| CMS Manual System | **Department of Health & Human Services (DHHS)** |
|---|---|
| Pub 100-04 Medicare Claims Processing | **Centers for Medicare & Medicaid Services (CMS)** |
| **Transmittal 1704** | **Date: March 20, 2009** |
| | **Change Request 6343** |

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

**I. SUMMARY OF CHANGES:** Through this instruction, CMS is requiring the Common Working File (CWF) to display all COBA bypass exclusion indicators within the Health Insurance Master Record (HIMR) claim detail screens. In addition, through this instruction 1) the CWF maintainer shall now begin to display crossover disposition indicators on HIMR even when COBA trading partners are in "test" mode with the COBC, with one noted exception; 2) Part A shared system shall modify the formatting of the special provider notification letters that it creates following Part A contractor receipt of Coordination of Benefits Contractor Detailed Error Reports (COBC DERs); and 3) at CMS's direction, the Coordination of Benefits Contractor (COBC) will modify the COBA Insurance File (COIF) to allow for separate displays of Test/Production indicator claim versions; and expand the bytes available for "error description" within the COBC Detailed Error Report layouts for 837 institutional and professional claims.

**New / Revised Material**
**Effective Date: July 1, 2009, for MCS, VMS, and CWF; October 1, 2009, for FISS**
**Implementation Date: July 6, 2009 (MCS and VMS—full implementation; CWF—full implementation except consistency edits); October 5, 2009 (FISS—full implementation; VMS—hours for testing; CWF—implementation of consistency edits)**

*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 | 27/80.15/ Claims Crossover Disposition and Coordination of Benefits Agreement By-Pass Indicators |
| R | 28/70.6.1/ The Coordination of Benefits Agreement (COBA) Detailed Error Report Notification Process |

**III. FUNDING:**
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):

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

**IV. ATTACHMENTS:**

**Business Requirements**

**Manual Instructions**

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

# Attachment - Business Requirements

| Pub. 100-04 | Transmittal: 1704 | Date: March 20, 2009 | Change Request: 6343 |
|---|---|---|---|

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

**Effective Date**: July 1, 2009, for MCS, VMS, and CWF;
October 1, 2009, for FISS

**Implementation Date:** July 6, 2009 (MCS and VMS—full implementation; CWF—full implementation except consistency edits); October 5, 2009 (FISS—full implementation; VMS—hours for testing; CWF—implementation of consistency edits)

## I. GENERAL INFORMATION

**A. Background:** Currently, the Common Working File (CWF) system posts the crossover disposition of the vast majority of claims that Medicare contractors transmit to it for verification and validation purposes. In this vein, CWF presently posts a 1 or 2-byte crossover disposition indicator in association with claims stored on history if the Coordination of Benefits Agreement (COBA) trading partner that has identified beneficiaries for crossover purposes is in "production" mode with the Coordination of Benefits Contractor (COBC). CWF presently bypasses certain claims from eligibility for the national COBA crossover process (e.g., requests for anticipated payment [RAPs]) without posting bypass indicators on the Health Insurance Master Record (HIMR) and also processes, in accordance with past CMS guidance, "test" crossover claims through for the COBA process without posting disposition indicators in association with these claims on HIMR. These practices will change effective with this instruction.

All Medicare contractors currently generate special provider notification letters when the COBC transmits Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) 837 compliance errors (or "222" errors) and COBA trading partner disputes errors ("333" errors) to them via the COBC Detailed Error Report process. These letters contain information about the affected beneficiaries, their associated claims, and the affected provider as well as the specific error code and accompanying description that explains why CMS was unable to transmit the affected claims to the COBA trading partner via the national crossover process. Medicare Part A contractors currently issue reports that mimic the Coordination of Benefits Contractor Detailed Error Report (COBC DER) to providers when they learn that either the COBC or COBA trading partner could not accept crossover claims. The current 114 report is unwieldy and does not feature a pre-printing of the provider address. CMS therefore is requesting that the Part A shared system reduce the manual effort that its associated contractors must expend in mailing the COBC DER special provider report by making the changes indicated in the business requirements below.

Lastly, CMS has identified a need to expand the COBC Detailed Error Report error description field in association with 837 institutional and professional claims. This business need is addressed in the requirements below.

Implementation strategy for this instruction: As indicated with the effective and implementation dates above, all shared systems, except the CWF, will implement all requirements except 6343.2 and 6343.2.1 as part of the July 2009 release. CWF shall implement formatting changes associated with the business requirements below during July 2009 but shall implement consistency edit requirements during the October 2009 release. All shared systems shall implement requirements tied to 6343.2 and 6343.2.1 as part of the October 2009 release.

**B. Policy:** Effective with the July 2009 release, the CWF maintainer shall display all auto-exclude/COBA by-pass events, as detailed below, in association with an adjudicated claim within the COBA bypass field on

page 3 of the HIMR intermediary claim detail screen and on page 2 of the HIMR Part B and Durable Medical Equipment Medicare Administrative Contractor (DME MAC) detail screen. The CWF shall, in addition, display a new "BT" crossover disposition exclusion indicator on pages 2 and 3 of the HIMR claim detail screens. As part of the October 2009 release, CWF shall discontinue the practice of inputting spaces on the claim detail records when the incoming claim contains invalid values within specifically-designated fields. CWF shall henceforth apply consistency edits to the following fields of the incoming claims transactions indicated: 1) "RAC adjustment indicator" field (valid values=R or space) within HUIP, HUOP, HUHH, HUHC, HUBC, and HUDC claims; 2) "NPI placeholder" field (valid values=Y or space) within HUIP, HUOP, HUHH, HUHC, HUBC, and HUDC claims; 3) "Beneficiary Liability indicator" field (valid values=L, N, or space) within HUBC and HUDC claims (**NOTE**: CWF already applies consistency edits to incoming Part A-oriented claims); and 4) "PQRI" indicator (valid values=Q or space) within HUBC claims. Upon receipt of a consistency edit for the reporting of invalid values within the foregoing claim fields, the contractor, working with its shared system, shall, as of the October 2009 release, take the following actions: 1) fix the incorrect application of non-valid values within the applicable claim fields; and 2) retransmit the corrected claims to CWF.

Through this instruction, the CWF maintainer shall, as part of the July 2009 release, create additional fields within claim page 3 of the HIMR intermediary claim detail screen and page 2 of the Part B and DME MAC claim detail screens to allow for the reporting of crossover disposition indicators in association with "test" COBA crossover claims. As occurs presently, the CWF maintainer shall determine that a COBA trading partner is in "test" mode by referencing the incoming COBA Insurance File (COIF). The CWF maintainer shall 1) create additional fields for displaying "test" crossover disposition indicators within both the eligibility file-based and claim-based crossover portions of the claim detail screens on HIMR; and 2) display the "test" crossover disposition indicators so that they mirror all such indicators used for "production" claims in association with the following four (4) claim versions: 4010A1, 5010, National Council for Prescription Drug Programs (NCPDP)-5.1, and NCPDP-D.0.

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

At CMS's direction, the COBC will modify the COIF, in accordance with Attachment A, so that the current "Test/Production" indicator field is renamed the "4010A1 Test/Production Indicator" **and** a new "NCPDP 5.1 Test/Production Indicator" is reflected.

CWF shall 1) accept and process the COBC-generated modified COIF on a weekly basis; and 2) accept the following values within the two newly defined COIF fields: "N" (format not in use for this trading partner); "P" (trading partner in production); and "T" (trading partner in "test" mode). In addition, CWF shall modify the BOI reply trailer (29) in the following manner: 1) Rename "COBA-TEST-PROD-IND PIC" as "COBA-4010A1-TEST-PROD-IND PIC"; 2) Rename "NCPDP-TEST-PROD-IND PIC" as "NCPDPD.0-TEST-PROD-IND PIC"; and 3) Add "NCPDP5.1-TEST-PROD-IND PIC" (see Attachment B). The shared systems shall accept and utilize the modified CWF-generated BOI reply trailer (29) as part of the national COBA crossover process. (**NOTE:** Specific scenarios involving the interaction of new indicators, as well as pre-existing indicators, are covered under change requests 6308 and 6374, the latter of which is in final clearance. Additionally, CWF shall modify the HIMR COIF File Summary Screen (COBS) as follows on page 3: 1) Rename "4010 TST/PRD" as "4010A1 TEST/PRD": 2) Rename "NCPDP TST/PRD" as "NCPDP D.0 TST/PRD"; and 3) Add "NCPDP5.1 TST/PRD."

The COBC will, at CMS's direction, modify the COBC Detailed Error Report layouts for 837 institutional and professional claims to expand the size of the "error description" field and to increment the filler field at the detail record level, as reflected in Attachment C. All shared system maintainers shall modify their version of the COBC Detailed Error Report layouts to coincide with the formats found in Attachment C.

Upon receipt of the COBC Detailed Error Report (DER), the Part A shared system shall configure the existing 114 report, as derived from the COBC DER, so that it 1) continues to display in landscape format; and 2) includes a cover page that contains the provider's correspondence mailing address.

## II. BUSINESS REQUIREMENTS TABLE

| Number | Requirement | Responsibility (place an "X" in each applicable column) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | DME MAC | FI | CARRIER | RHHI | Shared-System Maintainers | | | | Other |
| | | | | | | | FISS | MCS | VMS | CWF | |
| 6343.1 | The CWF maintainer shall display up to 8 new COBA bypass indicators in association with an adjudicated claim within the COBA bypass field on page 3 of the HIMR intermediary claim detail screen and on page 2 of the HIMR Part B and DME MAC claim detail screens. | | | | | | | | | X | |
| 6343.1.1 | The CWF maintainer shall display the following new 2-byte COBA bypass indicators in the COBA bypass field on page 3 of the HIMR intermediary claim detail screen:<br>• "BA"--Claim represents "Add History" only; therefore, the claim is bypassed and not crossed over;<br>• "BB"—Claim falls into one of two situations: 1) there is no eligibility record; and 2) the only available eligibility record contains a "Y" delete indicator; therefore, the claim is bypassed for crossover;<br>• "BC"—Claim represents an abbreviated encounter record (TOB 11z; condition code 04 or 69); therefore, the claim is bypassed and not crossed over;<br>• "BD"—Claim contains a Part A CWF claim disposition other than 01, 03, or 05; therefore, the claim is bypassed and not crossed over;<br>• "BE"—Submission of Notice of Elections (Hospice—TOB=8xA through 8xE on HUHC; CEPP—TOB=11A through 11D on HUIP; Religious Non-Medical Care—TOB=41A, 41B, and 41D on HUIP; Medicare Coordination Care—TOB=89A and 89B on HUOP); therefore, the submission is bypassed and not crossed over;<br>• "BF"—Claim represents an excluded | | | | | | | | | X | |

| Number | Requirement | Responsibility (place an "X" in each applicable column) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | DME MAC | FI | CARRIER | RHHI | Shared-System Maintainers | | | | Other |
| | | | | | | | FISS | MCS | VMS | CWF | |
| | demonstration (DEMO) project; therefore, the claim is bypassed and not crossed over;<br>• "BP"—Sanctioned provider claim during the service dates indicated; therefore, the claim is bypassed and not crossed over; and<br>• "BR"—Submission for Request for Anticipated Payment [RAP] claims (TOB=322 and 332); therefore, the submission is bypassed and not crossed over. | | | | | | | | | | |
| 6343.1.2 | The CWF maintainer shall display the following new 2-byte COBA bypass indicators in the COBA bypass field on page 2 of the HIMR Part B and DME MAC claim detail screens:<br>• "BA"--Claim represents "Add History" only; therefore, the claim is bypassed and not crossed over;<br>• "BB"—Claim falls into one of two situations: 1) there is no eligibility record; and 2) the only available eligibility record contains a "Y" delete indicator; therefore, the claim is bypassed and not crossed over;<br>• "BD"—Claim contains a Part B or DME MAC CWF claim disposition other than 01, 03, or 05; therefore, the claim is bypassed and not crossed over;<br>• "BF"—Claim represents an excluded demonstration (DEMO) project; therefore, the claim is bypassed and not crossed over; and<br>• "BP"—Sanctioned provider claim during the service dates indicated; therefore, the claim is bypassed and not crossed over. | | | | | | | | | X | |
| 6343.1.3 | The CWF maintainer shall display the value "BT"—Individual COBA ID did **not** have a matching COIF—as a crossover disposition exclusion indicator within the "eligibility-based" and "claim-based" portions of pages 2 and 3 of the HIMR claim detail screens. | | | | | | | | | X | |
| 6343.1.4 | The contractor responsible for the Next Generation Desktop (NGD) shall modify its application screens and accompanying documentation to reflect the foregoing COBA bypass indicators, as found in requirements | | | | | | | | | | X NGD Con-tractor |

| Number | Requirement | Responsibility (place an "X" in each applicable column) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | DME MAC | FI | CARRIER | RHHI | Shared-System Maintainers | | | | Other |
| | | | | | | | FISS | MCS | VMS | CWF | |
| | 6343.1.1 and 6343.1.2. | | | | | | | | | | |
| 6343.1.5 | The contractor responsible for the NGD shall modify its application screens and accompanying documentation to reflect the new "BT" crossover disposition indicator, together with its definition, as per 6343.1.3 | | | | | | | | | | X NGD Con-tractor |
| 6343.1.6 | The contractor or system responsible for the MCSDT application shall update that tool to capture the COBA bypass indicators, as found in 6343.1.1 and 6343.1.2. | | | | | | | X | | | X MCS DT |
| 6343.1.7 | The contractor or system responsible for the MCSDT application shall update that tool to capture the new "BT" claims crossover disposition indicator, together with its definition, as per 6343.1.3. | | | | | | | X | | | X MCS DT |
| 6343.1.8 | Contractors shall update their provider customer service materials to include the above COBA bypass indicators and new "BT" crossover disposition indicator along with their descriptions. | X | X | X | X | X | | | | | |
| 6343.2 | CWF shall discontinue the practice of inputting spaces on the claim detail records when the incoming claim contains invalid values within specifically-designated fields. | | | | | | | | | X | |
| 6343.2.1 | CWF shall henceforth apply consistency edits to the following fields of the incoming claims transactions indicated:<br>• "RAC adjustment indicator" field (valid values=R or space) within HUIP, HUOP, HUHH, HUHC, HUBC, and HUDC claims;<br>• "NPI placeholder" field (valid values=Y or space)within HUIP, HUOP, HUHH, HUHC, HUBC, and HUDC claims;<br>• "Beneficiary Liability indicator" field (valid values=L, N, or space) within HUBC and HUDC claims; and<br>• "PQRI" indicator (valid values=Q or space) within HUBC claims. | | | | | | | | | X | |
| 6343.2.2 | Upon receipt of a CWF-generated consistency edit for inappropriate values being reported within one of the fields outlined in 6343.2.1, the contractor, working with its shared system, shall take the following actions:<br>• Fix the incorrect application of non-valid values within the applicable claim fields; and | 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 | RHHI | Shared-System Maintainers | | | | Other |
| | | | | | | | FISS | MCS | VMS | CWF | |
| | • Retransmit the corrected claims to CWF. | | | | | | | | | | |
| 6343.3 | At CMS's direction, the COBC will modify the COBA Insurance File (COIF), in accordance with Attachment A, so that the "Test/Production" indicator field is renamed the "4010A1 Test/Production indicator" and a new "NCPDP 5.1 Test/Production Indicator" is reflected. | | | | | | | | | | X COBC |
| 6343.3.1 | CWF shall accept and process the COBC-generated modified COIF on a weekly basis. | | | | | | | | | X | |
| 6343.3.2 | CWF shall accept the following values within the COIF fields discussed in 6343.3: "N" (format not in use for this trading partner); "P" (trading partner in production); and "T" (trading partner in "test" mode). | | | | | | | | | X | |
| 6343.3.3 | CWF shall utilize the modified COIF in association with its posting of "test" crossover disposition indicator requirements and sub-requirements, beginning with 6343.4. | | | | | | | | | X | |
| 6343.3.4 | CWF shall modify the BOI reply trailer (29) as follows as reflected in Attachment B:<br>• Rename " COBA-TEST-PROD-IND PIC" as "4010A1-TEST-PROD-IND PIC";<br>• Rename "NCPDP-TEST-PROD-IND PIC" as "NCPDPD0-TEST-PROD-IND PIC"; and<br>• Add "NCPDP51-TEST-PROD-IND PIC" (see Attachment B).<br>**(NOTE: All other elements shall remain unchanged.)** | | | | | | | | | X | |
| 6343.3.5 | CWF shall modify the HIMR COIF File Summary Screen (COBS) as follows on page 3:<br>• Rename "4010 TST/PRD" as "4010A1 TEST/PRD":<br>• Rename "NCPDP TST/PRD" as "NCPDP D.0 TST/PRD"; and<br>• Add "NCPDP5.1 TST/PRD." | | | | | | | | | X | |
| 6343.3.5.1 | All shared systems indicated, as well as the contractor responsible for maintaining the MCSDT application, shall modify their interfaces with the HIMR COBS so that they capture the changes described in 6343.3.5 | | | | | | X | X | | | X MCSDT |
| 6343.3.6 | The shared systems shall accept and utilize the modified CWF-generated BOI reply trailer (29) as part of the national COBA crossover process. (**NOTE:** Specific scenarios involving the interaction of new indicators, as | | | | | | X | X | X | | |

| Number | Requirement | Responsibility (place an "X" in each applicable column) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | DME MAC | FI | CARRIER | RHHI | Shared-System Maintainers | | | | Other |
| | | | | | | | FISS | MCS | VMS | CWF | |
| | well as pre-existing indicators, are covered under change request 6308 and will be addressed as part of change request 6374 when final.) | | | | | | | | | | |
| 6343.3.7 | The contractor responsible for maintaining the NGD application shall modify all COIF-related screens to correspond to the above described changes. | | | | | | | | | | X NGD |
| 6343.3.8 | The contractor responsible for the MCSDT application shall modify all COIF-related screens to correspond to the above described changes. | | | | | | | X | | | X MCSDT |
| 6343.4 | The CWF maintainer shall create additional fields within claim page 3 of the HIMR intermediary claim detail screen and page 2 of the Part B and DME MAC claim detail screens to allow for the reporting of crossover disposition indicators in association with "test" COBA crossover claims. | | | | | | | | | X | |
| 6343.4.1 | The shared systems shall adjust their interfaces with HIMR to meet the requirements of 6343.4. | | | | | | X | X | X | | |
| 6343.4.2 | The CWF maintainer shall determine that a COBA trading partner is in "test" mode by reading the COIF. | | | | | | | | | X | |
| 6343.4.3 | The CWF maintainer shall create additional fields for displaying "test" crossover disposition indicators within both the eligibility file-based and claim-based crossover portions of the claim detail screens on HIMR. | | | | | | | | | X | |
| 6343.4.4 | The shared systems shall adjust their interfaces with HIMR to meet the requirements of 6343.4.3. | | | | | | X | X | X | | |
| 6343.4.5 | The CWF maintainer shall display "test" crossover disposition indicators so that they mirror all such indicators used for "production" claims in association with the following claim versions: 4010A1, 5010, NCPDP-5.1, and NCPDP-D.0. | | | | | | | | | X | |
| 6343.4.6 | If the COBC transmits a COIF that contains a "test" COBA ID within the range 79000 through 79999 (Medicaid quality project), CWF shall post an "MQ" disposition indicator in association with the claim instead of the traditional "A" indicator when it selects the claim for crossover. (**NOTE:** "MQ" shall designate that Medicare is transferring the claim for Medicaid quality project purposes only.) | | | | | | | | | X | |
| 6343.4.7 | CWF shall annotate claims whose COBA ID is 79000 through 79999 with "MQ" regardless of the claim version indicator in those instances where it selects the claims for transference to the COBC. | | | | | | | | | X | |

| Number | Requirement | Responsibility (place an "X" in each applicable column) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | DME MAC | FI | CARRIER | RHHI | Shared-System Maintainers | | | | Other |
| | | | | | | | FISS | MCS | VMS | CWF | |
| 6343.4.7.1 | If CWF excludes from crossover a claim whose COBA ID equals 79000 through 79999, CWF shall continue to post the crossover disposition indicator that corresponds to the reason for the exclusion on the appropriate HIMR claim detail screen. | | | | | | | | | X | |
| 6343.4.8 | The shared systems shall adjust their interfaces with HIMR to meet the requirements of 6343.4.6. | | | | | | X | X | X | | |
| 6343.5 | At CMS's direction, the COBC shall modify the COBC Detailed Error Report layouts for 837 institutional and professional claims to expand the size of the "error description" field at the detail record level, as reflected in Attachment C. | | | | | | | | | | X COBC |
| 6343.5.1 | The indicated shared system maintainers shall modify their versions of the COBC Detailed Error Report layouts to coincide with the formats found in Attachment C. (**NOTE:** This means that the shared systems shall include the expanded error description code as part of their special provider notification letters.) | | | | | | X | X | X | | |
| 6343.5.2 | Upon receipt of the COBC Detailed Error Report (DER), the Part A shared system shall configure the existing 114 report, as derived from the COBC DER, so that it 1) continues to display in landscape format; and 2) includes a cover page that contains the provider's correspondence mailing address | | | | | | X | | | | |
| 6343.5.3 | As occurs currently, all Part A contractors shall ensure that the newly formatted special provider notification letters are printing correctly and are ready for mailing. | X | | X | | X | | | | | |
| 6343.5.3.1 | All Part A contractors shall notify the shared system maintainer of instances where the generated special letters cannot be utilized due to problems with formatting or printing so that steps can be undertaken to correct the concerns as soon as possible. | X | | X | | X | | | | | |

## III. PROVIDER EDUCATION TABLE

| Number | Requirement | Responsibility (place an "X" in each applicable column) | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | A/B | DME | FI | CAR | RHH | Shared-System Maintainers | Other |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | FISS | MCS | VMS | CWF | | |
| | None. | | | | | | | | | | | |

**IV. SUPPORTING INFORMATION**

**Section A: Recommendations and supporting information associated with listed requirements:**
*"Should" denotes a recommendation.*

| X-Ref Requirement Number | Recommendations or other supporting information: |
|---|---|
| **N/A** | |

**Section B: All other recommendations and supporting information: N/A**

**V. CONTACTS**

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

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

**VI. FUNDING**

**Section A: For Fiscal Intermediaries, Regional Home Health Intermediaries and Carriers:**

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

**Section B: *For Medicare Administrative Contractors (MACs)*:**

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

**ATTACHMENTS**

**COBA INSURANCE FILE**

# ATTACHMENT A

| Field | Start | Length | End | Description |
|---|---|---|---|---|
| COBA ID | 1 | 10 | 10 | Unique identifier for each COB Agreement |
| COBA TIN | 11 | 9 | 19 | Tax Identification Number of COBA |
| COBA Name | 20 | 32 | 51 | Name of COBA Partner (Equivalent to Insurer Name on BOI Auxiliary File) |
| COBA Address 1 | 52 | 40 | 91 | Address 1 of COBA |
| COBA Address 2 | 92 | 40 | 131 | Address 2 of COBA |
| COBA City | 132 | 25 | 156 | Address city of COBA |
| COBA State | 157 | 2 | 158 | Postal State Abbreviation of COBA |
| COBA Zip | 159 | 9 | 167 | Zip plus 4 of COBA |
| **Common Claim Exclusions** | | | | **The following fields are 1 byte indicators dictating type of claim exclusions. A value of 'Y' in any of the following fields indicates those types of claims should be excluded.** |
| Non-assigned | 168 | 1 | 168 | Non-assigned claims |
| Orig. Claims Paid at 100% | 169 | 1 | 169 | Original claims paid at 100% |
| Orig. Claims Paid at >100% of the submitted.charges w/out deductible or co-ins. | 170 | 1 | 170 | Original claims paid at greater than 100% of the submitted charges without deductible or coinsurance remaining (**NOTE:** Also covers the exclusion of ambulatory surgical center claims, even if deductible or co-insurance applies.) |
| 100% Denied Claims, No Additional Liability | 171 | 1 | 171 | 100% denied claims, with no additional beneficiary liability |
| 100% Denied Claims, Additional Liability | 172 | 1 | 172 | 100% denied claims, with additional beneficiary liability |
| Adjustment Claims, Monetary | 173 | 1 | 173 | Adjustments, monetary claims |
| Adjustment Claims, Non-Monetary/Statistical | 174 | 1 | 174 | Adjustments, non-monetary/statistical claims |
| MSP Claims | 175 | 1 | 175 | Medicare Secondary Payer (MSP) claims. |
| Other Insurance | 176 | 1 | 176 | Claims if other insurance (such as Medigap, supplemental, TRICARE, or other) exists for beneficiary. **Applies to State Medicaid Agencies only. ** |
| NCPDP Claims | 177 | 1 | 177 | National Council Prescription Drug Program Claims |
| Adjustment Claims Paid at 100% | 178 | 1 | 178 | Adjustment claims paid at 100%. |
| Adjustment Claims, 100% Denied, No Additional Liability | 179 | 1 | 179 | Adjustment Claims, 100% Denied, with no additional beneficiary liability |
| Adjustment Claims, 100% Denied, Additional Liability | 180 | 1 | 180 | Adjustment Claims, 100% Denied, with additional beneficiary liability |
| MSP Cost-Avoided Claims | 181 | 1 | 181 | MSP claims that have been cost-avoided. |
| Mass Adjustment Claim-MPFS | 182 | 1 | 182 | Mass adjustment claim tied to Medicare Physician Fee Schedule (MPFS) updates. |
| Mass Adjustment Claim-Other | 183 | 1 | 183 | Mass adjustment claim-all other reasons besides MPFS updates. |
| All Adjustment Claims | 184 | 1 | 184 | All Adjustment Claims (NOTE: does not include credit only adjustments—“true voids”—for Part A) |
| Recovery Audit Contractor (RAC) Adjustment Claims (RA) | 185 | 1 | 185 | Indicates that COBA trading partner wishes to exclude all recovery audit contractor (RAC) adjustment claims (acceptable values=”Y” or space) |
| Filler | 186 | 2 | 187 | Future |
| Hospital Inpatient A | 188 | 1 | 188 | TOB 11 - Hospital: Inpatient Part A |
| Hospital Inpatient B | 189 | 1 | 189 | TOB 12 - Hospital: Inpatient Part B |
| Hospital Outpatient | 190 | 1 | 190 | TOB 13 - Hospital: Outpatient |
| Hospital Other B | 191 | 1 | 191 | TOB 14 - Hospital: Other Part B (Non-patient) |
| Hospital Swing | 192 | 1 | 192 | TOB 18 - Hospital: Swing Bed |
| SNF Inpatient A | 193 | 1 | 193 | TOB 21 - Skilled Nursing Facility: Inpatient Part A |

| | | | | |
|---|---|---|---|---|
| SNF Inpatient B | 194 | 1 | 194 | TOB 22 - Skilled Nursing Facility: Inpatient Part B |
| SNF Outpatient | 195 | 1 | 195 | TOB 23 - Skilled Nursing Facility: Outpatient |
| SNF Other B | 196 | 1 | 196 | TOB 24 - Skilled Nursing Facility: Other Part B (Non-patient) |
| SNF Swing Bed | 197 | 1 | 197 | TOB 28 - Skilled Nursing Facility: Swing Bed |
| Home Health B | 198 | 1 | 198 | TOB 32 - Home Health: Part B Trust Fund |
| Home Health A | 199 | 1 | 199 | TOB 33 - Home Health: Part A Trust Fund |
| Home Health Outpatient | 200 | 1 | 200 | TOB 34 - Home Health: Outpatient |
| Religious Non-Med Hospital | 201 | 1 | 201 | TOB 41 - Christian Science/Religious Non-Medical Services (Hospital) |
| Clinic Rural Health | 202 | 1 | 202 | TOB 71 - Clinic: Rural Health |
| Clinic Freestanding Dialysis | 203 | 1 | 203 | TOB 72 - Clinic: Freestanding Dialysis |
| Clinic Fed Health Center | 204 | 1 | 204 | TOB 73 - Clinic: Federally Qualified Health Center |
| Clinic Outpatient Rehab | 205 | 1 | 205 | TOB 74 - Clinic: Outpatient Rehabilitation Facility |
| Clinic CORF | 206 | 1 | 206 | TOB 75 - Clinic: Comprehensive Outpatient Rehabilitation Facility (CORF) |
| Clinic Comp Mental Health | 207 | 1 | 207 | TOB 76 - Clinic:  Comprehensive Mental Health Clinic |
| Clinic Other | 208 | 1 | 208 | TOB 79 - Clinic:  Other |
| SF Hospice Non-Hospital | 209 | 1 | 209 | TOB 81 - Special Facility: Hospice Non-Hospital |
| SF Hospice Hospital | 210 | 1 | 210 | TOB 82 - Special Facility: Hospice  Special Facility: Hospice Hospital |
| Ambulatory Surgical Center | 211 | 1 | 211 | TOB 83 - Special Facility: Ambulatory Surgical Center |
| Primary Care Hospital | 212 | 1 | 212 | TOB 85 - Primary Care Hospital |
| **Claim Header Level Exclusions** | | | | **The following fields are 1 byte indicators dictating type of claim exclusions.  A value of 'Y' in any of the following fields indicates those types of claims should be excluded.** |
| All Part A Claims | 213 | 1 | 213 | Claims identified as Part A in the HUIP, HUOP, HUHH, and HUHC queries to CWF. |
| All Part B Claims | 214 | 1 | 214 | Claims identified as Part B in the HUBC query to CWF. |
| All DMERC Claims | 215 | 1 | 215 | Claims identified as DMERC in the HUDC query to CWF. |
| Filler | 216 | 7 | 222 | Filler |
| **Part A/RHHI Provider Inclusion/Exclusion** | | | | **Part A/RHHI claims may be included or excluded by providers by specifying the Inclusion/Exclusion type. Inclusion or exclusion may be limited by either provider ID or provider state.** |
| Inclusion/Exclusion Type | 223 | 1 | 223 | Indicates whether providers are to be included or excluded (I - Inclusion or E - Exclusion) |
| Provider Qualifier | 224 | 1 | 224 | Indicates whether providers are identified by state or by provider ID (P - Provider number or S - Provider state) |
| Provider ID (P) | 225 | 650 | 874 | Specific providers IDs to be included or excluded (occurs 50 times--13-digit alpha/numeric provider number. |
| Provider State (S) | 875 | 100 | 974 | Specific provider states to be included or excluded (occurs 50 times—2-digit provider state code) |
| **Adjustment Claims, Mass Adjustment Claims,  and Recovery Audit Contractor Adjustment (RAC) Claims Inclusion** | | | | |
| Inclusion Indicator (used for trading partners wishing to receive adjustment claims only) | 975 | 1 | 975 | Indicates that COBA trading partner wishes to include adjustment claims ONLY(acceptable values=”I” or space) |
| Mass Adjustment Claims-MPFS Updates | 976 | 1 | 976 | Indicates that COBA trading partner wishes to include all mass adjustment claims tied to Medicare Physician Fee Schedule (MPFS) updates (acceptable values=”Y” or space) |

| | | | | |
|---|---|---|---|---|
| Mass Adjustment Claims—Other | 977 | 1 | 977 | Indicates that COBA trading partner wishes to include all mass adjustment claims—other (acceptable values="Y" or space) |
| Recovery Audit Contractor (RAC) Adjustment Claims (RA) | 978 | 1 | 978 | Indicates that COBA trading partner wishes to include all recovery audit contractor (RAC) adjustment claims (acceptable values="Y" or space) |
| Filler | 979 | 6 | 984 | Future |
| **Part B Contractor Inclusion/Exclusion** | | | | **Specific contractors may be included or excluded on Part B claims by specifying the Inclusion/Exclusion type.** |
| Inclusion/Exclusion Type | 985 | 1 | 985 | Indicates whether contractors are to be included or excluded (I – Inclusion or E - Exclusion) |
| Contractor ID | 986 | 100 | 1085 | State-specific Part B contractor claims to be excluded (occurs 50 times. First 2 positions of BSI indicator.) |
| Filler | 1086 | 160 | 1245 | Future |
| **DMERC Contractor Exclusion** | | | | **Specific contractors may be excluded on DMERC claims.** |
| Contractor ID | 1246 | 20 | 1265 | Specific contractors to be excluded on DMERC claims (occurs 4 times). |
| **HIPAA 5010 & NCPDP D.0 Test/Production Indicator** | | | | |
| 5010 Test/Production Indicator | 1266 | 1 | 1266 | COBA trading partner status for acceptance of HIPAA 5010 (acceptable values= N--not ready or not applicable; T--Test mode; P--Production mode) |
| NCPDP D.0 Test/Production Indicator | 1267 | 1 | 1267 | COBA trading partner status for acceptance of NCPDP D.0 (acceptable values= N--not ready or not applicable; T--Test mode; P--Production mode) |
| ***NCPDP 5.1 Test/Production Indicator*** | | | | |
| *NCPDP 5.1 Test/Production Indicator* | *1268* | *1* | | *COBA trading partner status for acceptance of NCPDP version 5.1 claims (acceptable values=N—format not in use; T—Test mode; P—Production mode)* |
| Filler | *1269* | *7* | 1275 | Future |
| **Medicare Summary Notice (MSN) Indicator for Trading Partner Name** | | | | |
| MSN Indicator for Printing of Trading Partner Name | 1276 | 1 | 1276 | Indicates whether the COBA trading partner wishes its name to appear on the MSN. (Y=Yes N=No) |
| *4010-A1* **Test/ Production Indicator** | | | | |
| *4010-A1* Test/Production Indicator | 1277 | 1 | 1277 | One-position indicator that communicates *a COBA trading partner's status for acceptance of HIPAA 4010-A1 claims* (T= Test Mode; P=Production Mode; *N=format not in use*) |

# CWF Beneficiary Other Insurance (BOI)
# Reply Trailer Requirements Attachment B

CWF shall return a BOI Reply Trailer 29 to the Medicare contractors that displays the following elements as part of the national Coordination of Benefits Agreement (COBA) eligibility file-based and Medigap claim-based crossover processes:

01: X:-29-TRAILER.
05: X:-29-TRLR-CODE PIC X (02).
05: X:-29-OCCURRENCES PIC 9(02).
05: X:-29-COBA-CROS-IND PIC X (01).
05: X:-29-DATA OCCURS 1 TO 10 TIMES,
DEPENDING ON X:-29-OCCURRENCES
INDEXED: X:-29-INDEX.

10: X:-29-COBA-NUM PIC X (10).
10: X:-29-COBA-NAME PIC X (32).
10: X:-29-COBA-MSN-IND PIC X (01).
10: X:-29-COBA-EFF-DATE PIC S9 (07) COMP-3.
10: X:-29-COBA-TRM-DATE PIC S9 (07) COMP-3.
10: X:-29-*4010A1-*TEST-PROD-IND PIC X (01)
10: X:-29-5010-TEST-PROD-IND PIC X (01)
10: X:-29-NCPDP *D0*-TEST-PROD-IND PIC X (01)
*10X- 29 NCPDP 51-TEST-PROD-IND PIC X (01)*
*10: X:-filler PIC X (9)*

# ATTACHMENT C

## 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. | Filler | 100 | 83-182 |
| 12. | Field Contents | 50 | 183-232 |
| 13. | BHT 03 Identifier | 30 | 233-262 |
| 14. | Claim DCN/ICN | 23 | 263-285 |
| 15. | Error Description | 300 | 286-585 |
| 16. | Filler | 15 | 586-600 |

### 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 | 524 | 77-600 |

## 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. | Filler | 100 | 83-182 |
| 13 | Field Contents | 50 | 183-232 |
| 14 | BHT 03 Identifier | 30 | 233-262 |
| 15 | Claim DCN/ICN | 23 | 263-285 |
| 16. | Error Description | 300 | 286-585 |
| 17. | Filler | 15 | 586-600 |

### 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 | 524 | 77-600 |

## 80.14 - Consolidated Claims Crossover Process

***(Rev. 1704, Issued: 03-20-09, Effective: 07-01-09 MCS, VMS, CWF/10-01-09 FISS, Implementation: 07-06-09 MCS, VMS, CWF/10-05-09 FISS, VMS, CWF)***

### 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*, unless there is a COBA ID in range 55000 through 55999 present on the incoming HUBC or HUDC claim (which identifies Medigap claim-based crossover),* 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.)

*Effective with July 7, 2009, at CMS's direction, the COBC will modify the COIF so that the "Test/Production" indicator, originally created as part of the October 2004 release, is renamed the "4010A1 Test/Production indicator" and a new field, the "NCPDP-5.1 Test/Production indicator," is also reflected. In turn, CWF shall 1) accept and process the COBC-generated modified COIF on a weekly basis; and 2) accept the following values within the two newly defined COIF fields: "N" (format* ***not*** *in use for this trading partner); "P" (trading partner in production); and "T" (trading partner in "test" mode).. CWF shall also modify the BOI reply trailer (29) to reflect these changes, as further specified under "BOI Reply Trailer 29 Processes" 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.

*Effective with July 7, 2009, CWF shall modify the BOI reply trailer (29) to rename the existing Test/Production indicator as "4010A1 Test/Production indicator" and rename the NCPDP Test/Production indicator as "NCPDPD0 Test/Production indicator." In addition, CWF shall include a new 1-byte field "NCPDP51 Test/Production indicator" as part of the BOI reply trailer (29).*

**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.)

Effective January 5, 2009, when CWF returns a BOI reply trailer (29) to a Medicare contractor that contains **only** a COBA ID in the range 89000 through 89999, the contractor's system shall suppress all crossover information, including name of insurer and generic message#35.1, from all beneficiary MSNs. (See chapter 28, §70.6 for details regarding additional Medicare contractor requirements.)

In addition, the contractor shall **not** issue special provider notification letters following their receipt of COBC Detailed Error Reports when the claim's associated COBA ID is within the range 89000 through 89999 (see chapter 28, §70.6.1 for more details.)

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

Beginning with the October 2004 release, when CWF returns a BOI reply trailer (29) that contains a "T" Test/Production Indicator to the Medicare contractors, 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 CWF returns a BOI reply trailer (29) that contains a "P" Test/Production Indicator to the Medicare contractors, 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 January 5, 2009, if CWF returns **only** a COBA ID range 89000 through 89999 on a BOI reply trailer (29) to a Medicare contractor, the contractor's system shall suppress all crossover information (the entire 2100 loop) on the 835 ERA.

Effective January 5, 2009, 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 has signed a national COBA), CWF shall sort the COBA IDs and trading partner names in the following order:

1) Eligibility-based Medigap (30000-54999); 2) Claim-based Medigap (55000-59999); 3) Supplemental (00001-29999); 4) TRICARE (60000-69999); 5) Other Insurer (80000-88999); 6) Medicaid (70000-79999); and 7) Other—Health Care Pre-Payment Plan [HCPP] (89000-89999). 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.

Effective with April 1, 2008, the CWF shall also include total submitted/billed charges as part of the foregoing elements used to exclude adjustment claims, monetary as well as adjustment claims, non-monetary. (See sub-section N, "Overarching Adjustment Claim Exclusion Logic," for details concerning the processes that CWF shall follow when the COBA trading partner's COIF specifies exclusion of **all** adjustment claims.)

## 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:

- 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;

- 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, the 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, the 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, the 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:

- 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:

- 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.

**N. Overarching Adjustment Claim Exclusion Logic**

"Overarching adjustment claim logic" is defined as the logic that CWF will employ, independent of a specific review of claim monetary changes, when a COBA trading partner's COBA Insurance File (COIF) specifies that it wishes to exclude all adjustment claims.

New CWF Logic

Effective with April 1, 2008, the CWF maintainer shall change its systematic logic to accept a new version of the COIF that now features a new "all adjustment claims" exclusion option.

For the COBA eligibility file-based crossover process, where CWF utilizes both the BOI auxiliary record and the COIF when determining whether it should include or exclude a claim for crossover, CWF shall apply the overarching adjustment claim logic as follows:

- Verify that the incoming claim has an action code of 3 or entry code of 5 or, if the claim has an action or entry code of 1 (original claim), confirm whether it has an "A" claim header value, which designates adjustment claim for crossover purposes; and

- Verify that the COIF contains a marked exclusion for "all adjustment claims." If these conditions are met, CWF shall exclude the claim for crossover under the COBA eligibility file-based crossover process.

If both of these conditions are met, CWF shall exclude the claim for crossover under the COBA eligibility file-based crossover process. IMPORTANT: Independent of the foregoing requirements, CWF shall continue to only select an adjustment claim for

COBA crossover purposes if 1) it locates the matching original claim; and 2) it determines that the original claim was selected for crossover (see "H. Excluding Adjustment Claims When the Original Claim Was Also Excluded" above for more information).

New Crossover Disposition Indicator

Upon excluding the claim, CWF shall mark the claim as it is stored on the appropriate Health Insurance Master Record (HIMR) claim detail history screen with a newly developed "AC" crossover disposition indicator, which designates that CWF excluded the claim because the COBA trading partner wished to exclude all adjustment claims. (See §80.15 of this chapter for a description of this crossover disposition indicator.)

The CWF shall display the new indicator within the "eligibility file-based crossover" segment of the HIMR detailed claim history screen.

Exception Concerning COBA IDs in the Medigap Claim-based Range

CWF shall never apply the new overarching adjustment claim exclusion logic to incoming HUBC or HUDC claims whose field 34 ("Crossover ID") header value falls within the range of 0000055000 to 0000059999, which represents the COBA identifier of a COBA Medigap claim-based crossover recipient, and for which there is not a corresponding BOI auxiliary record that likewise contains that insurer identifier. (See §80.17 of this chapter for more information concerning the COBA Medigap claim-based crossover process.)

## O. Exclusion of Claims Containing Placeholder National Provider Identifier (NPI) Values

Effective October 6, 2008, the CWF maintainer shall create space within the header of its HUIP, HUOP, HUHH, HUHC, HUBC, and HUDC claims transactions for a new 1-byte "NPI-Placeholder" field (acceptable values=Y or space).

In addition, the CWF maintainer shall create space within page two (2) of the HIMR detail of the claim screen for 1) a new category "COBA Bypass"; and 2) a 2-byte field for the indicator "BN," which shall designate that CWF auto-excluded the claim because it contained a placeholder provider value (see §80.15 of this chapter for more details regarding the "BN" bypass indicator).

**NOTE:** With the implementation of the October 2008 release, the CWF maintainer shall remove all current logic for placeholder provider values with the implementation of this new solution for identifying claims that contain placeholder provider values.

As contractors, including Medicare Administrative Contractors (MACs) and Durable Medical Equipment Medicare Administrative Contractors (DME MACs), adjudicate non VA MRA claims that fall within any of the NPI placeholder requirements, their shared system shall take the following combined actions:

1) Input a "Y" value in the newly created "NPI Placeholder" field on the HUIP, HUOP, HUHH, HUHC, HUBC, or HUDC claim transaction if a placeholder value exists on or is created anywhere within the SSM claim record (Note: Contractor systems shall include spaces within the "NPI Placeholder" field when the claim does not contain a placeholder NPI value); and

2) Transmit the claim to CWF, as per normal requirements.

Upon receipt of claims where the NPI Placeholder field contains the value "Y," CWF shall auto-exclude the claim from the national COBA crossover process. In addition, CWF shall populate the value "BN" in association with the newly developed "COBA Bypass" field on page 2 of the HIMR Part B and DME MAC claim detail screens and on page 3 of the HIMR intermediary claim detail screen.

**P. Excluding Physician Quality Reporting Initiative (PQRI) Only Codes Reported on 837 Professional Claims**

Effective October 6, 2008, the CWF maintainer shall create space within the header of its HUBC claim transmission for a 1-byte PQRI indicator (valid values=Q or space).

In addition, CWF shall create a 2-byte field on page 2 of the HIMR claim detail in association with the new category "COBA Bypass" for the value "BQ," which shall designate that CWF auto-excluded the claim because it contained only PQRI codes (see §80.15 of this chapter for more details regarding the bypass indicator).

Prior to transmitting the claim to CWF for normal processing, the Part B shared system shall input the value "Q" in the newly defined PQRI field in the header of the HUBC when all service lines on a claim contain PQRI (status M) codes.

Upon receipt of a claim that contains a "Q" in the newly defined PQRI field (which signifies that the claim contains only PQRI codes on all service detail lines, CWF shall auto-exclude the claim from the national COBA eligibility file-based and Medigap claim-based crossover processes. Following exclusion of the claim, CWF shall populate the value "BQ" in association with the newly developed "COBA Bypass" field on page 2 of the HIMR Part B claim detail screen.

**6. CWF Requirements for Health Care Pre-Payment Plans (HCPPs) that Receive Crossover Claims**

Effective January 5, 2009, at CMS's direction, the COBC will assign all HCPP COBA participants a unique 5-byte COBA ID that falls within the range 89000 through 89999. The CWF system shall accept the reporting of this COBA ID range. (Refer to chapter 28, §70.6 for Medicare contractor requirements in association with HCPP crossovers.)

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

***(Rev. 1704, Issued: 03-20-09, Effective: 07-01-09 MCS, VMS, CWF/10-01-09 FISS, Implementation: 07-06-09 MCS, VMS, CWF/10-05-09 FISS, VMS, CWF)***

## 1. Claims Crossover Disposition Indicators

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

*Prior to the July 2009 release,* CWF shall **not** annotate processed Medicare claims on the detailed history screens in HIMR when a COBA trading partner is in test mode (Test/Production Indicator sent via the COIF submission=T).

Once the claims crossover process is fully consolidated under the Coordination of Benefits Contractor (COBC), Medicare contractor customer service staff will have access to a CWF auxiliary file that will display the crossover disposition of each beneficiary claim. The crossover disposition indicators that will appear on the HIMR detailed history screens (INPH, OUTH, HOSH, PTBH, DMEH, and HHAH) are summarized below.

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

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

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

Effective January 5, 2009, the CWF maintainer is creating crossover disposition indicators "AD" and "AE," as indicated in the table below. The CWF shall utilize the "AD" indicator when an incoming claim does not meet any of the new adjustment, mass

adjustment, or recovery audit contractor (RAC)-initiated adjustment inclusion criteria, as specified in §80.18 of this chapter. The CWF shall utilize the "AE" indicator when the COBA trading partner specifies that it wishes to exclude RAC-initiated adjustments and CWF does **not** otherwise exclude the claim for some other reason identified higher within its crossover exclusion logic hierarchy.

*Effective with the July 2009 release, the CWF maintainer shall display all auto-exclude/COBA by-pass events, as detailed below, in association with an adjudicated claim within the COBA bypass field on page 3 of the HIMR intermediary claim detail screen and on page 2 of the HIMR Part B and Durable Medical Equipment Medicare Administrative Contractor (DME MAC) detail screen.*

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

*Through this instruction, the CWF maintainer shall create additional fields within claim page 3 of the HIMR intermediary claim detail screen and page 2 of the Part B and DME MAC claim detail screens to allow for the reporting of crossover disposition indicators in association with "test" COBA crossover claims. As occurs presently, the CWF maintainer shall determine that a COBA trading partner is in "test" mode by referencing the incoming COBA Insurance File (COIF). The CWF maintainer shall 1) create additional fields for displaying "test" crossover disposition indicators within both the eligibility file-based and claim-based crossover portions of the claim detail screens on HIMR; and 2) display the "test" crossover disposition indicators so that they mirror all such indicators used for "production" claims in association with the following four (4) claim versions: 4010A1, 5010, National Council for Prescription Drug Programs (NCPDP)-5.1, and NCPDP-D.0.* ***IMPORTANT:*** *If the COBC transmits a COIF that contains a COBA ID within the range 79000 through 79999 (Medicaid quality project), CWF shall post an "MQ" disposition indicator in association with the claim instead of the traditional "A" indicator when it selects the claim for crossover. (NOTE: "MQ" shall designate that Medicare is transferring the claim for Medicaid quality project purposes only.) CWF shall annotate claims whose COBA ID is 79000 through 79999 with "MQ" regardless of the claim version indicator in those instances where it selects the claims for crossover to the COBC. If CWF excludes from crossover a claim whose COBA ID equals 79000 through 79999, CWF shall continue to post the crossover disposition indicator that corresponds to the reason for the exclusion on the appropriate HIMR claim detail screen.*

| **Claims Crossover Disposition Indicator** | **Definition/Description** |
|---|---|
| A | This claim was selected to be crossed over. |
| B | This Type of Bill (TOB) excluded. |

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

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

**2. COBA By-Pass Indicators**

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

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

| **Claims Crossover By-Pass Indicator** | **Definition/Description** |
|---|---|
| *BA* | *Claim represents an "Add History" only (action code 7 on HUOP claims; entry code 9 on HUBC and HUDC claims). Therefore, the claim is bypassed and not crossed over.* |
| *BB* | *Claim falls into one of two situations: 1) there is no eligibility record (exception: if HUBC or HUDC claim has a Medigap claim-based COBA ID); **or** 2) the only available eligibility record contains a "Y" delete indicator. Therefore, the claim is bypassed and not crossed over.* |
| *BC* | *Claim represents an abbreviated encounter record (TOB=11z; condition code=04 or 69); therefore, the claim is bypassed and not crossed over.* |
| *BD* | *Claim contains a Part B/DME MAC CWF claim disposition code other than 01, 03, or 05; therefore, the claim is bypassed and not crossed over.* |
| *BE* | *Submission of Notice of Elections [NOEs] (Hospice—TOB= 8xA through 8xE on HUHC; CEPP—TOB=11A through 11D on HUIP; Religious Non-Medical Care—TOB=41A, 41B, and 41D on HUIP; Medicare Coordinated Care – TOB=89A and 89B on HUOP). Therefore, the submission is bypassed and not crossed over.* |
| *BF* | *Claim represents an excluded demonstration (DEMO) project; therefore, the claim is bypassed and not crossed over.* |

| | |
|---|---|
| BN | CWF auto-excluded the claim because it contained a placeholder provider value. |
| *BP* | *Sanctioned provider claim during service dates indicated; therefore, the claim is bypassed and not crossed over..* |
| BQ | CWF auto-excluded the claim because it contained only PQRI codes. |
| *BR* | *Submission for Request for Anticipated Payment [RAP] claims (TOB=322 and 332); therefore, the submission is bypassed and not crossed over.* |

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

***(Rev. 1704, Issued: 03-20-09, Effective: 07-01-09 MCS, VMS, CWF/10-01-09 FISS, Implementation: 07-06-09 MCS, VMS, CWF/10-05-09 FISS, VMS, CWF)***

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); and

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, DME MACs shall begin to utilize the additional Data Center identification number 17 **only** in association with their NCPDP claim files transmissions to the COBC for crossover purposes.

| **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<br><br>(Used **only** by DME MACs when sending NCPDP claim transactions to the COBC) | 17 |

**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.

*Effective with July 2009, the shared systems shall accept the modified versions of the COBC Detailed Error Reports for institutional and professional claims as reflected below. As part of the July 2009 changes, the COBC will, at CMS's direction, expand the length of the "error description" field. (**NOTE:** This means that the shared systems shall therefore include the expanded error description code as part of their special provider notification letters.)*

**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. Filler | 100 | 83-182 |
| *13.* Field Contents | 50 | 183-232 |
| *14.* BHT 03 Identifier | 30 | 233-262 |
| *15.* Claim DCN/ICN | 23 | 263-285 |
| 16. Error Description | 300 | 286-585 |
| 17. Filler | 15 | 586-600 |

## 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 | 524 | 77-600 |

**The Professional Error File Layout, including summary portion, will be used for Part B and *DME MAC* 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. | Filler | 100 | 83-182 |
| 13 | Field Contents | 50 | 183-232 |
| 14 | BHT 03 Identifier | 30 | 233-262 |
| 15 | Claim DCN/ICN | 23 | 263-285 |
| 16. | Error Description | 300 | 286-585 |
| 17. | Filler | 15 | 586-600 |

## 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 | 524 | 77-600 |

**The NCPDP Error File Layout, including summary portion, will be used by *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 *DME MACs*, 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.)

### a) 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 two specified 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.

2. 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.

   *Effective with the July 7, 2009, release, upon receipt of the COBC Detailed Error Report (DER), the Part A shared system shall configure the existing 114 report, as derived from the COBC DER, so that it 1) continues to display in landscape format; and 2) includes a cover page that contains the provider's correspondence mailing address.*

b) Special Exemption from Generating Provider Notification Letters

Effective July 7, 2008, upon their receipt of COBC Detailed Error Reports that contain "222" error codes 000100 ("Claim is contained within a BHT envelope previously crossed; claim rejected") and 00010 ("Duplicate claim; duplicate ST-SE detected"), all contractor systems shall automatically suppress generation of the special provider notification letters that they would normally generate for their associated contractors in accordance with the requirements of this section as well as §70.6.3 of this chapter. In addition, upon receipt of COBC Detailed Error Reports that contain "333" (trading partner dispute) error code 000100 (duplicate claim) or 000110 (duplicate ISA-IEA) or 000120 (duplicate ST-SE), all contractor systems shall automatically suppress generation of the special provider notification letters, as would normally be required in accordance with this section as well as §70.6.3 of this chapter.

**NOTE:** When suppressing their provider notification letters for the foregoing qualified situations, the contractors shall also not update their claims histories to reflect the non-crossing over of the associated claims. Contractors should, however, continue to take into account the volume of claims that they are suppressing for financial reconciliation purposes.

Effective with October 6, 2008, when the COBC returns the "222" error code "N22225" to Medicare contractors via the COBC Detailed Error Report, the contractors' shared systems shall suppress generation of the special provider notification letters that they would normally issue in accordance with CRs 3709 and 5472.

When suppressing their provider notification letters following their receipt of a "N22225" error code, the contractors' shared systems shall also not update their claims histories to reflect the non-crossing over of the associated claims. Contractors should, however, continue to take into account the volume of claims that they are suppressing for financial reconciliation purposes.

Effective with January 5, 2009, when the COBC returns claims on the COBC Detailed Error Report whose COBA ID falls in the range 89000 through 89999 (range designates "Other-Health Care Pre-payment Plan [HCPP]"), the contractors' systems shall take the following actions:

1) Suppress generation of the special provider letters; and

2) Not update their affiliated contractors' claims histories to indicate that the COBC will **not** be crossing the affected claims over.