CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 521	**Date: JULY 24, 2009**
	Change Request 6498

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

I. SUMMARY OF CHANGES: Through this change request, the Centers for Medicare and Medicaid Services (CMS) will ensure that Part A claims with action code 8 are handled in a standard manner within the context of the Common Working File (CWF) exclusion logic for fully denied claims. In addition, CMS will modify the Part A shared system to ensure that all fully denied claims that the Common Working File (CWF) selects for crossover shall be consistently output to the 837 flat file with an appropriate and complete Claim Adjustment Segment (CAS).

New / Revised Material
Effective Date: January 1, 2010
Implementation Date: January 4, 2010

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
N/A	

III. FUNDING:
Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*: Not Applicable.

Section B: *For Medicare Administrative Contractors (MACs)*: Not Applicable.

IV. ATTACHMENTS:

One-Time Notification

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

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 521	Date: July 24, 2009	Change Request: 6498

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

Effective Date: January 1, 2010
Implementation Date: January 4, 2010

I. GENERAL INFORMATION

A. Background: At present, the Common Working File (CWF) utilizes the action code reported on incoming Part A HUIP, HUOP, HUHA, and HUHH claim transactions to determine whether a claim represents an "original" (action code 1) versus "adjustment/replacement" (action code 3) claim for claims selection inclusion and exclusion logic under the national COBA crossover process. The current logic does not address instances where Part A contractors may generate claims to CWF for verification and validation that contain action code 8 (benefits refused) in association with fully denied claims. The Centers for Medicare & Medicaid Services (CMS) mitigates this issue through this instruction.

The CMS has determined that the Part A shared system does **not** reliably include Claims Adjustment Segment (CAS) information in association with the fully denied 837 institutional flat file claims that it generates to the Coordination of Benefits Contractor (COBC) on a daily basis. The CMS addresses this business need through this change request.

B. Policy: In association with "original" and "adjustment/replacement" claims, CWF shall modify its current logic to exclude fully denied HUIP and HUOP claims, with or without beneficiary liability remaining. In addition to reading action code 1 for original claims, and action code 3 for adjustment/replacement claims, CWF's logic shall read action code 8 to exclude fully denied original and adjustment HUIP and HUOP claims, whether with additional beneficiary liability remaining (crossover indicators G and U) **or** without additional beneficiary liability remaining (crossover indicators F and T). All other aspects of this specific exclusion logic for original and adjustment/replacement claims shall remain unchanged.

In all instances where a Medicare Part A contractor fully denies an incoming inpatient-oriented claim (regardless of whether the beneficiary has liability on any portion of the fully denied claim), the Fiscal Intermediary Shared System (FISS) shall output a complete CAS in that portion of the 837 coordination of benefits (COB) flat file that is equivalent to the loop 2320 elements CAS01 through CAS06 for all inpatient-oriented bill types. For fully denied outpatient-oriented claims, FISS shall output individual CAS segments at each service line reporting level in the portion of the 837 COB flat file equivalent to loop 2430 elements CAS01 through CAS06. The Part A shared system shall apply these requirements to all version 4010-A1 and 5010 claims that it creates for the national COBA crossover process.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
6498.1	Effective with this instruction, the CWF system shall modify its current logic for the exclusion of fully denied HUIP and HUOP claims, with beneficiary liability remaining and fully denied HUIP and HUOP claims, without beneficiary liability remaining in association with "original" and "adjustment/replace-ment" claims.									X	
6498. 1.1	In addition to reading action code 1 for original claims and action code 3 for adjustment/replacement claims, CWF's logic shall read action code 8 to exclude fully denied original and adjustment HUIP and HUOP claims, whether with additional beneficiary liability remaining (crossover indicators G and U) or without additional beneficiary liability remaining (crossover indicators F and T).									X	
6498.1.2	All other aspects of the fully denied logic for incoming HUIP and HUOP original and adjustment claims—such as determining that the claim is fully denied and reading the reported beneficiary liability indicator L or N within the incoming claim's header—shall remain unchanged.									X	
6498.2	In all instances where a Medicare Part A contractor fully denies an incoming inpatient-oriented claim (regardless of whether the beneficiary has liability on any portion of the fully denied claim), FISS shall output a complete CAS in that portion of the 837 coordination of benefits (COB) flat file that is equivalent to the loop 2320 elements CAS01 through CAS06 for all inpatient-oriented bill types.						X				
6498. 2.1	For fully denied outpatient-oriented claims, FISS shall output individual CAS segments at each service line reporting level in the portion of the 837 COB flat file equivalent to loop 2430 elements CAS01 through CAS06.						X				
6498.2.2	The Part A shared system shall apply requirements 6498.2 and 6498.2.1 to all version 4010-A1 and 5010 claims that it creates for the national COBA crossover process.						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: Recommendations and supporting information associated with listed requirements, use the box below:

"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

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VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*: Not Applicable.

Section B: *For Medicare Administrative Contractors (MACs)*: Not Applicable.