CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2189	**Date: April 4, 2011**
	Change Request 7136

NOTE: Transmittal 2189, dated April 4, 2011, rescinds and replaces CR 7136, Transmittal 2076, dated October 28, 2010, to clarify language within paragraph 3 under "Background." Additionally, CMS is changing all references to Public Law 111-148 throughout the business requirements document and accompanying manual sections from the Patient Protection and Affordable Care Act (PPACA) or ACA to the Affordable Care Act. All other information remains unchanged.

SUBJECT: Modifications to the National Coordination of Benefits Agreement (COBA) Crossover Process Stemming Principally From the Affordable Care Act (ACA)

I. SUMMARY OF CHANGES: This change request outlines several revisions that are needed within the Centers for Medicare and Medicaid Services" base national COBA crossover program in general and accommodates specific ACA requirements in particular.

EFFECTIVE DATE: April 1, 2011
IMPLEMENTATION DATE: April 4, 2011

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.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row*.

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	27/80.14/ Consolidated Claims Crossover Process
R	28/70.6.1/ Coordination of Benefits Agreement (COBA) Detailed Error Report Notification Process

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

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

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2189	Date: April 4, 2011	Change Request: 7136

NOTE: Transmittal 2189, dated April 4, 2011, rescinds and replaces CR 7136, Transmittal 2076, dated October 28, 2010, to clarify language within paragraph 3 under "Background." Additionally, CMS is changing all references to Public Law 111-148 throughout the business requirements document and accompanying manual sections from the Patient Protection and Affordable Care Act (PPACA) or ACA to the Affordable Care Act. All other information remains unchanged.

SUBJECT: Modifications to the National Coordination of Benefits Agreement (COBA) Crossover Process Stemming Principally From the Affordable Care Act

Effective Date: April 1, 2011

Implementation Date: April 4, 2011

I. GENERAL INFORMATION

A. Background: Currently, the Common Working File (CWF) reads the incoming Coordination of Benefits Contractor (COBC)-created Coordination of Benefits Agreement Insurance File (COIF) to determine each national COBA trading partner's specific claims selection as tied to each COBA ID. To accommodate the inclusion or exclusion of Part A specific provider identifiers (IDs), CWF currently reads the numeric value reported on the COIF by COBA ID and then interrogates the "Provider ID" reported on the incoming HUIP, HUOP, HUHH, or HUHC claims transaction. For instances where a match is found, CWF either includes or excludes the claim from the national crossover process, in accordance with the "I" or "E" indicator that precedes the provider ID value reported. Though CMS has confirmed that the current field length for Part A provider ID is sufficient to hold a given National Provider Identifier (NPI) for an institutional facility, CMS recently discovered that CWF is not reading both the Provider ID and NPI fields as part of its COBA crossover claims inclusion or exclusion logic processing. The CMS remedies this issue through this instruction.

Currently, as specified within the Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12N 837 version 4010A1 institutional claims, the Medicare Part A shared system expresses covered days, non-covered days, co-insurance days, and life-time reserve (LTR) days as QTY01 and QTY02 within the 2300 HI (Health Care Information Codes) portion of the claim. Under version 5010 of the HIPAA ANSI ASC X12 837 institutional requirements, all payers, including Medicare, will be required to reflect these day components appropriately as value codes, ranging from 80 to 83, within the 2300 HI portion of the claim. This instruction contemplates the scenario during calendar year 2011 of what occurs when COBA trading partners have migrated to version 5010 in production but the provider is continuing to submit claims in version 4010A1.

With the passage of Public Law 111-148 [the Affordable Care Act], Medicare will be required to reprocess (mass adjust) hundreds of thousands of Part A and B claims with service dates/dates of discharges beginning with January 1, 2010 (or earlier in certain qualified instances). The high volume adjustment actions required through the Affordable Care Act have prompted CMS to re-examine its strategies for systematically identifying and segmenting mass adjustment claims, such as those that Medicare will create under the PPACA provisions. The resulting systems changes appear in the business requirements below.

B. Policy: Upon receipt of either a 6-byte Online Survey, Certification, and Reporting (OSCAR) provider ID or a 10-digit NPI, as found starting in position 225 of the COIF, CWF shall check both the "Provider ID" and "NPI" fields of the incoming HUIP, HUOP, HUHH, or HUHC for potential matches. If CWF finds a

provider ID **or** NPI match, it shall either include or exclude the claim based upon the indicator (I or E) reported in field 224 of the COIF. The CWF shall continue to either 1) include the claim if the "I" indicator precedes the provider ID or NPI reported on the COIF **or** 2) exclude the claim and annotate Part A claims history with crossover indicator "K" when the reported provider ID or NPI on the COIF is identified for exclusion from the crossover process.

The Part A shared system shall ensure that it takes the following actions in those situations where the provider bills an 837 institutional claim to Medicare in the 4010A1 format but the COBA trading partner has migrated to the HIPAA 5010 format for production use: Convert any incoming 4010A1 2300 QTY01 and QTY02 data (covered days, non-covered days, co-insurance days, and LTR days) to the appropriate corresponding value codes/amounts (value codes 80-83) within the 837 version 5010 institutional flat file.

Effective with this instruction, the shared systems shall send all test and production "original" claims under a BHT03 that is distinct from the BHT03 created for all test and production "adjustment" claims. Specifically, the shared systems shall group together all test and production adjustment claims for transference to the COBC by five (5) broad categories: 1) mass adjustment claims—Affordable Care Act/other congressional imperative; 2) mass adjustment claims—MPFS; 3) mass adjustment claims--all others; 4) recovery audit contractor (RAC)-initiated adjustment claims; and 5) routine adjustment claims, not previously classified. To ensure continuity of processing, the shared systems shall be modified so that they create a 23 byte BHT03 identifier on all version 4010A1 and 5010 outbound 837 COB claims as follows: O—for original claims; P—for Affordable Care Act/other congressional imperative mass adjustment; M—for non-Affordable Care Act mass adjustments tied to Medicare Physician Fee Schedule (MPFS); S—for mass adjustment claims—all others; R—for RAC adjustment claims, and A—for routine adjustment claims, not previously classified. At CMS' direction, the COBC shall modify its system to accept the foregoing new BHT03 values as received on incoming 837 COB flat files.

The COBC shall, at CMS' direction, modify the COBC Detailed Error Reports for institutional and professional claims to accommodate the extra 1-byte value within the BHT03. (**NOTE:** The overall length for the BHT03 will remain 30 bytes.) The shared systems shall modify their COBC Detailed Error Reports for institutional and professional claims to accommodate the extra 1-byte value within the BHT03 element.

Additionally, the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) shared system shall send an additional 1-byte value (defined as "reserved for future use") as spaces in field 504-F4 (Message) of its version 5.1 and D.0 NCPDP flat file that it transmits to the COBC for crossover purposes. The COBC shall, at CMS' direction, modify the COBC Detailed Error Reports for NCPDP claims to accommodate the extra 1-byte value within the "Unique Identifier" field. (**NOTE:** The overall field length for the Unique Identifier will remain 30 bytes.) Lastly, the DME MAC shared system shall modify its COBC Detailed Error Report process for NCPDP version 5.1 and D.0 claims to accommodate 1 extra byte (defined as "reserved for future use") within the "Unique Identifier" portion of the NCPDP claim format.

II. BUSINESS REQUIREMENTS TABLE

"Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
7136.1	Upon receipt of either a 6-byte OSCAR provider ID or a 10-digit NPI, as found starting in position 225 of the									X	

"Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
	COIF, CWF shall check both the "Provider ID" and "NPI" fields of the incoming HUIP, HUOP, HUHH, or HUHC for potential matches.										
7136.1.1	If CWF finds a provider ID **or** NPI match, it shall either include or exclude the claim based upon the indicator (I or E) reported in field 224 of the COIF.									X	
7136.1.2	The CWF shall continue to either 1) include the claim if the "I" indicator precedes the provider ID or NPI reported on the COIF **or** 2) exclude the claim and annotate Part A claims history with crossover indicator "K" when the reported provider ID or NPI on the COIF is identified for exclusion from the crossover process.									X	
7136.2	The Part A shared system shall ensure that it takes the following actions in those situations where the provider bills an 837 institutional claim to Medicare in the 4010A1 format but the COBA trading partner has migrated to the HIPAA 5010 format for production use: Convert any incoming 4010A1 2300 QTY01 and QTY02 data (covered days, non-covered days, co-insurance days, and LTR days) to the appropriate corresponding value codes/amounts (value codes 80-83) within the 837 version 5010 institutional flat file.						X				
7136.3	The shared systems shall send all test and production "original" version 4010A1 and 5010 claims under a BHT03 that is distinct from the BHT03 created for all test and production "adjustment" claims.						X	X	X		
7136.3.1	Specifically, the shared systems shall group together all test and production version 4010A1 and 5010 "adjustment" claims for transference to the COBC by five (5) broad categories: 1) mass adjustment claims—Affordable Care Act/other congressional imperative; 2) mass adjustment claims—MPFS; 3) mass adjustment claims--all others; 4) recovery audit contractor (RAC)-initiated adjustment claims; and 5) routine adjustment claims, not previously classified.						X	X	X		
7136.3.2	To ensure continuity of processing, the shared systems						X	X	X		

"Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
	shall be modified so that they create a 23 byte BHT03 identifier on all version 4010A1 and 5010 outbound 837 COB claims as follows: O—for original claims; P— for Affordable Care Act/other congressional imperative mass adjustment; M—for non-Affordable Care Act mass adjustments tied to Medicare Physician Fee Schedule (MPFS); S— for mass adjustment claims—all others; R—for RAC adjustment claims, and A—for routine adjustment claims, not previously classified.										
7136.3.2.1	At CMS' direction, the COBC shall modify its system to accept the new BHT03 values specified in 7136.3.2 as received on incoming 837 COB flat files.										X COBC
7136.3.3	The COBC shall, at CMS' direction, modify the COBC Detailed Error Reports for institutional and professional claims to accommodate the extra 1-byte value within the BHT03. (**NOTE:** The overall field length for the BHT03 will remain 30 bytes.)										X COBC
7136.3.4	The shared systems shall modify their COBC Detailed Error Reports for institutional and professional claims to accommodate the extra 1-byte value within the BHT03 element.						X	X	X		
7136.3.5	Contractors shall perform updates as necessary to any reporting or peripheral systems that may be impacted by the above changes resulting from the inclusion of the new 23rd byte within the BHT03 element.	X	X	X	X	X					
7136.4	At CMS' direction, the COBC shall modify its system to accept an additional 1-byte Unique Identifier Value within field 504-F4 (Message) of incoming version 5.1 and D.0 NCPDP claims.										COBC
7136.4.1	The DME MAC shared system shall send an additional 1-byte value (defined as "reserved for future use") as spaces in field 504-F4 (Message) of its version 5.1 and D.0 NCPDP flat file that it transmits to the COBC for crossover purposes.								X		

"Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
7136.4.2	The COBC shall, at CMS' direction, modify the COBC Detailed Error Reports for NCPDP claims to accommodate the extra 1-byte value within the "Unique Identifier" field. (**NOTE:** The overall field length for the Unique Identifier will remain 30 bytes.).										X COBC
7136.4.3	The DME MAC shared system shall modify its COBC Detailed Error Report process for NCPDP version 5.1 and D.0 claims to accommodate 1 extra byte (defined as "reserved for future use") within the "Unique Identifier" portion of the NCPDP claim format.								X		

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	None.										

IV. SUPPORTING INFORMATION

Section A: Any recommendations and supporting information associated with listed requirements: N/A

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

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

Post-Implementation Contact(s): Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or 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.

80.14 - Consolidated Claims Crossover Process

(Rev. 2189, Issued: 04-04-11, Effective: 04-01-11, Implementation: 04-04-11)

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 only 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. As of January 4, 2010, CWF shall read action code 8, in addition to action code 1, in association with incoming fully denied original HUIP and HUOP claims. CWF shall continue to read action code 1 for purposes of excluding all other fully denied original HUHH and HUHA claims. (See items J and K within this section for more specifics regarding revised logic for exclusion of fully denied HUIP and HUOP adjustment claims.)

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.

Claims with Fully Paid Lines, without Deductible or Co-insurance Remaining, and Additional Denied Service Lines

New HUBC Line-Level Indicator Field

Effective January 4, 2010, the CWF maintainer shall create a new 1-byte liability denial indicator (LIAB IND) at the service line level for individually denied claim lines in association with the HUBC claim transaction (valid values=B or spaces).

Part B Shared System Requirements

When the Part B shared system adjudicates claims where most of the claim service detail lines are fully [or 100 percent] paid (i.e., contain allowed amounts per line that are the same as the paid amounts per line **and** the lines do **not** carry deductible or co-insurance amounts) but where some detail lines are denied, it shall take the following actions:

1) Input a "B" value in the newly created 1-byte LIAB IND field for each denied service line where the beneficiary has payment liability (NOTE: there may be multiple instances where the "B" value will be applied, contingent upon whether the beneficiary is liable for each of the denied service lines);

2) Input spaces in the newly created 1-byte LIAB IND field for each denied service line where the provider, rather than the beneficiary, is contractually liable for the denied service; and

3) Transmit the HUBC claim to CWF for normal verification and validation processing.

CWF Requirements

The CWF system shall modify its logic for "original" fully paid claims, without deductible or co-insurance remaining, in association with Part B HUBC claims as follows:

1) Continue to verify the claim's entry or action code for confirmation that the claim is an original;

2) Confirm that the claim contains service lines where the amount allowed per line equals the amount paid per line;

3) Check for the presence of a "B" line LIAB IND in association with any of the denied service lines on the claim;

4) Suppress the claim from the crossover process if the claim does not contain a "B" line LIAB IND for any of the denied service lines; and

5) Select the claim for crossover if even one of the denied lines contains a "B" line LIAB IND.

Upon suppressing the Part B claim from the crossover process, CWF shall annotate the claim on the Part B claim detail (PTBH) screen with a newly created "AF" (Fully reimbursable claim containing denied lines with no beneficiary liability) claims crossover disposition indicator. (See § 80.15 of this chapter for more details regarding crossover disposition indicators.)

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.

Claims with Fully Paid Lines, without Deductible or Co-insurance Remaining, and Additional Denied Service Lines

New HUBC Line-Level Indicator Field

Effective January 4, 2010, the CWF maintainer shall create a new 1-byte LIAB IND at the service line level for individually denied claim lines in association with the HUBC claim transaction (valid values=B or spaces).

Part B Shared System Requirements

When the Part B shared system adjudicates adjustment claims where most of the claim service detail lines are fully [or 100 percent] paid (i.e., contain allowed amounts per line that are the same as the paid amounts per line **and** the lines do **not** carry deductible or co-insurance amounts) but where some detail lines are denied, it shall take the following actions:

1) Input a "B" value in the newly created 1-byte LIAB IND field for each denied service line where the beneficiary has payment liability (NOTE: there may be multiple instances where the "B" value will be applied, contingent upon whether the beneficiary is liable for each of the denied service lines);

2) Input spaces in the newly created 1-byte LIAB IND field for each denied service line where the provider, rather than the beneficiary, is contractually liable for the denied service; and

3) Transmit the HUBC claim to CWF for normal verification and validation processing.

CWF Requirements

The CWF system shall modify its logic for "adjustment" fully paid claims, without deductible or co-insurance remaining, in association with Part B HUBC claims as follows:

1) Continue to verify the claim's entry or action code for confirmation that the claim is an adjustment;

2) Where applicable, also continue to check additionally to determine if the incoming claim contains entry code 5 **or** an "R" recovery audit contractor (RAC) adjustment indicator, as directed in previous CMS instructions;

3) Where applicable, continue to check additionally to determine if the incoming claim contains an entry or action code value of "1," along with Claim Adjustment Indicator=A, as per previous CMS direction;

4) Confirm that the claim contains service lines where the amount allowed per line equals the amount paid per line;

5) Check for the presence of a "B" line LIAB IND in association with any of the denied service lines on the claim;

6) Suppress the claim from the crossover process if the claim does **not** contain a "B" line LIAB IND for any of the denied service lines; and

7) Select the claim for crossover if even one of the denied lines contains a "B" LIAB IND.

Upon suppressing the Part B claim from the crossover process, CWF shall annotate the claim on the Part B claim detail (PTBH) screen with a newly created "AF" (Fully reimbursable claim containing denied lines with no beneficiary liability) claims crossover disposition indicator. (See § 80.15 of this chapter for more details regarding crossover disposition indicators.)

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 of January 4, 2010, that logic shall be changed to also include the reading of action code 8, in addition to action code 3, for HUIP and HUOP claims. The revised logic will thus be as follows:

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

2) Verify also if an HUIP or HUOP claim contains action code '8' rather than an action code '3'; and

3) 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 of January 4, 2010, that logic shall be changed to also include the reading of action code 8, in addition to action code 3, for HUIP and HUOP claims. The revised logic will thus be as follows:

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

2) Verify also if an HUIP or HUOP claim contains action code '8' rather than an action code '3'; and

3) 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.

<u>New CWF Logic</u>

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 <u>or</u>, 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.

Q. 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.)

R. Inclusion or Exclusion of Part A Claims By Provider Identification Number (ID) as well as Provider State

Since July 2004, the CWF has read the incoming COBC- created COIF to determine each national COBA trading partner's specific claims selection as tied to each COBA ID. To

accommodate the inclusion or exclusion of Part A specific provider identifiers (IDs), CWF currently reads the numeric value reported on the COIF by COBA ID and then interrogates the "Provider ID" (internal Online Survey, Certification, and Reporting [OSCAR] identifier) reported on the incoming HUIP, HUOP, HUHH, or HUHC claims transaction. For instances where a match is found, CWF either includes or excludes the claim from the national crossover process, in accordance with the "I" or "E" indicator that precedes the provider ID value reported beginning with field 225 of the COIF.

Also, since July 2004, CWF has read the 2-digit state code as referenced on the COIF as a basis for including or excluding Part A claims by provider state. In performing this function, CWF locates the incoming "Provider ID" on the HUIP, HUOP, HUHH, or HUHC claims transaction and determines if the first 2 bytes match the 2-byte state code on the COBC-created COIF. If a match is found, CWF either includes or excludes the claim based upon the "I" or "E" value reported in field 224 of the COIF.

*Effective April 4, 2011, upon its receipt of either a 6-byte Online Survey, Certification, and Reporting (OSCAR) provider ID **or** a 10-digit NPI, as found starting in position 225 of the COIF, CWF shall check both the "Provider ID" and "NPI" fields of the incoming HUIP, HUOP, HUHH, or HUHC for potential matches. If CWF finds a provider ID or NPI match, it shall either include **or** exclude the claim based upon the indicator (I or E) reported in field 224 of the COIF.*

*The CWF shall continue to either 1) include the claim if the "I" indicator precedes the provider ID or NPI reported on the COIF **or** 2) exclude the claim and annotate Part A claims history with crossover indicator "K" when the reported provider ID or NPI on the COIF is identified for exclusion from the crossover process. (See §80.15 of this chapter for more information concerning the "K" crossover disposition indicator.)*

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

(Rev. 2189, Issued: 04-04-11, Effective: 04-01-11, Implementation: 04-04-11)

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.

Effective with April 3, 2011, all Medicare contractors shall begin an extra 1-byte "Original versus Adjustment Claim Indicator" value within the BHT03 identifier on all 837 institutional and professional claims they transmit to the COBC for crossover purposes. The COBC shall, in turn, return this value to the appropriate Medicare contractor via the COBC Detailed Error Report process. In addition, the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) shared system shall send an additional 1-byte value (defined as "reserved for future use") as spaces in field 504-F4 (Message) of the NCPDP flat file sent to the COBC. The COBC shall, in turn, also return this value to the appropriate Medicare contractor via the COBC Detailed Error Report process.

A. Inclusion of the Unique 2*3*-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 2*3*-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. Claim version indicator (2 bytes, numeric, to denote claim version)
**Acceptable values=40 (for 4010A1 version claims), 50 (for 5010 claims), 11 (for NCPDP 5.1 claims), and 20 (for NCPDP D.0 claims)*;*

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*;*

f. Original versus Adjustment Claim Indicator (1-byte alpha indicator; acceptable values are defined as the following:

O—for original claims;

P— for Affordable Care Act or other congressional imperative mass adjustments;

M—for non-Affordable Care Act mass adjustments tied to Medicare Physician Fee Schedule (MPFS);

S—for mass adjustment claims—all others;

R—for RAC adjustment claims, and

A—for routine adjustment claims, not previously classified.)

The 2*3*-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.)

2. NCPDP 2*3*-Digit Unique Identifier

Effective with April 3, 2011, the DMERC/DME Medicare Administrative Contractor (DME MAC) contractor system shall also adopt a 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 2*3*-digit identifier *(defined as "future use") with spaces* in field 504-F4 (Message) within the NCPDP file (field length=35 bytes). The DMERC/DME MAC contractor system shall populate the *unique* 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** *(23 bytes used)*
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** *(23 bytes used)*
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** *(23 bytes used)*
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.