Refer to the COIF associated with each COBA ID (NOTE: CWF shall pull the COBA ID from the BOI auxiliary record) to obtain the COBA trading partner's name and claims selection criteria;

c. Apply the COBA trading partner's selection criteria; and

d. Transmit a BOI reply trailer 29 to the Medicare contractor <u>only</u> if the claim is to be sent, via 837 COB flat file or National Council for Prescription Drug Programs (NCPDP) file, to the COBC to be crossed over. (See Pub.100-04, Chap. 28, §70.6 for more information about the claim file transmission process involving the Medicare contractor and the COBC.)

Effective with the October 2004 systems release, CWF shall read the COIF submission to determine whether a Test/Production Indicator "T" (test mode) or "P" (production mode) is present. CWF will then include the Test/Production Indicator on the BOI reply trailer 29 that is returned to the Medicare contractor. (See additional details below.)

2. BOI Reply Trailer 29 Processes

For purposes of eligibility file-based crossover, if CWF selects a claim for crossover, it shall return a BOI reply trailer 29 to the Medicare contractor. The returned BOI reply trailer 29 shall include, in addition to COBA ID(s), the COBA trading partner name(s), an "A" crossover indicator that specifies that the claim has been selected to be crossed over, the insurer effective and termination dates, and a 1-digit indicator ["Y"=Yes; "N"=No] that specifies whether the COBA trading partner's name should be printed on the beneficiary MSN. Effective with the October 2004 systems release, CWF shall also include a 1-digit Test/Production Indicator "T" (test mode) or "P" (production mode) on the BOI reply trailer 29 that is returned to the Medicare contractor.

B. MSN Crossover Messages

As specified above, during the COBA parallel production period (July 6, 2004, to October 1, 2004), CWF will exclusively return an "N" MSN indicator via the BOI reply trailer, in accordance with the information received via the COIF submission. If a Medicare contractor receives a "Y" MSN indicator during the parallel production period, it shall ignore it.

Beginning with the October 2004 systems release, when a contractor receives a BOI reply trailer 29 from CWF that contains a Test/Production Indicator "T" (test mode), it shall ignore the MSN Indicator provided on the trailer. Instead, the Medicare contractor shall follow its existing procedures for inclusion of trading partner names on MSNs for those trading partners with whom it has existing Trading Partner Agreements (TPAs).

Beginning with the October 2004 systems release, when a contractor receives a BOI reply trailer 29 from CWF that contains a Test/Production Indicator "P" (production mode), it shall read the MSN indicator (Y=Yes, print trading partner's name; N=Do not print trading partner's name) returned on the BOI reply trailer 29. (Refer to Pub.100-4, chapter 28, §70.6 for additional details.)

C. Electronic Remittance Advice (835)/Provider Remittance Advice Crossover Messages

Beginning with the October 2004 release, when contractors receive a BOI reply trailer (29) from CWF that contains a "T" Test/Production Indicator, they shall not print information received from the BOI reply trailer (29) in the required crossover fields on the 835 Electronic Remittance Advice or other provider remittance advice(s) that is/are in production. Contractors shall, however, populate the 835 ERA (or provider remittance advice(s) in production) with required crossover information when they have existing agreements with trading partners.

Beginning with the October 2004 release, when contractors receive a BOI reply trailer (29) from CWF that contains a "P" Test/Production Indicator, they shall use the returned BOI

trailer information to take the following actions on the provider's 835 Electronic Remittance Advice:

1. Record code 19 in CLP-02 (Claim Status Code) in Loop 2100 (Claim Payment Information) of the 835 ERA (v. 4010-A1). [NOTE: Record "20" in CLP-02 (Claim Status Code) in Loop 2100 (Claim Payment Information) when Medicare is the secondary payer.]

2. Update the 2100 Loop (Crossover Carrier Name) on the 835 ERA as follows:

- NM101 [Entity Identifier Code]—Use "TT," as specified in the 835 Implementation Guide.
- NM102 [Entity Type Qualifier]—Use "2," as specified in the 835 Implementation Guide.
- NM103 [Name, Last or Organization Name]—Use the COBA trading partner's name that accompanies the first sorted COBA ID returned to you on the BOI reply trailer.
- NM108 [Identification Code Qualifier]—Use "PI" (Payer Identification.)
- NM109 [Identification Code]—Use the first COBA ID returned to you on the BOI reply trailer. (See line 24 of the BOI aux. file record.

If the 835 ERA is not in production and the contractor receives a "P" Test/Production Indicator, it shall use the information provided on the BOI reply trailer (29) to populate the existing provider remittance advices that it has in production.

*Effective with the implementation of the COBA Medigap claim-based crossover process, w*hen a beneficiary's claim is associated with more than one COBA ID (i.e., the beneficiary has more than one health insurer/benefit plan that has signed a national COBA), CWF shall sort the COBA IDs and trading partner names in the following order:

1) Eligibility-based Medigap, 2) Supplemental, 3) TRICARE, 4) Others, *5) Claim-based Medigap, and 6*) Eligibility-based Medicaid. When two or more COBA IDs fall in the same range (see item 24 in the BOI Auxiliary File table above), CWF shall sort numerically within the same range.

3. CWF Treatment of Non-assigned Medicaid Claims

When CWF receives a non-assigned Medicare claim for a beneficiary whose BOI auxiliary record contains a COBA ID with a current effective date in the Medicaid eligibility-based range (70000-77999), it shall reject the claim by returning edit 5248 to the Part B contractor's system only when the Medicaid COBA trading partner is in production mode (Test/Production Indicator=P) with the COBC. At the same time, CWF shall only return a

Medicaid reply trailer 36 to the Part B contractor that contains the trading partner's COBA ID and beneficiary's effective and termination dates under Medicaid when the Medicaid COBA trading partner is in production mode with the COBC. CWF shall determine that a Medicaid trading partner is in production mode by referring to the latest COBA Insurance File (COIF) update it has received.

If, upon receipt of CWF edit 5248 and the Medicaid reply trailer (36), the Part B contractor determines that the non-assigned claim's service dates fall during a period when the beneficiary is eligible for Medicaid, it shall convert the assignment indicator from "non-assigned" to "assigned" and retransmit the claim to CWF. After the claim has been retransmitted, the CWF will only return a BOI reply trailer to the Part B contractor if the claim is to be sent to the COBC to be crossed over.

Effective with October 1, 2007, CWF shall cease returning an edit 5248 and Medicaid reply trailer 36 to a Durable Medical Equipment Medicare Administrative Contractor (DMAC). In lieu of this procedure, CWF shall ***only*** *return a BOI reply trailer (29) to the DMAC for the claim if the COBA Insurance File (COIF) for the State Medicaid Agency indicates that the entity wishes to receive non-assigned claims.*

NOTE: *Most Medicaid agencies will not accept such claims for crossover purposes.*

If CWF determines via the corresponding COIF that the State Medicaid Agency does not wish to receive non-assigned claims, it shall exclude the claim for crossover. In addition, CWF shall mark the excluded claim with its appropriate claims crossover disposition indicator (see §80.15 of this chapter for more details) and store the claim with the information within the appropriate Health Insurance Master Record (HIMR) detailed history screen.

DMACs shall no longer modify the provider assignment indicator on incoming non-assigned supplier claims for which there is a corresponding COBA ID in the 'Medicaid' range (70000-77999).

4. Additional Information Included on the *HUIP, HUOP, HUHH, HUHC,* HUBC and HUDC Queries to CWF

Beneficiary Liability Indicators on Part B and DMAC CWF Claims Transactions

Effective with the January 2005 release, the Part B and *DMAC* systems shall be required to include an indicator 'L' (beneficiary is liable for the denied service[s]) or 'N' (beneficiary is not liable for the denied service[s]) in an available field on the HUBC and HUDC queries to CWF for claims on which all line items are denied. The liability indicators (L or N) will be at the header or claim level rather than at the line level.

Currently, the *DMAC* shared system is able to identify, through the use of an internal indicator, whether a submitted claim is in the National Council for Prescription Drug Programs (NCPDP) format. The *DMAC* shared system shall pass an indicator "P" to CWF

in an available field on the HUDC query when the claim is in the NCPDP format. The indicator "P" shall be included in a field on the HUDC query that is separate from the fields used to indicate whether a beneficiary is liable for all services denied on his/her claim.

The CWF shall read the new indicators passed via the HUBC or HUDC queries for purposes of excluding denied services on claims with or without beneficiary liability and NCPDP claims.

Beneficiary Liability Indicators on Part A CWF Claims Transactions

Effective with October 2007, the CWF maintainer shall create a 1-byte beneficiary liability indicator field within the header of its HUIP, HUOP, HUHH, and HUHC Part A claims transactions (valid values for the field=L or N).

As Part A contractors adjudicate claims and determine that the beneficiary has payment liability for any part of the fully denied services or service lines, they shall set an 'L' indicator within the newly created beneficiary liability field in the header of their HUIP, HUOP, HUHH, and HUHC claims that they transmit to CWF. In addition, as Part A contractors adjudicate claims and determine that the beneficiary has no payment liability for any of the fully denied services or service lines—that is, the provider must absorb all costs for the fully denied claims—they shall include an 'N' beneficiary indicator within the designated field in the header of their HUIP, HUOP, HUHH, and HUHC claims that they transmit to CWF.

Upon receipt of an HUIP, HUOP, HUHH, or HUHC claim that contains an 'L' or 'N' beneficiary liability indicator, CWF shall read the COBA Insurance File (COIF) to determine whether the COBA trading partner wishes to receive 'original' fully denied claims with beneficiary liability (crossover indicator 'G') or without beneficiary liability (crossover indicator 'F') or 'adjustment' fully denied claims with beneficiary liability (crossover indicator 'U') or without beneficiary liability (crossover indicator 'T').

CWF shall deploy the same logic for excluding Part A fully denied 'original' and 'adjustment' claims with or without beneficiary liability as it now utilizes to exclude fully denied 'original' and 'adjustment' Part B and DMAC/DME MAC claims with and without beneficiary liability, as specified elsewhere within this section.

If CWF determines that the COBA trading partner wishes to exclude the claim, as per the COIF, it shall suppress the claim from the crossover process.

CWF shall post the appropriate crossover disposition indicator in association with the adjudicated claim on the HIMR detailed history screen (see §80.15 of this chapter).

In addition, the CWF maintainer shall create and display the new 1-byte beneficiary liability indicator field within the HIMR detailed history screens (INPL, OUTL, HHAL, and HOSL), to illustrate the indicator ('L' or 'N') that appeared on the incoming HUIP, HUOP, HUHH, or HUHC claim transaction.

CWF Editing for Incorrect Values

If a Part A contractor sends values other than 'L' or 'N' in the newly defined beneficiary liability field in the header of its HUIP, HUOP, HUHH, or HUHC claim, CWF shall reject the claim back to the Part A contractor for correction. Following receipt of the CWF rejection, the Part A contractor shall change the incorrect value placed within the newly defined beneficiary liability field and retransmit the claim to CWF.

5. Modification to the CWF Inclusion or Exclusion Logic for the COBA Crossover Process

Beginning with the October 2006 release, the CWF or its maintainer shall modify its COBA claims selection logic and processes as indicated below. The CWF shall continue to include or exclude all other claim types in accordance with the logic and processes that it had in place prior to that release.

***D*. New Part B Contractor Inclusion or Exclusion Logic**

The CWF shall read the first two (2) positions of the Business Segment Identifier (BSI), as reported on the HUBC claim, to uniquely include or exclude claims from state-specific Part B contractors, as indicated on the COBA Insurance File (COIF).

***E*. Exclusion of *Fully Paid* Claims**

The CWF shall continue to exclude Part B claims paid at 100 percent by checking for the presence of claims entry code '1' and determining that each claim's allowed amount equals the reimbursement amount *and confirming that the claim contains no denied services or service lines.*

The CWF shall continue to read action code '1' and determine that there are no deductible or co-insurance amounts for the purpose of excluding Part A original claims paid at 100 percent. In addition, CWF shall determine that the Part A claim contained a reimbursement amount before excluding a claim with action code '1' that contained no deductible and co-insurance amounts *and that the claim contained no denied services or service lines.*

***F*. Claims Paid at Greater than 100 Percent of the Submitted Charge**

The CWF shall modify its current logic for excluding Part A original Medicare claims paid at greater than 100 percent of the submitted charges as follows:

> In addition to meeting the CWF exclusion criteria for Part A claims paid at greater than 100 percent of the submitted charges, CWF shall exclude these claims only when there is no deductible or co-insurance amounts remaining on the claims.

NOTE: The current CWF logic for excluding Part B original Medicare claims paid at greater than 100 percent of the submitted charges/allowed amount (specifically, type F

ambulatory surgical center claims*, which typically carry deductible and co-insurance amounts*) shall remain unchanged.

G. Claims with Monetary or Non-Monetary Changes

The CWF shall check the reimbursement amount as well as the deductible and co-insurance amounts on each claim to determine whether a monetary adjustment change to an original Part A, B, or *DMAC* claim occurred.

To exclude non-monetary adjustments for Part A, B, and *DMAC* claims, the CWF shall check the reimbursement amount as well as the deductible and co-insurance amounts on each claim to confirm that there were no monetary changes on the adjustment claim as compared to the original claim.

H. Excluding Adjustment Claims When the Original Claim Was Also Excluded

When the CWF processes an adjustment claim, it shall take the following action when the COIF indicates that the "production" COBA trading partner wishes to receive adjustment claims, monetary **or** adjustment claims, non-monetary:

1) Return a BOI reply trailer 29 to the contractor if CWF locates the original claim that was marked with an 'A' crossover disposition indicator **or** if the original claim's crossover disposition indicator was blank/non-existent;

2) Exclude the adjustment claim if CWF locates the original claim and it was marked with a crossover disposition indicator other than 'A,' meaning that the original claim was excluded from the COBA crossover process.

CWF shall **not** be required to search archived or purged claims history to determine whether an original claim had been crossed over.

The CWF maintainer shall create a new 'R' crossover disposition indicator, as referenced in a chart within §80.15 of this chapter, to address this exclusion for customer service purposes. The CWF maintainer shall ensure that adjustment claims that were excluded because the original claim was not crossed over shall be marked with an 'R' crossover disposition indicator after they have been posted to the appropriate Health Insurance Master Record (HIMR) detailed history screen.

I. Excluding Part A, B, and DMAC Contractor *Fully Paid* Adjustment Claims *Without Deductible and Co-Insurance Remaining*

The CWF shall apply logic to exclude Part A and Part B (including *DMAC*) adjustment claims (identified as action code '3' for Part A claims and entry code '5' for Part B and *DMAC* claims) when the COIF indicates that a COBA trading partner wishes to exclude adjustment claims that are *fully paid and without deductible or co-insurance amounts remaining.*

*Effective with October 1, 2007, t*he CWF shall develop logic as follows to **exclude** *fully paid* Part A adjustment claims *without deductible and co-insurance remaining*:

1) Verify that the claim contains action code '3';

2) Verify that there are no deductible and co-insurance amounts on the claim;

3) Verify that the reimbursement on the claim is greater than zero*; and*

4) *Confirm that the claim contains no denied services or service lines.*

Special Note: *Effective with October 1, 2007, CWF shall cease by-passing the logic to exclude Part A adjustments claims fully (100 percent) paid in association with home health prospective payment system (HHPPS) types of bills 329 and 339. The CWF shall exclude such claims if the COBA Insurance File (COIF) designates that the trading partner wishes to exclude "adjustment claims fully paid without deductible or co-insurance remaining" or if these bill types are otherwise excluded on the COBA Insurance File (COIF).*

The CWF shall develop logic as follows to **exclude** Part B or *DMAC fully paid* adjustment claims *without deductible or co-insurance remaining*:

1) Verify that the claim contains an entry code '5';

2) Verify that the allowed amount equals the reimbursement amount; *and*

3) Confirm that the claim contains no denied services or service lines.

The CWF maintainer shall create a new 'S' crossover disposition indicator for adjustment claims that are paid at 100 percent. The CWF maintainer shall ensure that excluded adjustment claims that are paid at 100 percent shall be marked with an 'S' crossover disposition indicator after they have been posted to the appropriate HIMR detailed history screen. In addition, the CWF maintainer shall add "Adj. Claims-100 percent PD" to the COBA Insurance File Summary screen (COBS) on HIMR so that this exclusion will be appropriately displayed for customer service purposes.

J. Excluding Part A, B, and DMAC Contractor Adjustment Claims That Are *Fully* Denied with No Additional Liability

The CWF shall apply logic to exclude Part A and Part B (including *DMAC*) *fully* denied adjustment claims that carry no additional beneficiary liability when the COIF indicates that a COBA trading partner wishes to exclude such claims.

*Effective with October 1, 2007, t*he CWF shall apply logic to the Part A adjustment claim (action code '3') where the entire claim is denied **and** the beneficiary has no additional liability as follows:

1) Verify that the claim was sent as action code '3'; and

2) Check for the presence of an *'N' beneficiary liability indicator in the header of* the fully denied claim. *(See the "Beneficiary Liability Indicators on Part A CWF Claims Transactions" section above for additional information.)*

The CWF shall apply logic to the Part B and *DMAC* adjustment claims (entry code '5') where the entire claim is denied **and** the beneficiary has **no** additional liability as follows:

1) Verify that the claim was sent as entry code '5'; and

2) Check for the presence of an 'N' liability indicator on the fully denied claim.

The CWF maintainer shall create a new 'T' crossover disposition indicator for adjustment claims that are 100 percent denied with no additional beneficiary liability. The CWF maintainer shall ensure that excluded adjustment claims that were entirely denied and contained no beneficiary liability shall be marked with a 'T' crossover disposition indicator after they have been posted to the appropriate HIMR detailed history screen. In addition, the CWF maintainer shall add "Denied Adjs-No Liab" to the COBS on HIMR so that this exclusion will be appropriately displayed for customer service purposes.

K. Excluding Part A, B, and DMAC Contractor Adjustment Claims That Are *Fully* Denied with No Additional Liability

The CWF shall apply logic to exclude Part A and Part B (including *DMAC*) *fully* denied adjustment claims that carry additional beneficiary liability when the COIF indicates that a COBA trading partner wishes to exclude such claims.

*Effective with October 1, 2007, t*he CWF shall apply logic to the Part A adjustment claim (action code '3') where the entire claim is denied and the beneficiary has additional liability as follows:

1) Verify that the claim was sent as action code '3'; and

2) Check for the presence of an *'L' beneficiary liability indicator in the header of* the fully denied claim. *(See the "Beneficiary Liability Indicators on Part A CWF Claims Transactions" section above for additional information.)*

The CWF shall apply logic to exclude Part B and *DMAC* adjustment claims (entry code '5') where the entire claim is denied **and** the beneficiary has additional liability as follows:

1) Verify that the claim was sent as entry code '5'; and

2) Check for the presence of an 'L' liability indicator on the fully denied claim.

The CWF maintainer shall create a new 'U' crossover disposition indicator for adjustment claims that are 100 percent denied with additional beneficiary liability. The CWF maintainer shall ensure that excluded adjustment claims that were entirely denied and contained beneficiary liability shall be marked with a 'U' crossover disposition indicator after they have been posted to the appropriate HIMR detailed history screen. In addition, the CWF maintainer shall add "Denied Adjs-Liab" to the COBS on HIMR so that this exclusion will be appropriately displayed for customer service purposes.

L. Excluding MSP Cost-Avoided Claims

The CWF shall develop logic to **exclude** MSP cost-avoided claims when the COIF indicates that a COBA trading partner wishes to exclude such claims.

The CWF shall apply the following logic to **exclude** Part A MSP cost-avoided claims:

a) Verify that the claim contains one of the following MSP non-pay codes: E, F, G, H, J, K, Q, R, T, U, V, W, X, Y, Z, 00, 12, 13, 14, 15, 16, 17, 18, 25, and 26.

The CWF shall apply the following logic to **exclude** Part B and DMAC MSP cost-avoided claims:

a) Verify that the claim contains one of the following MSP non-pay codes: E, F, G, H, J, K, Q, R, T, U, V, W, X, Y, Z, 00, 12, 13, 14, 15, 16, 17, 18, 25, and 26.

The CWF maintainer shall create a new 'V' crossover disposition indicator for the exclusion of MSP cost-avoided claims. The CWF maintainer shall ensure that excluded MSP cost-avoided claims shall be marked with a 'V' crossover disposition indicator after they have been posted to the appropriate HIMR detailed history screen. In addition, the CWF maintainer shall add "MSP Cost-Avoids" to the COBS on HIMR so that this exclusion will be appropriately displayed for customer service purposes.

M. Excluding Sanctioned Provider Claims from the COBA Crossover Process

Effective with April 2, 2007, the CWF maintainer shall create space within the HUBC claim transaction for a newly developed 'S' indicator, which designates 'sanctioned provider.'

Contractors, including Medicare Administrative Contractors *(MACs)*, that process Part B claims from physicians (e.g., practitioners and specialists) and suppliers (independent

laboratories and ambulance companies) shall set an ‘S’ indicator in the header of a fully denied claim if the physician or supplier that is billing is suspended/sanctioned. NOTE: Such physicians or suppliers will have been identified by the Office of the Inspector General (OIG) and will have had their Medicare billing privileges suspended. Before setting the ‘S’ indicator in the header of a claim, the Part B contractor shall first split the claim it is contains service dates during which the provider is no longer sanctioned. This will ensure that the Part B contractor properly sets the ‘S’ indicator for only those portions of the claim during which the provider is sanctioned.

Upon receipt of an HUBC claim that contains an ‘S’ indicator, the CWF shall exclude the claim from the COBA crossover process. The CWF therefore shall not return a BOI reply trailer 29 to the multi-carrier system (MCS) Part B contractor for any HUBC claim that contains an ‘S’ indicator.

70.6 - Consolidation of the Claims Crossover Process

(Rev.1296, Issued: 07-18-07, Effective: 10-01-07, Implementation: 10-01-07)

The CMS has decided to streamline the claims crossover process to better serve our customers. Beginning with July 6, 2004, approximately ten COBA trading partners will participate in the beta-site testing of the consolidated claims crossover or Coordination of Benefits Agreement (COBA) process. During this time, the COBA beta-site testers will participate in a parallel production crossover process (a pilot for only COBA trading partners using production/live data). During the parallel production period, the ten COBA trading partners will receive consolidated crossover claims as part of the COBA process. In addition, if the ten COBA trading partners have individual Trading Partner Agreements (TPAs) executed with Medicare contractors, they will receive crossover claims based on the terms and conditions of those TPAs. The Coordination of Benefits Contractor (COBC) will not charge the COBA beta-testers for crossed over claims during the parallel production period. Medicare contractors will, however, continue to charge these partners for claims that they continue to cross over to them during the beta-testing period.

Under the consolidated claims crossover process, trading partners will be transitioned from the current TPA process with Medicare contractors to new agreements called Coordination of Benefits Agreements (COBAs). These agreements, which will be negotiated on behalf of CMS by the COBC, will be entered into directly between CMS and the COBA trading partners. Through the COBA process, each COBA trading partner will send one national eligibility file that includes eligibility information for each Medicare beneficiary that it insures to the COBC. The COBC will transmit the beneficiary eligibility file(s) to the Common Working File (CWF) via a maintenance transaction. The transaction is known as the Beneficiary Other Insurance (BOI) auxiliary file. (See Chapter 27, §80.14, of Publication 100-4, Medicare Claims Processing Manual, for more details about the contents of the BOI auxiliary file.)

The CWF is being modified so that it will apply each COBA trading partner's claims selection criteria against processed claims with service dates that fall between the effective and termination date of one or more BOI records.

I. Contractor Actions Relating to CWF Claims Crossover Exclusion Logic

A. Determination of Beneficiary Liability for Claims with Denied Services

Effective with the January 2005 release, the Part B and Durable Medical Equipment Regional Carrier (DMERC)/DME Medicare Administrative Contractor (DME MAC) contractor shared systems will be required to include an indicator "L" (beneficiary is liable for the denied service[s]) or "N" (beneficiary is not liable for the denied service[s]) in an available field on the HUBC and HUDC queries to CWF for claims on which all line items are denied. The liability indicators (L or N) will be at the header or claim level rather than at the line level.

For purposes of applying the liability indicator L or N at the header/claim level and, in turn, including such indicators in the HUBC or HUDC query to CWF, the Part B and DMERC/DME MAC contractor shared systems shall follow these business rules:

- The L or N indicators are not applied at the header/claim level if any service on the claim is payable by Medicare;

- The "L" indicator is applied at the header/claim level if the beneficiary is liable for any of the denied services on a fully denied claim; and

- The "N" indicator is applied at the header/claim level if the beneficiary is not liable for all of the denied services on a fully denied claim.

Effective with October 2007, the CWF maintainer shall create a 1-byte beneficiary liability indicator field within the header of its HUIP, HUOP, HUHH, and HUHC Part A claims transactions (valid values for the field="L," "N," or space).

As Part A contractors adjudicate claims and determine that the beneficiary has payment liability for any part of the fully denied services or service lines, they shall set an "L" indicator within the newly created beneficiary liability field in the header of their HUIP, HUOP, HUHH, and HUHC claims that they transmit to CWF. In addition, as Part A contractors adjudicate claims and determine that the beneficiary has no payment liability for any of the fully denied services or service lines—that is, the provider must absorb all costs for the fully denied claims—they shall include an "N" beneficiary indicator within the designated field in the header of their HUIP, HUOP, HUHH, and HUHC claims that they transmit to CWF. ***NOTE:*** *Part A contractors shall* ***not*** *set the "L" or "N" indicator on partially denied/partially paid claims.*

Upon receipt of an HUIP, HUOP, HUHH, or HUHC claim that contains an "L" or "N" beneficiary liability indicator, CWF shall read the COBA Insurance File (COIF) to determine whether the COBA trading partner wishes to receive "original" fully denied claims with beneficiary liability (crossover indicator "G") or without beneficiary liability (crossover indicator "F") or "adjustment" fully denied claims with beneficiary liability (crossover indicator "U") or without beneficiary liability (crossover indicator "T").

If CWF determines that the COBA trading partner wishes to exclude the claim, as per the COIF, it shall suppress the claim from the crossover process.

CWF shall post the appropriate crossover disposition indicator in association with the adjudicated claim on the HIMR detailed history screen (see §80.15 of this chapter).

In addition, the CWF maintainer shall create and display the new 1-byte beneficiary liability indicator field within the HIMR detailed history screens (INPL, OUTL, HHAL, and HOSL), to illustrate the indicator ("L" or "N") that appeared on the incoming HUIP, HUOP, HUHH, or HUHC claim transaction.

CWF Editing for Incorrect Values

If a Part A contractor sends values other than "L," "N," or space in the newly defined beneficiary liability field in the header of its HUIP, HUOP, HUHH, or HUHC claim,

CWF shall reject the claim back to the Part A contractor for correction. Following receipt of the CWF rejection, the Part A contractor shall change the incorrect value placed within the newly defined beneficiary liability field and retransmit the claim to CWF.

B. Developing a Capability to Treat Entry Code "5" and Action Code "3" Claims As Recycled "Original" Claims For Crossover Purposes

Effective with July 2007, in instances when CWF returns an error code 5600 to a contractor, thereby causing it to reset the claim's entry code to "5" to action code to "3," the contractor shall set a newly developed "N"(non-adjustment) claim indicator ("treat as an original claim for crossover purposes") in the header of the HUBC, HUDC, HUIP, HUOP, HUHH, HUIP, HUOP, HUHH, and HUHC claim in the newly defined field before retransmitting the claim to CWF. The contractor's system shall then resend the claim to CWF.

Upon receipt of a claim that contains entry code "5" or action code "3" with a non-adjustment claim header value of "N," the CWF shall treat the claim as if it were an "original" claim (i.e., as entry code "1" or action code "1") for crossover inclusion or exclusion determinations. If CWF subsequently determines that the claim meets all other inclusion criteria, it shall mark the claim with an "A" ("claim was selected to be crossed over") crossover disposition indicator.

Following receipt of a Beneficiary Other Insurance (BOI) reply trailer (29) for the recycled claim, the contractors' systems shall ensure that, as part of their 837 flat file creation processes, they populate the 2300 loop CLM05-3 (Claim Frequency Type Code) segment with a value of "1" (original). In addition, the contractors' systems shall ensure that, as part of their 837 flat file creation process, they do not create a corresponding 2330 loop REF*T4*Y segment, which typically signifies "adjustment."

C. Developing a Capability to Treat Claims with Non-Adjustment Entry or Action Codes as Adjustment Claims For Crossover Purposes

Effective with July 2007, in instances where contractors must send adjustment claims to CWF as entry code "1" or as action code "1" (situations where CWF has rejected the claim with edit 6010), they shall set an "A" indicator in a newly defined field within the header of the HUBC, HUDC, HUIP, HUOP, HUHH, or HUHC claim.

If contractors send a value other than "A" or spaces within the newly designated header field within their HUBC, HUDC, HUIP, HUOP, HUHH, and HUHC claims, CWF shall apply an edit to reject the claim back to the contractor. Upon receipt of the CWF rejection edit, the contractors' systems shall correct the invalid value and retransmit the claim to CWF for verification and validation.

Upon receipt of a claim that contains entry code "1" or action code "1" with a header value of "A," the CWF shall take the following actions:

- Verify that, as per the COIF, the COBA trading partner wishes to exclude **either** adjustments, monetary or adjustments, non-monetary, **or both**; and

- Suppress the claim if the COBA trading partner wishes to exclude **either** adjustments, monetary or adjustments, non-monetary, **or both**.

(**NOTE:** The expectation is that such claims do not represent mass adjustments tied to the MPFS or mass adjustments-other.)

If contractors receive a BOI reply trailer (29) on a claim that had an "A" indicator set in its header, the contractors' systems shall ensure that, as part of their 837 flat file creation processes, they populate the 2300 loop CLM05-3 ("Claim Frequency Type Code") segment with a value that designates "adjustment" rather than "original" to match the 2330B loop REF*T4*Y that they create to designate "adjustment claim."

If a contractor's system does not presently create a loop 2330B REF*T4*Y to designate adjustments, it shall not make a change to do so as part of this instruction.

Correcting Invalid Claim Header Values Sent to CWF

If contractors send a value other than "A," "N," or spaces within the newly designated header field within their HUBC, HUDC, HUIP, HUOP, HUHH, and HUHC claims, CWF shall apply an edit to reject the claim back to the contractor. Upon receipt of the CWF rejection edit, the contractors' systems shall correct the invalid value and retransmit the claim to CWF for verification and validation.

D. CWF Identification of National Council for Prescription Drug Claims

Currently, the DMERC/DME MAC contractor shared system is able to identify, through the use of an internal indicator, whether a submitted claim is in the National Council for Prescription Drug Programs (NCPDP) format. Effective with January 2005, the DMERC/DME MAC contractor shared system shall pass an indicator "P" to CWF in an available field on the HUDC query when the claim is in the NCPDP format. The indicator "P" should be included in a field on the HUDC that is separate from the fields used to indicate whether a beneficiary is liable for all services that are completely denied on his/her claim.

The CWF shall read the new indicators passed via the HUBC or HUDC queries for purposes of excluding 100% denied claims with or without beneficiary liability and NCPDP claims. After applying the claims selection options, CWF will return a BOI reply trailer (29) to the Medicare contractor only in those instances when the COBA trading partner expects to receive a Medicare processed claim from the COBC.

Effective with July 2007, CWF shall reject claims back to DMERCs/DME MACs if their HUDC claim contains a value other than "P" in the established field used to identify NCPDP claims.

Additional Information Regarding the COBA Process

Upon receipt of a BOI reply trailer (29) that contains (a) COBA ID (s) and other crossover information required on the HIPAA 835 Electronic Remittance Advice (ERA), Medicare contractors will send processed claims via an 837 COB flat file or National Council for Prescription Drug Programs (NCPDP) file to the COBC. The COBC, in turn, will cross the claims to the COBA trading partner.

The CWF is also being modified in preparation for future receipt of claim-based Medigap and/ or Medicaid COBA IDs in field 36 of the HUBC or HUDC query. For claim-based crossover, CWF will also be equipped to search the Coordination of Benefits Agreement Insurance File (COIF) to locate a matching COBA IDs; apply the Medigap claim-based trading partner's claims selection criteria; and return a claim-based reply trailer 37 to the Part B or DMERC contractor if a claim-based COBA ID has been located and the claim is to be sent to the COBC to be crossed over.

In addition, CMS shall arrange for the invoicing of COBA trading partners for crossover fees.

The effort to consolidate the claims crossover function will be implemented via a phased-in approach, beginning with a small-scale implementation on July 6, 2004, involving approximately ten COBA trading partners that will serve as beta-site testers.

CMS will not move trading partners into crossover production with the COBC any earlier than December 2004. Consequently, the COBA parallel production period will be extended until CMS, the Coordination of Benefits Contractor (COBC), and the participating beta-testing trading partners conclude the testing results demonstrate a high-level of confidence.

Contractors shall operate under the assumption that all of their existing eligibility file-based crossover trading partners will at least be in test mode with the COBC by the end of fiscal year 2005 (i.e., by September 30, 2005).

II. CWF Crossover Processes In Association with the Coordination of Benefits Contractor

A. CWF Processing of the COBA Insurance File (COIF) and Returning of BOI Reply Trailers

Effective July 6, 2004, the COBC will begin to send initial copies of the COBA Insurance File (COIF) to the nine CWF host sites. The COIF will contain specific information that will identify the COBA trading partner, including name, COBA ID,

address, and tax identification number (TIN). It will also contain each trading partner's claims selection criteria along with an indicator (Y=Yes or N=No) of whether the trading partner wishes its name to be printed on the Medicare Summary Notice (MSN). Effective with the October 2004 systems release, the COIF will also contain a 1-digit Test/Production Indicator that will identify whether a COBA trading partner is in test (T) or production (P) mode. The CWF will be required to return that information as part of the BOI reply trailer (29) to Medicare contractors.

Upon receipt of a claim, CWF shall take the following actions:

1) Search for a COBA eligibility record on the BOI auxiliary record for each beneficiary and obtain the associated COBA ID(s) [NOTE: There may be multiple COBA IDs associated with each beneficiary.];

2) Refer to the COIF associated with each COBA ID (NOTE: The CWF shall pull the COBA ID from the BOI auxiliary record) to obtain the COBA trading partner's name and claims selection criteria;

3) Apply the COBA trading partner's selection criteria; and

4) Transmit a BOI reply trailer to the Medicare contractor only if the claim is to be sent, via 837 COB flat file or NCPDP file, to the COBC to be crossed over.

B. BOI Reply Trailer and Claim-based Reply Trailer Processes

1. BOI Reply Trailer Process

For eligibility file-based crossover, Medicare contractors shall send processed claims information to the COBC for crossover to a COBA trading partner in response to the receipt of a CWF BOI reply trailer (29). Medicare contractors will only receive a BOI reply trailer (29) under the consolidated crossover process for claims that CWF has selected for crossover after reading each COBA trading partner's claims selection criteria as reported on the weekly COIF submission.

When a BOI reply trailer (29) is received, the COBA assigned ID will identify the type of crossover (see the Data Elements Required for the BOI Aux File Record Table in Chapter 27, §24). Although each COBA ID will consist of a five-digit prefix that will be all zeroes, Medicare contractors are only responsible for picking up the last five digits within these ranges, which will be right justified in the COBA number field. In addition to the trading partner's COBA ID, the BOI reply trailer shall also include the COBA trading partner name (s), an "A" crossover indicator that specifies that the claim has been selected to be crossed over, and a one-digit indicator ["Y"=Yes; "N"=No] that specifies whether the COBA trading partner's name should be printed on the beneficiary MSN. As discussed above, effective with the October 2004 systems release, CWF shall also include

a 1-digit Test/Production Indicator on the BOI reply trailer (29) that is returned to the Medicare contractor.

Larger-Scale Implementation of the COBA Process

Medicare contractors should note that the larger-scale COBA process, where additional trading partners are first identified as testing participants with the COBC and then are moved to crossover production with the COBC following the successful completion of testing, may be activated at any time during the COBA smaller-scale parallel production period. Activation of the larger-scale COBA process will most likely not occur before the early months of calendar year 2005.

MSN Crossover Messages

Effective with the October 2004 systems release, the Medicare contractor will begin to receive BOI reply trailers (29) that contain an MSN indicator "Y" (Print trading partner name on MSN) or "N" (Do not print trading partner name on MSN).

Also, effective with the October 2004 systems release, when a Medicare contractor receives a BOI reply trailer (29) that contains a Test/Production Indicator of "T," it shall ignore the MSN indicator on the trailer. Instead, the Medicare contractor shall follow its existing procedures for inclusion of trading partner names on MSNs for those trading partners with whom it has existing TPAs.

When a COBA trading partner is in full production (Test/Production Indicator=P), the Medicare contractor shall read the MSN indicator returned on the BOI reply trailer (29). If the Medicare contractor receives an MSN indicator "N," it shall print its generic crossover message(s) on the MSN rather than including the trading partner's name. Examples of existing generic MSN messages include the following:

(For all COBA ID ranges other than Medigap)

MSN #35.1 - "This information is being sent to private insurer(s). Send any questions regarding your benefits to them."

(For the Medigap COBA ID range)

MSN#35.2- "We have sent your claim to your Medigap insurer. Send any questions regarding your Medigap benefits to them."

Beginning with the October 2004 systems release, contractors shall follow these procedures when determining whether to update its claims history to show that a beneficiary's claim was selected by CWF to be crossed over.

1.) If the Medicare contractor receives a BOI reply trailer (29) that contains a Test/Production Indicator "T," it shall not update its claims history to show that a beneficiary's claim was selected by CWF to be crossed over.

2.) If the Medicare contractor receives a BOI reply trailer (29) that contains a Test/Production Indicator "P," it shall update its claims history to show that a beneficiary's claim was selected by CWF to be crossed over.

Electronic Remittance Advice (835)/Provider Remittance Advice Crossover Messages

Beginning with the October 2004 release, when contractors receive a BOI reply trailer (29) that contains a "T" Test/Production Indicator, they shall not print information received from the BOI reply trailer (29) in the required crossover fields on the 835 Electronic Remittance Advice or other provider remittance advices that are in production. Contractors shall, however, populate the 835 ERA (or provider remittance advice(s) in production) with required crossover information when they have existing agreements with trading partners.

Beginning with the October 2004 release, when contractors receive a BOI reply trailer (29) that contains a "P" Test/Production Indicator, they shall use the returned BOI trailer information to take the following actions on the provider's 835 Electronic Remittance Advice:

1.) Record code 19 in CLP-02 (Claim Status Code) in Loop 2100 (Claim Payment Information) of the 835 ERA (v. 4010-A1). [NOTE: Record "20" in CLP-02 (Claim Status Code) in Loop 2100 (Claim Payment Information) when Medicare is the secondary payer.]

2.) Update the 2100 Loop (Crossover Carrier Name) on the 835 ERA as follows:

- NM101 [Entity Identifier Code]—Use "TT," as specified in the 835 Implementation Guide.

- NM102 [Entity Type Qualifier]—Use "2," as specified in the 835 Implementation Guide.

- NM103 [Name, Last or Organization Name]—Use the COBA trading partner's name that accompanies the first sorted COBA ID returned to you on the BOI reply trailer.

- NM108 [Identification Code Qualifier]—Use "PI" (Payer Identification)

- NM109 [Identification Code]—Use the first COBA ID returned to you on the BOI reply trailer. (See line 24 of the BOI aux. file record

If the 835 ERA is not in production and the contractor receives a "P" Test/Production Indicator, it shall use the information provided on the BOI reply trailer (29) to populate the existing provider remittance advices that it has in production.

CWF Sort Routine for Multiple COBA IDs

When a beneficiary's claim is associated with more than one COBA ID (i.e., the beneficiary has more than one health insurer/benefit plan that pays after Medicare), CWF shall sort the COBA IDs and trading partner names in the following order on the returned BOI reply trailer (29): 1) Eligibility-based Medigap, 2) Supplemental, 3) TRICARE, 4) Others, and 5) Eligibility-based Medicaid. When two or more COBA IDs fall in the same range (see element 24 of the "Data Elements Required for the BOI Aux File Record" Table in chapter 27, §80.14 for more details), CWF shall sort numerically within the same range.

2. Medicare Summary Notice (MSN) and Electronic Remittance Advice (ERA) Crossover Messages During the Parallel Production Period

During the COBA parallel production period, which began July 6, 2004: 1) CWF will only return an "N" MSN indicator on the BOI reply trailer (29), in accordance with information received via the COIF submission; 2) If a "Y" indicator is returned, the Medicare contractor shall ignore it; and 3) the Medicare contractor shall follow its existing procedures for the printing of MSN crossover messages.

During the COBA parallel production period, Medicare contractors shall follow their current procedures for the reporting of crossover claims information in CLP-02 (Claim Status Payment) and in the NM101, NM102, NM103, NM108, and NM109 segments of Loop 2100 of the provider ERA. They shall also continue with their current procedure for inclusion of COB trading partner names on other kinds of provider remittance advices that you have in production.

3. Business Rules for Receipt of a CWF BOI Reply Trailer When Other Indicators of Crossover Are Present

COBA Parallel Production Period

During the COBA parallel production period, which began July 6, 2004, the Medicare contractor shall observe the following business rules when it receives a BOI reply trailer 29 and some other indication of crossover eligibility:

If the Medicare contractor receives a BOI reply trailer 29 with COBA IDs that fall in the ranges of 00001-89999, it shall continue to cross over claims a) per its existing TPAs and b) when Medigap or Medicaid information is reported on the claim. (**NOTE:** The preceding claim-based scenario does not apply to Part A contractors.) In addition, the Medicare contractor shall send claims for which it receives BOI reply trailers to the COBC on the 837 v4010A1 flat file or National Council for Prescription Drug Programs

(NCPDP) file. (**NOTE:** The COBA trading partner will only be charged for the claims that the Medicare contractor continues to cross to it during the parallel production period.)

During the parallel production period, the Medicare contractor shall not change its current procedures regarding suppression of Medicaid claims when a beneficiary has non-Medigap and/or Medigap insurance. The Medicare contractor's Medicaid suppression logic should remain the same as today with its existing trading partners, even when it receives a BOI reply trailer that includes a Medicaid COBA ID.

Larger-Scale Implementation of the COBA Process

Beginning with the October 2004 release, Medicare contractors shall follow these rules when they receive a BOI reply trailer (29) that contains Test/Production Indicator "T" and there is some other indication of crossover eligibility:

If the Medicare contractor receives a BOI reply trailer (29) with COBA IDs that fall in the ranges of 00001-89999 (See Attachment A, element 24), it shall cross over claims 1) per its existing TPAs or 2) when Medigap or Medicaid information is reported on the claim (if that is how the Part B or DMERC contractor currently crosses over claims to Medicaid). (**NOTE:** Claim-based crossover scenarios only apply to Part B and DMERC/ DME MAC contractors.)

In addition, the contractor shall send claims for which it receives BOI reply trailer to the COBC on the 837 v4010A1 flat file or National Council for Prescription Drug Programs (NCPDP) file.

When a COBA trading partner is in test mode, the contractor shall not change its current procedures regarding suppression of Medicaid claims when a beneficiary has non-Medigap and/or Medigap insurance. The contractor's Medicaid suppression logic should remain the same as with current existing trading partners, even when you receive a BOI reply trailer (29) that includes a Medicaid COBA ID.

Beginning with the October 2004 release, contractors shall follow these rules when they receive a BOI reply trailer (29) that contains Test/Production Indicator "P" and there is some other indication of crossover eligibility:

1. If the Medicare contractor receives a BOI reply trailer (29) with a COBA ID that falls in the Medigap eligibility-based range (30000-54999), it shall not cross over claims based on an existing Medigap TPA or when Medigap information is reported on the claim. Instead, the Medicare contractor shall send the claim to the COBC (based on the BOI reply trailer 29) on the 837 v4010A1 flat file or NCPDP file for crossover by the COBC to the COBA trading partner. (NOTE: The assumption is that a beneficiary will have only one true Medigap insurer.)

2. If the Medicare contractor receives a COBA ID via a BOI reply trailer (29) that falls in the Supplemental range (00001-29999) and it has an existing TPA with a supplemental insurer for the beneficiary, it shall transmit the claim to the COBC for crossover to the COBA trading partner and cross the claim to your existing trading partner.

3. If the Medicare contractor receives a COBA ID via a BOI reply trailer (29) that falls in the Supplemental range (00001-29999), and it also receives Medigap crossover information on the claim, it shall cross the claim to the Medigap insurer identified on the claim and transmit the claim to the COBC for crossover to the COBA trading partner based on the Supplemental COBA ID.

4. If the Medicare contractor receives a COBA ID via a BOI reply trailer (29) that falls in the Medicaid range (70000-77999), it shall not cross over claims based on an existing Medicaid TPA or when Medicaid information is reported on the claim (if that is how the Part B or DMERC contractor currently crosses over claims to Medicaid). Instead, the Medicare contractor shall send the claim to the COBC (based on the BOI reply trailer 29) on the 837 v4010A1 flat file or NCPDP file for crossover by the COBC to the COBA trading partner.

5. If the Medicare contractor receives a BOI reply trailer (29) that contains a Medicaid COBA ID (70000-77999) and it has an existing TPA with a supplemental insurer or Medigap insurer, it shall suppress the Medicaid claim from inclusion on the COB 837 flat file or NCPDP file and cross the claim to the supplemental insurer.

6. If the Medicare contractor receives a BOI reply trailer (29) that contains a Supplemental COBA ID (00001-29999) or a Medigap eligibility-based COBA ID (30000-54999) and it has an existing TPA with Medicaid, it shall suppress its crossover to Medicaid but send the claim to the COBC.

NOTE: For the scenarios above, the trading partner shall be responsible for canceling any existing TPA that it has with the Medicare contractor once it has signed a COBA with the Coordination of Benefits Contractor (COBC).

C. Transmission of the COB Flat File or NCPDP File to the COBC

Regardless of whether a COBA trading partner is in test mode (Test/Production Indicator returned via the BOI reply trailer 29=T) or production mode (Test/Production Indicator returned via the BOI reply trailer 29=P), Medicare contractors shall transmit all non-NCPDP claims received with a COBA ID via a BOI reply trailer to the COBC in an 837 v.4010A1 flat file, as described in Transmittal AB-03-060. In a separate transmission, DMERCs shall send the claims received in the NCPDP file format to the COBC. Medicare contractors shall enter the 5-digit COBA ID picked up from the BOI reply trailer (29) in the 1000B loop of the NM1 segment in the NM109 field. In a situation where multiple COBA IDs are received for a claim, Medicare contractors shall send a separate 837 or NCPDP transaction to the COBC for each COBA ID. Medicare

contractors shall perform the transmission at the end of their regular batch cycle, when claims come off the payment floor, to ensure crossover claims are not processed by the COBA trading partner prior to Medicare's final payment. Transmission should occur via Network Data Mover (NDM) over AGNS (AT&T Global Network Services).

Effective with October 4, 2005, when contractor systems transfer processed claims to the COBC as part of the COBA process, they shall include an additional 1-digit alpha character ("T"=test or "P"=production) as part of the BHT03 identifier (Beginning of the Hierarchical Transaction Reference Identification) that is included within the 837 flat file or NCPDP submissions. The contractor shared systems shall determine that a COBA trading partner is in test or production mode by referring to the BOI reply trailer (29) originally received from CWF for the processed claim. (See §70.6.1 of this chapter for further details about the BHT03 identifier.)

Effective with October 2, 2006, the contractors or their Data Centers shall transmit a combined COBA "test" and "production" 837 flat file and a combined "test" and "production" NCPDP file to the COBC. (NOTE: This requirement changes the direction previously provided in October 2005 through the issuance of Transmittal 586.)

With respect to 837 COB flat file submissions to the COBC, Part B and DMERC contractors shall observe these process rules:

The following segments shall not be passed to the COBC:

a) ISA (Interchange Control Header Segment);

b) IEA (Interchange Control Trailer Segment);

c) GS (Functional Group Header Segment); and

d) GE (Functional Group Trailer Segment).

The 1000B loop of the NM1 segment denotes the crossover partner. If multiple COBA IDs are received via the BOI reply trailer, the contractor system shall ensure that a separate 837 transaction should be submitted for each COBA ID received. As the crossover partner information will be unknown to the standard systems, the following fields should be formatted as indicated for the NM1 segment:

NM103—Use spaces; and

NM109—Include COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29).

The 2010BA loop denotes the subscriber information. If available, the subscriber name, address, and policy number should be used to complete the NM1, N3, and N4 segments.

If unknown, the segments should be formatted as follows, with COBC completing any missing information:

NM1 segment—For NM103, NM104, NM105, and NM107, use spaces;
NM1 segment—For NM109, include HICN;
N3 segment—Use all spaces; and
N4 segment—Use all spaces.

The 2010BB loop denotes the payer name. Per the HIPAA Implementation Guide (IG), this loop should define the secondary payer when sending the claim to the second destination payer. Consequently, given that the payer related to the COBA ID will be unknown by the standard systems, the NM1, N3, and N4 segments should be formatted as follows, with COBC completing any missing information:

NM1 segment—For NM103, use spaces;
NM1 segment—For NM109, include the COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29);
N3 segment—Use all spaces; and
N4 segment—Use all spaces.

The 2330B loop denotes other payers for the claim. If multiple COBA IDs are returned via the BOI reply trailer, payer information for the additional COBA IDs will be unknown. As with the 2010BB loop, the NM1 segment should be formatted as follows, with COBC completing any missing information:

NM103—Use spaces; and
NM109—Include COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29).

The 2330B loop shall be repeated to allow for the inclusion of the name (NM103) and associated Trading Partner ID (NM109) for each existing trading partner.

The 2320 loop denotes other subscriber information. Within the SBR segment, the SBR03 and SBR04 segments are used to define the group/policy number and insured group name, respectively. If the information is available for these fields, those values should be propagated accordingly for both current trading partners and COBA trading partners. The COBC will inspect these values for COBA related eligibility based claims and overlay as appropriate. Spaces should only be used for COBA-related situations.

SBR01—Treat as normally do.

With respect to 837 COB flat file submissions to the COBC, Part A contractors shall observe these process rules:

As the ISA, IEA, and GS segments are included in the “100” record with other required segments, the “100” record must be passed to the COBC. However, as

the values for these segments will be recalculated, spaces may be placed in all of the fields related to the ISA, IEA, and GS segments.

The 1000B loop of the NM1 segment denotes the crossover trading partner. If multiple COBA IDs are received via the BOI reply trailer, the contractor system shall ensure that a separate 837 transaction should be submitted for each COBA ID received. As the crossover trading partner information will be unknown to the standard systems, the following fields should be formatted as follows for the NM1 segment on the"100" record:

NM103—Use spaces; and
NM109—Include COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29).

The 2010BA loop denotes the subscriber information. If available, the subscriber name, address, and policy number should be used to complete the NM1, N3, and N4 segments. If unknown, the segments should be formatted as follows for the "300" record, with COBC completing any missing information:

NM1 segment – For NM103, NM104, NM105, and NM107, use spaces;
NM1 segment—For NM109, include HICN;
N3 segment—Use all spaces; and
N4 segment—Use all spaces.

The 2010BC loop denotes the payer name. Per the HIPAA IG, this loop should define the secondary payer when sending the claim to the second destination payer. Consequently, since the payer related to the COBA ID will be unknown to the standard systems, the NM1, N3, and N4 segments should be formatted as follows for the "300" record, with COBC completing any missing information:

M1 segment—For NM103, use spaces;
NM1 segment—For NM109, include COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29);
N3 segment—Use all spaces; and
N4 segment—Use all spaces.

The 2330B loop of the "575" record denotes other payers for the claim. If multiple COBA IDs are returned via the BOI reply trailer, payer information for the additional COBA IDs will be unknown. As with the 2010BC loop, the NM1 segment should be formatted as follows, with COBC completing any missing information:

NM103—Use spaces; and
NM109—Include COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29).

The 2330B loop shall be repeated to allow for the inclusion of the name (NM103) and associated Trading Partner ID (NM109) for each existing trading partner.

The 2320 loop denotes other subscriber information. Within the SBR segment, the SBR03 and SBR04 segments are used to define the group/policy number and insured group name, respectively. If the information is available for these fields, those values should be propagated accordingly for both current trading partners and COBA trading partners. The COBC will inspect these values for COBA related eligibility based claims and overlay as appropriate. Spaces should only be used for COBA-related situations.

SBR01—Treat as normally do.

D. COBC Processing of COB Flat Files or NCPDP Files

When a Medicare contractor receives the reject indicator "R" via the Claims Response File, it is to retransmit the entire file to the COBC. If the Medicare contractor receives an acceptance indicator "A," this confirms that its entire COB flat file or NCPDP file transmission was accepted. Once COB flat files or NCPDP files are accepted and translated into the appropriate outbound format(s), COBC will cross the claims to the COBA trading partner. The format of the Claims Response File that will be returned to each Medicare contractor by the COBC, following its COB 837 flat file or NCPDP file transmission, appears in the table below. (See §70.6.1 for specifications regarding the receipt and processing of the COBC Detailed Error Reports.)

Claims Response File Layout (80 bytes)				
Field	Name	Size	Displacement	Description
1.	Contractor Number	5	1-5	Contractor Identification Number
2.	Transaction Set Control Number/Batch Number	9	6-14	Found within the ST02 data element from the ST segment of the X12N 837 flat file or in field 806-5C from the batch header of the NCPDP file.
3.	Number of claims	9	15-23	Number of Claims contained in the X12N 837 flat file or NCPDP file. This is a numeric field that will be right justified and zero-filled.
4.	Receipt Date	8	24-31	Receipt Date of X12N 837 flat file or NCPDP file in CCYYMMDD format
5.	Accept/Reject indicator	1	32	Indicator of either the acceptance or rejection of the X12N 837 flat file or NCPDP file. Values will either be an "A" for accepted or "R" for rejected.
6.	Filler	48	33-80	Spaces

Claims response files will be returned to contractors after receipt and initial processing of a claim file. Thus, for example, if a Medicare contractor sends a COB flat file daily, the COBC will return a claim response file to that contractor on a daily basis.

COB 837 flat files and NCPDP files that will be transmitted by the Medicare contractor to the COBC will be assigned the following file names, regardless of whether a COBA trading partner is in test or production mode:

PCOB.BA.NDM.COBA.Cxxxxx.PARTA(+1) [Used for Institutional Claims]
PCOB.BA.NDM.COBA.Cxxxxx.PARTB(+1) [Used for Professional Claims]
PCOB.BA.NDM.COBA.Cxxxxx.NCPDP(+1). [Used for Drug Claims]

Note that "xxxxx" denotes the Medicare contractor number.

Medicare contractors shall perform the 837 flat file and NCPDP file transmission at the end of the regular batch cycle, when claims come off the payment floor, to ensure crossover claims are not processed by the COBA trading partner prior to Medicare's final payment.

Files transmitted by the Medicare contractor to the COBC shall be stored for 51 business days from the date of transmission.

The file names for the Claims Response File returned to the Medicare contractor will be created as part of the NDM set-up process.

Outbound COB files transmitted by COBC to the COBA trading partners will be maintained for 50 business days following the date of transmission.

E. The COBA Medigap Claim-Based Process Involving CWF

Refer to §70.6.3 of this chapter for more information regarding this process.

F. COBA Claim-Based Crossover Process

Until CMS *issues a final instruction concerning this process*, *all* Part B and *DMAC* contractors shall not cease their existing claim-based Medigap crossover process.

G. Transition to the National COBA and Customer Service Issues

1. Maintenance of Current Crossover Processes, Including Entry into New Claims Crossover Agreements (also known as Trading Partner Agreements or TPAs)

   Medicare contractors shall keep their present crossover process in place, including invoicing for claims crossed to current trading partners, as described in Pub. 100-06, Financial Management, chapter 1, §450 and §460, until each of their present trading partners has been transitioned to the COBA process. Once CMS has fully consolidated the claims crossover process under the COBC, the COBC will have exclusive responsibility for the collection of crossover claim fees for those Medigap and non-Medigap claims that are sent to the COBC to be crossed over to trading partners. The COBC will also have responsibility for distribution of the collected crossover fees to Medicare Part A contractors and Part B contractors. (See also Pub.100-06, Chapter 1, §450.)

   As trading partners are signed on to national COBAs, they will be advised that it is their responsibility to simultaneously cancel current agreements with the Medicare contractors and to cease submission of eligibility files. (NOTE: During the parallel production period, the COBA trading partner will be instructed by CMS to not cancel current TPAs with you.) By current estimates, CMS expects to at least have all current eligibility file-based trading partners in test mode by end of fiscal year 2005 (September 30, 2005).

   Medicare contractors shall execute new TPAs only with trading partners that will be converted to full crossover production by April 1, 2005. Therefore, CMS expects contractors to cease execution of new crossover TPAs by January 31, 2005.

Trading partners that either wish to go into live crossover production after January 31, 2005, or have current questions regarding the COBA process shall be referred to the COBC at 1-646-458-6740.

2. Workload and Crossover Financial Reporting In Light of COBA

For workload reporting purposes, Medicare contractors shall provide counts for those claims that they individually cross to current trading partners (including Medicaid), just as they currently do in CAFM II and in CROWD. Medicare contractors shall separately track claims transmitted to the COBC for crossover to the COBA trading partners for future reporting requirements by COBA ID.

Effective with October 4, 2005, contractors or their shared systems shall report the number of claims submitted to the COBC via the 837 flat files or NCPDP files to their associated contractors' financial management staff only for those BHT03 (Beginning of Hierarchical Transaction Reference Identification) indicators that include a "P" in the final position of the BHT03 (position 22).

Reports generated by the contractors or their shared systems to the contractors' financial management staff shall include like data that are submitted following receipt of the COBC Detailed Error Reports to fulfill the necessary provider notification requirements. (Note: The Detailed Error Reports shall contain the same BHT03 identifier for purposes of reporting to financial management staff as was included by the contractor shared systems on the 837 flat file and NCPDP claim file submissions sent to the COBC.) [See §70.6.1 of this chapter for more information about the COBC Detailed Error Reports]. Minimum information for each BHT03 shall include claim counts sorted by COBA ID and shall be organized into groupings that allow for separate totals by Medicaid (COBA ID range=70000-77999), Medigap (COBA ID range=30000-54999), Supplemental (COBA ID ranges=00001-29999 and 60000-69999), and Other (COBA ID range 80000-89999), as well as grand totals for all less Medicaid.

3. Customer Service

a. COBA Parallel Production or COBA Testing Process

During the parallel production period, and while a COBA trading partner is in test mode with the COBC (Test/Production Indicator="T"), the Medicare contractor shall proceed with its current claims crossover customer service process. In addition, the Medicare contractor's claims history shall not be updated with crossover information based upon the receipt of a CWF BOI reply trailer (29).

b. Updating of the HIMR Detailed History Screens By CWF and the Larger Scale Implementation of COBA

Effective with the October 2004 release, when a COBA trading partner is in production mode (Test/Production Indicator=P), CWF shall annotate each processed claim on detailed history within the Health Insurance Master Record (HIMR) with an indicator that will inform all users of the claim's crossover status. (See Pub.100-04, Chapter 27, §80.15 for more information.). CWF shall allow for repeating of the application of crossover disposition indicators for up to ten (10) COBA IDs.

In addition, 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 COBA.

CWF shall not annotate processed claims on the detailed history screens in HIMR when a COBA trading partner is in test mode (Test/Production Indicator=T).

Effective with the October 2004 systems release, when a COBA trading partner is in production mode, the Medicare contractor's customer service personnel shall answer provider/supplier and beneficiary questions about a claim's crossover status by referring to your internal claims history. In addition, the Medicare contractor's customer service staff shall access information regarding why a claim did not cross by referring to the detailed history screens on HIMR (e.g., INPH, OUTH, HOSH, PTBH, DMEH, and HHAH). [See chapter 27, §80.15 of the Medicare Claims Processing Manual for a listing of all claims crossover disposition indicators.] These screens will also display indicator "A" when a claim was selected by CWF to be crossed over to the COBA ID shown. The BOI auxiliary file will identify the name associated with the COBA ID. Such information may also be available to contractor customer service staff via the Next Generation Desktop (NGD) application.

The CWF maintainer *issued* instructions on the use of the new HIMR screens as part of the October 2004 release.

c. Medicare Contractors shall use the COBC and CMS COBA Problem Inquiry Request Form to identify and send COBA related problems and issues to the COB contractor for research.

In order to track trading partner requests for research of 837 X12 issues, CMS requires contractors to submit a COBA Problem Inquiry Request Form to the COBC or CMS. This process is being implemented to reduce the number of duplicate issues being researched and to ensure your requests are processed timely. The standard form enables CMS and COBC to track issues through completion and manage the process of addressing post-COBA production issues. Upon receipt the submitter shall receive a response from the COBC with the assigned contact information.

CMS is also requiring Medicare contractors to use the COBA Problem Inquiry Request Form when requesting a COBC representative to research a COBA issue. The COBC and CMS COBA Problem Inquiry Request Form appears below.

MEDICARE CONTRACTOR: COBA PROBLEM INQUIRY REQUEST FORM

(Completed by Submitter – control number if applicable *Write in this column only*

Contractor ID *#(Enter the Contractor ID # assigned by CMS)*		
Contractor Reference ID (If applicable - BHT03)		
Reported By *(Enter submitter's last name, first name)*		
Date Submitted *(Enter current date – MM/DD/YR)*		
Contact # *(Enter submitter's phone #)*		
E-mail Address *(Enter submitter's e-mail address)*		
COBA ID #		

Description of Problem *(Check applicable category)*

☐ HIPAA Error Code

ICN Date (Date file was transmitted to the COBC)	
HIPAA Error Code(s)	
Part A/Part B/NCPDP Claim	

☐ Technical Issue *(Claims file transmission failures)*

File Name	
Transmission Date	

Summary of Issue- *Provide detail of problem and note if back-up information will be faxed, e.g., Sample Claims to be Faxed on MM/DD/YR. Indicate whether you would like your issue on the next HIPAA issues log – **do not include any PHI information on this form if sent via email.** All PHI information must be submitted via fax to the COBC contractor to the attention of your COBC representative at 646-458-6761. **Do not include PHI information on the fax cover sheet.** Claim examples of issues to be addressed must include the beneficiary HICN and the claim ICN/DCN.*

COBC USE ONLY. Date: Ticket #:

III. Identification of Mass Adjustments for COBA Crossover Purposes

All contractors and their systems shall develop a method for differentiating "mass adjustments tied to the Medicare Physician Fee Schedule (MPFS) updates" and "all other mass adjustments" from all other kinds of adjustments and non-adjustment claims.

(**NOTE:** For appropriate classification, all adjustments that do not represent "mass adjustments-MPFS" or "mass adjustments-other" shall be regarded as "other adjustments.") DMERCs/DME MACs and their shared system shall only be required to identify mass adjustments-other, which represents a current functionality available within VMS. This is because DMERCs/DME MACs do not use pricing from the MPFS when processing their claims.)

Working Definition of "Mass Adjustment"

For COBA crossover purposes, a "mass adjustment" refers to an action that a contractor undertakes using special software (e.g., Super-Op Events or Express Adjustments) to pull claims with the anticipated purpose of making monetary changes to a high number of those claims. If, however, contractors do not have special software to perform high volume adjustments (i.e., typically adjustments to 100 or more claims), but instead must perform their high volume adjustments manually, this action also fulfills the definition of a "mass adjustment."

Inputting a One-Byte Header Value on Claim Transactions to Designate Mass Adjustment and Associated Processes

Before contractors cable their claims to CWF for verification and validation, they shall populate a 1-byte "mass adjustment" indicator in the header of their HUBC, HUDC, HUIP, HUOP, HUHH, or HUHC entry code "5" or action code "3" claim transactions. The CWF maintainer shall create a new 1-byte field within the header of its HUBC, HUDC, HUIP, HUOP, HUHH, or HUHC claims transactions for this purpose.

Contractors shall determine whether the "M" or "O" indicator applies in relation to a given claim at the point that they initiate a mass adjustment action on that claim using a manual process or an automated adjustment process; e.g., Super Op Events or Express Adjustments. Upon making this determination, the contractors and their shared systems shall populate one (1) of the following mass adjustment claim indicators, specific to the particular claim situation, within the header of the contractors' processed claims that they will cable to CWF for verification and validation:

"M"—if mass adjustment claim tied to an MPFS update; ***or***
"O"—if mass adjustment claim-other.

If contractors send values other than "M" or "O" within the newly designated field within the header of their HUBC, HUDC, HUIP, HUOP, HUHH, or HUHC entry code "5" or

action code “3” claims, CWF shall apply an edit to reject the claims back to the contractor. Upon receipt of the CWF rejection edit, the contractors’ systems shall correct the invalid value and retransmit the claims to CWF for verification and validation.

70.6.1 - Coordination of Benefits Agreement (COBA) Detailed Error Report Notification Process

(Rev.1296, Issued: 07-18-07, Effective: 10-01-07, Implementation: 10-01-07)

Effective with the July 2005 release, CMS will implement an automated process to notify physicians, suppliers, and providers that specific claims that were previously tagged by the Common Working File (CWF) for crossover will not be crossed over due to claim data errors. Claims transmitted via 837 flat file by the Medicare contractor systems to the COBC may be rejected at the flat file level, at an HIPAA ANSI pre-edit validation level, or by trading partners as part of a financial dispute arising from an invoice received. By contrast, claims transmitted via NCPDP file will be rejected only at the flat file and trading partner dispute levels. Effective with the April 2005 release, the contractor systems will have begun to populate the BHT 03 (Beginning of Hierarchical Reference Identification) portion of their 837 COB flat file submissions to the COBC with a unique 22-digit identifier. This unique identifier will enable the COBC to successfully tie a claim that is rejected by the COBC at the flat file or HIPAA ANSI pre-edit validation levels as well as claims disputed by trading partners back to the original 837 flat file submissions.

Effective with October 4, 2005, contractors or their shared systems will receive notification via the COBC Detailed Error Reports, whose file layout structures appear below, that a COBA trading partner is in test or production mode via the BHT 03 identifier that is returned from the COBC.

A. Inclusion of the Unique 22-Digit Identifier on the 837 Flat File and NCPDP File

1. Populating the BHT 03 Portion of the 837 Flat File

The contractor shared systems shall populate the BHT 03 (Beginning of Hierarchical Transaction Reference Identification; **field length=30 bytes**) portion of their 837 flat files that are sent to the COBC for crossover with a 22-digit Contractor Reference Identifier (CRI). The identifier shall be formatted as follows:

a. Contractor number (9-bytes; until the 9-digit contractor number is used, report the 5-digit contractor number, left-justified, with spaces for the remaining 4 positions);

b. Julian date as YYDDD (5 bytes);

c. Sequence number (5 bytes; this number begins with “00001,” so the sequence number should increment for each ST-SE envelope, which is specific to a trading partner, on a given Julian date);

d. Data Center ID (2 bytes; a two-digit numeric value assigned by CMS; see Table below for specific value for each contractor Data Center);

e. COBA Test/Production Indicator (1-byte alpha indicator; acceptable values = ”T” [test] and “P” [production]) *or “R” if the claims were recovered for a “production” COBA trading partner (see §70.6.3 of this chapter for more details*;

The 22-digit CRI shall be left-justified in the BHT 03 segment of the 837 flat file, with spaces used for the remaining 8 positions. (**NOTE:** The CRI is unique inasmuch as no two files should ever contain the same combination of numbers.) ***Special Note:*** *In advance of October 2007, as directed by CMS, contractors shall begin to utilize the additional Data Center identification numbers, beginning with “17” within the BHT 03 segments of those claims that they transmit to the COBC for crossover purposes. The information conveyed within an earlier non-systems instruction shall* ***supersede*** *the information provided in this “Data Center Name and Identification Number” table.*

Data Center Name	**Data Center Identification Number for BHT 03 Field**
AdminaStar Federal	01
Alabama (Cahaba)	02
Arkansas BCBS	03
CIGNA	04
EDS/MCDC2 (Plano)	05
EDS/MCDC2 (Sacramento)	06
Empire Medicare Services	07
Florida BCBS	08
Highmark	09
IBM/MCDC1 (Southbury, CT)	10
Info Crossing	11
Medicare Northwest/Regence of Oregon	12
Mutual of Omaha	13
South Carolina BCBS (Palmetto GBA)	14
TrailBlazer Health Enterprises	15
Veritus Medicare Services	16
Enterprise Data Center (EDC)-EDS	*17 **See special note above.***
EDC- CDS	*18 **See special note above.***
EDC - IBM	*19 **See special note above.***

2. NCPDP 22-Digit Unique Identifier

The DMERC/DME Medicare Administrative Contractor (DME MAC) contractor system shall also adopt the unique 23-digit format, referenced directly above

under “Populating the BHT 03 Portion of the 837 Flat File.” However, the system shall populate the unique 22-digit identifier in field 504-F4 (Message) within the NCPDP file (field length=35 bytes). The DMERC/DME MAC contractor system shall populate the new identifier, left justified, in the field. Spaces shall be used for the remaining bytes in the field.

B. COBC Institutional, Professional, and NCPDP Detailed Error Reports

The contractor systems shall accept the COBC Institutional, Professional, and NCPDP Detailed Error Reports received from the COBC. The formats for each of the Detailed Error Reports appear below.

Beginning with July 2007, all contractor systems shall no longer interpret the percentage values received for 837 institutional and professional claim “222” and “333” errors via the COBC Detailed Error Reports as if the values contained a 1-position implied decimal (e.g., “038”=3.8 percent). DMERCs/DME MACs shall also no longer interpret the percentage values received for NCPDP claims for “333” errors via the COBC Detailed Error Report for such claims as if the values should contain a 1-position implied decimal.

In addition, contractors and their systems shall now base their decision making calculus for initiation of a claims repair of “111” (flat file) errors upon the number of errors received rather than upon an established percent parameter, as otherwise described within this section.

The Institutional Error File Layout, including summary portion, will be used for Part A claim files.

COBC Detailed Error Report

Institutional Error File Layout
(Detail Record)

1.	**Date**	**8**	**1-8**
2.	**Control Number**	**9**	**9-17**
3.	**COBA-ID**	**10**	**18-27**
4.	**Subscriber ID/HICN**	**12**	**28-39**
5.	**Claim DCN/ICN**	**14**	**40-53**
6.	**Record Number**	**9**	**54-62**
7.	**Record/Loop Identifier**	**6**	**63-68**
8.	**Segment**	**3**	**69-71**
9.	**Element**	**2**	**72-73**
10.	**Error Source Code**	**3**	**74-76 (‘111,’ ‘222,’ or ‘333’)**
11.	**Error/Trading Partner Dispute Code**	**6**	**77-82**

12. Error Description	**100**	**83-182**
13. Field Contents	**50**	**183-232**
14. BHT 03 Identifier	**30**	**233-262**
15. Claim DCN/ICN	**23**	**263-285**
16. Filler	**18**	**286-303**

Institutional Error File Layout – (Summary Record)

1. Date	**8**	**1-8**
2. Total Number of Claims For Processing Date	**10**	**9-18**
3. Number of '111' Errors	**10**	**19-28**
4. Number of '222' Errors	**10**	**29-38**
5. Percentage of '222' Errors	**3**	**39-41**
6. Number of '333' Errors	**10**	**42-51**
7. Percentage of '333' Errors	**3**	**52-54**
8. Filler	**19**	**55-73**
9. Summary Record Id (Error Source Code)	**3**	**74-76 ('999')**
10. Filler	**227**	**77-303**

The Professional Error File Layout, including summary portion, will be used for Part B and DMERC claim files.

COBC Detailed Error Report

Professional Error File Layout
(Detail Record)

1.	**Date**	**8**	**1-8**
2.	**Control Number**	**9**	**9-17**
3.	**COBA-ID**	**10**	**18-27**
4.	**Subscriber ID/HICN**	**12**	**28-39**
5.	**Claim DCN/ICN**	**14**	**40-53**
6.	**Record Number**	**9**	**54-62**
7.	**Record/Loop Identifier**	**6**	**63-68**
8.	**Segment**	**3**	**69-71**
9.	**Element**	**2**	**72-73**
10.	**Error Source Code**	**3**	**74-76 (‘111,’’ 222,’ or’ 333’)**
11.	**Error/Trading Partner**		
	Dispute Code	**6**	**77-82**
12.	**Error Description**	**100**	**83-182**
13.	**Field Contents**	**50**	**183-232**
14.	**BHT 03 Identifier**	**30**	**233-262**
15.	**Claim DCN/ICN**	**23**	**263-285**
16.	**Filler**	**18**	**286-303**

Professional Error File Layout – (Summary Record)

1.	**Date**	**8**	**1-8**
2.	**Total Number of Claims**		
	For Processing Date	**10**	**9-18**
3.	**Number of ‘111’ Errors**	**10**	**19-28**
4.	**Number of ‘222’ Errors**	**10**	**29-38**
5.	**Percentage of ‘222’ Errors**	**3**	**39-41**
6.	**Number of ‘333’ Errors**	**10**	**42-51**
7.	**Percentage of ‘333’ Errors**	**3**	**52-54**
8.	**Filler**	**19**	**55-73**
9.	**Summary Record Id**		
	(Error Source Code)	**3**	**74-76 (‘999’)**
10.	**Filler**	**227**	**77-303**

The NCPDP Error File Layout, including summary portion, will be used for by DMERCs/DME MACs for Prescription Drug Claims

COBC Detailed Error Report

NCPDP Error File Layout
(Detail Record)

1.	**Date**	**8**	**1-8**
2.	**Batch Number**	**7**	**9-15**
3.	**COBA-ID**	**5**	**16-20**
4.	**HICN**	**12**	**21-32**
5.	**CCN**	**14**	**33-46**
6.	**Record Number**	**9**	**47-55**
7.	**Batch Record Type**	**2**	**56-57**
8.	**Segment ID**	**2**	**58-59**
9.	**Error Source Code**	**3**	**60-62 ('111' or '333')**
10.	**Error/Trading Partner Dispute Code**	**6**	**63-68**
11.	**Error Description**	**100**	**69-168**
12.	**Field Contents**	**50**	**169-218**
13.	**Unique File Identifier**	**30**	**219-248**
14.	**CCN**	**23**	**249-271**
15.	**Filler**	**18**	**272-289**

NCPDP Error File Layout – (Summary Record)

1.	**Date**	**8**	**1-8**
2.	**Total Number of Claims For Processing Date**	**10**	**9-18**
3.	**Number of '111' Errors**	**10**	**19-28**
4.	**Number of '333' Errors**	**10**	**29-38**
5.	**Percentage of '333' Errors**	**3**	**39-41**
6.	**Filler**	**18**	**42-59**
7.	**Summary Record Id (Error Source Code)**	**3**	**60-62 ('999')**
8.	**Filler**	**227**	**63-289**

If the COB Contractor has rejected back to the contractor system for 2 or more COBA Identification Numbers (IDs), the contractor system shall receive a separate error record for each COBA ID. Also, if a file submission from a contractor system to the COBC contains multiple provider, subscriber, or patient level errors for one COBA ID, the

system will receive a separate error record for each provider, subscriber, or patient portion of the file on which errors were found.

C. Further Requirements of the COBA Detailed Error Report Notification Process

1. Error Source Code

Contractors, or their shared systems, shall use all information supplied in the COBC Detailed Error Report (particularly error source codes provided in Field 10 of Attachment B) to (1) identify shared system changes necessary to prevent future errors in test mode or production mode (Test/Production Indicator= T or P) and (2) to notify physicians, suppliers, and providers that claims with the error source codes "111," "222," and "333" will not be crossed over to the COBA trading partner.

The DMERC contractors, or their shared system, will only receive error source codes for a flat file error ("111") and for a trading partner dispute ("333"). Both error types shall be used to identify shared system changes necessary to prevent future errors and notify physicians, suppliers, and providers that claims with error source codes of "111" and "333" will not be crossed over to the COBA trading partner.

2. Time frames for Notification of Contractor Financial Management Staff and Providers

Contractors, or their shared systems, shall provide notification to contractor financial management staff for purposes of maintaining an effective reconciliation of crossover fee/ complementary credit accruals within five (5) business days of receipt of the COBC Detailed Error Report.

Effective with the October 2005 release, contractors and their shared systems shall receive COBC Detailed Error Reports that contain BHT03 identifiers that indicate "T" (test) or "P" (production) status for purposes of fulfilling the provider notification requirements. (Note: The "T" or the P" portion of the BHT03 indicator will be identical to the Test/Production indicator originally returned from CWF on the processed claim.)

Special Automated Provider Correspondence
Contractors, or their shared systems, shall also take the following actions indicated below only when they determine via the Beneficiary Other Insurance (BOI) reply trailer (29) that a COBA trading partner is in crossover production mode with the COBC (Test/Production Indicator=P). After a contractor, or its shared system, has received a COBC Detailed Error Report that contains claims with error source codes of "111" (flat file error) "222" (HIPAA ANSI error), or "333" (trading partner dispute), it shall take the following actions within five (5) business days:

1. Notify the physician, supplier, or provider via automated letter from your internal correspondence system that the claim did not cross over. The letter shall include specific claim information, not limited to, Internal Control Number

(ICN)/Document Control Number (DCN), Health Insurance Claim (HIC) number, Medical Record Number (for Part A only), Patient Control Number (only if it is contained in the claim), beneficiary name, date of service, and the date claim was processed.

Effective with July 2007, contractors and their systems shall ensure that*, in addition to the standard letter language (the claim(s) was/were not crossed over due to claim data errors and was/were rejected by the supplemental insurer),* their contractors' special provider letters/reports, which are generated for '222' and '333' error rejections in accordance with CR 4277, now include the following additional elements, as derived from the COBC Detailed Error Report: 1) Claredi HIPAA rejection code or other rejection code, and 2) the rejection code's accompanying description.

NOTE: Contractors, or their shared systems, are not required to reference the COBA trading partner's name on the above described automated letter, since the original remittance advice (RA)/electronic remittance advice (ERA) would have listed that information, if appropriate.

Update its claims history to reflect that the claim(s) did not cross over as a result of the generation of the automated letter.

Effective with October 1, 2007, all contractors shall modify their special provider notification letters that are generated for '111,' '222,' and '333' error situations to include the following standard language within the opening paragraph of their letters: "This claim(s) was/were not crossed over due to claim data errors or was/were rejected by the supplemental insurer."

Contractors shall reformat their provider notification letters to ensure that, in addition to the new standard letter language, they continue to include the rejection code and accompanying description, as derived from the COBC Detailed Error Report, for '222' or '333' errors in association with each errored claim.

70.6.2 – Coordination of Benefits Agreement (COBA) Full Claim File Repair Process

(Rev.1296, Issued: 07-18-07, Effective: 10-01-07, Implementation: 10-01-07)

Effective with the July 2006 release, CMS will implement a full claim file repair process at its Medicare contractors to address situations where one or more of the contractor shared systems inadvertently introduced a severe error condition into the claims processing cycle, with the effect being that the Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X12-N 837 Coordination of Benefits (COB) Institutional and Professional crossover claims files or National Council for Prescription Drug Programs (NCPDP) claim files become unusable for COB purposes**.**

When a Medicare contractor, the COBC, or a COBA trading partner identifies a shared system problem that will prevent, or has prevented, the COBA trading partner from accepting a HIPAA ANSI X12-N 837 COB Institutional and Professional claims file from the COBC, the Medicare contractor shall work with its shared system maintainer to assess the feasibility of executing a full claim file repair. Contractors shall utilize the COBC Detailed Error Reports to determine the percentage of errors present for each error source code—"111" (flat file) errors, "222" (HIPAA ANSI X12-N 837 COB) errors, and "333" (trading partner dispute) errors. When the contractors or their shared system maintainers determine that the error percentages are at or above the parameters discussed later within this section, the contractors shall begin the process of analyzing the claim files for a possible full claim repair process. If the Medicare contractors and their shared systems subsequently initiate a full claim file repair process, that process shall be accomplished within a maximum of 14 work days, unless determined otherwise by CMS.

Effective with July 2, 2007, contractors and their systems shall now base their decision making calculus for initiation of a claims repair of "111" (flat file) errors upon the number of errors received rather than upon an established percent parameter, as specified in §70.6.1 of this chapter. If a contractor receives even one (1) "111" error via the COBC Detailed Error Report, the contractor, working with its Data Center or shared system as necessary, shall immediately attempt a repair of the claims file, in accordance with all other requirements communicated within this section.

1. Medicare Contractor or Shared System Identification of a Full Claim File Problem and Subsequent Actions

When a contractor, working with its shared system maintainer, identifies a severe error condition that will negatively impact the claims that it has transmitted to the COBC, the contractor shall, upon detection, immediately notify CMS and the COBC by calling current COBC or CMS COBA crossover contacts and sending e-mail communications to: COBAProcess@cms.hhs.gov and cobva@ghimedicare.com.

The contractor shall work closely with its system maintainer to determine the timeframes for developing, testing, and applying a fix to correct the severe error(s) that was/were identified within the 837 or NCPDP files that were previously transmitted to the COBC. The Part A, Part B, or *DMAC* shared system maintainers shall then report the timeframes for developing, testing, and applying a fix to the full claim file problem in accordance with their procedures as outlined in their systems maintenance contract. If CMS determines that the timeframes for affecting a full claim file repair of the previously transmitted claims exceed what is considered reasonable (a maximum of 14 work days, unless determined otherwise by CMS), a designated COBA team representative will notify the Medicare contractors and their shared system maintainers via e-mail to abort the full claim file repair process.

Upon receipt of a notification from the CMS COBA team representative that indicates that the timeframes for fixing a full claim file problem exceed those that are acceptable to CMS, the contractors' shared systems shall abort the full claim file repair process. Contractors shall then follow the requirements provided in §70.6.1 of this chapter with respect to the special provider notification and other COBA crossover operational processes. In such cases, however, contractors shall not be required to wait the customary five (5) business days before generating the special provider notification letters to their affected physicians, suppliers, or other providers of service.

2. Alerting Contractors to the Possible Need for a Full Claim File Repair via the COBC Detailed Error Reports and Subsequent Contractor Actions

a. Severe Error Percentage Parameters and Suppression of the Special Provider Notification Letters

Effective with July 2006, the CMS, working in conjunction with the COBC, shall modify the COBC Detailed Error Report layouts, as found in §70.6.1 of this chapter, to include the following new elements: Total Number of Claims for Date of Receipt; Total Number of "111" (flat file) Errors and corresponding percentage; Total Number of "222" (HIPAA ANSI X12-N 837 COB) Errors and corresponding percentage; and Total Number of "333" (trading partner dispute) Errors and corresponding percentage.

Effective with July 2007, CMS is directing its Medicare contractors to now base their severe error decision calculus upon the number of "111" errors received rather than percentage of such errors. Therefore, when a contractor or its shared system maintainer receives a COBC Detailed Error Report that indicates that the trading partner is in production and the number of "111" (flat file) errors is equal to or greater than one, the contractor's shared system shall suppress the generation of special provider notifications, as provided in § 70.6.1 of this chapter, until after the severe error condition(s) has/have been analyzed. (**NOTE:** If the "222" and/or "333" errors indicated on the COBC Detailed Error Report do **not** exceed the four (4) percent parameter, then the

contractor shall continue with the generation of the provider notification letters for those errors while it is analyzing the "111" severe error(s). **IMPORTANT:** *Effective with October 1, 2007, contractors and their systems shall have the capability to initiate a claims repair process, internally or at CMS direction, for situations in which they encounter high volume "222" or "333" error rejections that do not meet or exceed the established error threshold parameters. Before initiating a claims repair for error situations that fall below the established percentage parameters, the affected contractors shall first contact a member of the CMS COBA team to obtain clearance for that process.*

When a contractor or its shared system maintainer receives a COBC Detailed Error Report that indicates that the trading partner is in production and the percentage of "222" (HIPAA ANSI X12-N 837) errors and "333" (trading partner dispute) errors is equal to or greater than four (4) percent, the contractor's shared system shall suppress the generation of special provider notifications, as provided in §70.6.1 of this chapter, until after the severe error condition(s) has/have been analyzed. **NOTE:** If the number of "111" errors indicated on the COBC Detailed Error Report is **not** equal to or greater than one (1), then the contractor shall continue with the generation of the provider notification letters for those errors while it is analyzing the "222" and "333" severe errors.

For each of the severe error situations discussed above, contractors, or their shared systems, shall suppress the special provider notification for a minimum of five (5) business days. *T*he contractors' shared systems shall also have the capability to adjust the parameters for generation of the provider notification letters, as referenced in §70.6.1 of this chapter, of up to 14 work days while analysis of the claims that are being "held" for possible full claim file repair is proceeding.

Effective with October 1, 2007, all contractors shall have the capability to suppress their provider notification letters for a timeframe of up to 14 work days, or longer at CMS direction, where they initiate a claims repair process when claims with "222" or "333" errors fall below the "normally established" four (4) percent threshold.

Also, for each of the situations discussed above, the contractors' shared systems shall establish percentage parameters for each error source code (222 and 333) that allow for flexibility within a range (e.g., 1 to 10 percent).

b. Additional Information Highlighting Possible Severe Error Conditions on the COBC Detailed Error Reports.

Effective with July 2006, the COBC will report one of the following error sources and error codes/trading partner dispute codes that may be indicative of

a severe error condition on the returned COBC Institutional and Professional Detailed Error Reports:

1.) Error source code "111" will be reported in field 10, along with a 6-digit error code in field 11 (note: unlike routine reporting of flat file errors, a full claim file error condition would be indicated if there were numerous instances of the same error code repeated throughout a Report); the description of the problem(s) that has/have caused the full claim file to be unusable will be reported in field 12 (error description);

2.) Error source code "222" will be reported in field 10, along with a 6-digit error code in field 11 that begins with an "N"; the description of the problem(s) that has/have caused the full claim file to be unusable will be reported in field 12 (error description);

3.) Error source code "333" will be reported in field 10; an error/trading partner dispute code "999" (trading partner dispute—"other") will be reported in field 11, left-justified and followed by spaces; and a description of the problem(s) that has/have caused the full claim file to be unusable will be reported in field 12 (error description).

DMAC contractors and their shared systems shall process NCPDP Detailed Error Reports returned from the COBC that contain the following combination of error source codes, error/trading partner dispute codes, and error descriptions within the Reports:

1.) Error source code "111" will be reported in field 9, along with a 6-digit error code in field 10 (note: unlike routine reporting of flat file errors, a full claim file error condition would be indicated if there were numerous instances of the same error code repeated throughout a Report); and a description of the problem(s) that has/have caused the full claim file to be unusable will be reported in field 11; **or**

2.) Error source code "333" will be reported in field 9; an error/trading partner dispute code "999" will be reported in field 10, left-justified and followed by spaces; and a description of the problem(s) that has/have caused the full claim file to be unusable will be reported in field 11 (error description).

c. Contractor Actions Following Suppression of the Special Provider Notification Letters to Analyze Possible Severe Error Conditions

When contractors receive COBC Detailed Error Reports that contain "222" or "333" errors with percentages that are at or above the established parameters—or if the contractors receive "111" errors that are at or above zero ("0")—they shall work closely with their system maintainers to determine the timeframes for developing, testing, and applying a fix to correct the severe

error(s) that was/were identified within the 837 or NCPDP files that were previously transmitted to the COBC. The Part A, Part B, or *DMAC* shared system maintainers shall then report the timeframes for developing, testing, and applying a fix to the full claim file problem in accordance with their procedures as outlined in their systems maintenance contract. If CMS determines that the timeframes for affecting a full claim file repair of the previously transmitted claims exceed what is considered reasonable (a maximum of 14 work days, unless determined otherwise by CMS), a designated COBA team representative will notify the Medicare contractors and their shared system maintainers via e-mail to abort the full claim file repair process.

As noted above, effective with October 1, 2007, all contractors shall have the capability to suppress their provider notification letters for a timeframe of up to 14 work days, or longer at CMS direction, where they initiate a claims repair process when claims with "222" or "333" errors fall below the "normally established" four (4) percent threshold.

Upon receipt of a notification from the CMS COBA team representative that indicates that the timeframes for fixing a full claim file problem exceed those that are acceptable to CMS, the contractors' shared systems shall abort the full claim file repair process. Contractors shall then follow the requirements provided in §70.6.1 of this chapter with respect to the special provider notification and other COBA crossover operational processes. In such cases, however, contractors shall not be required to wait the customary five (5) business days before generating the special provider notification letters to their affected physicians, suppliers, or other providers of service.

In the event that CMS indicates that a full claim file repair process is feasible, the contractors' shared systems shall have the ability to cancel the generation of the provider notification letters, as stipulated in §70.6.1 of this chapter, for the "repaired" claims **and** only generate the provider notification letters for the claims containing legitimate 111, 222, or 333 errors not connected with the severe error condition(s).

3. Steps for Ensuring that Only "Repaired" Claims are Re-transmitted to the COBC

Once the contractors' shared systems have determined that they are able to affect a "timely" repair to the full claim files that were previously transmitted to the COBC, they shall take the following actions:

a.) Apply the fix to the unusable claims;

b.) Compare the claims files previously sent to the COBC with the repaired claims file to isolate the claims that previously did **not** contain the error condition(s);

c.) Strip off the claims that did not contain the error condition(s), including claims that contained 111, 222, and 333 errors that were not connected with the severe error condition(s). For the latter set of claims (those with 111, 222, and 333 errors that were **not** connected to the severe error condition), contractors shall then generate the provider notification letters, as stipulated in §70.6.1 of this chapter and specified in the concluding paragraph of the above sub-section entitled, "Contractor Actions Following Suppression of the Special Provider Notification Letters to Analyze Possible Severe Error Conditions";

d.) Recreate the job; and

e.) Send only the "repaired" claims to the COBC.

Contractors' shared systems shall add an indicator"18" to the BHT02 (Beginning of the Hierarchical Transaction/Transaction Set Purpose Code) segment of the HIPAA 837 flat file to designate that the file contains only repaired claims. In addition, the contractor systems shall include the repaired claims in different ST-SE envelopes to differentiate the repaired claims from normal 837 flat file transmissions.

The *DMAC* contractor system shall add an indicator "R" after the COBA ID reported in the Batch Header Record in the Receiver ID field (field number 880-K7) of the NCPDP claim when transmitting the repaired claims to the COBC.