

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2810	Date: November 7, 2013
	Change Request 8454

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

I. SUMMARY OF CHANGES: Through this instruction, the Centers for Medicare & Medicaid Services (CMS) includes new indicators that make it possible to identify various high volume COBA crossover claims that our A/B Medicare Administrative Contractors (MACs) and Durable Medical Equipment Medicare Administrative Contractors (MACs) created following CMS-directed claims reprocessing actions. An additional scenario that merits a systems change is also addressed in this instruction.

EFFECTIVE DATE: April 1, 2014

IMPLEMENTATION DATE: April 7, 2014

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-Only One Per Row.

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	27/80.14/ Consolidated Claims Crossover Process
R	28/70.6.1/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's 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 obliged 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: 2810	Date: November 7, 2013	Change Request: 8454
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SUBJECT: Modifications to the National Coordination of Benefits Agreement (COBA) Crossover Process

EFFECTIVE DATE: April 1, 2014

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I. GENERAL INFORMATION

A. Background: Through Change Request (CR) 7136, the Centers for Medicare & Medicaid Services (CMS) instructed the shared system maintainers to develop a methodology for grouping together similar Medicare crossover claims so that they could be transmitted under a common 1-byte file identifier to the Coordination of Benefits Contractor (COBC). The 1-byte value comprises position 23 of the Beginning of the Hierarchical Transaction Reference Identification (BHT03) file identifier, which appears on all COBA crossover claims transmitted to COBA trading partners. CMS now seeks to create a few more 1-byte indicators that will appear in byte 23 of the BHT03 element and in the collateral element found within National Council for Prescription Drug Programs (NCPDP) version D.0 batch claims.

Currently, in accordance with CR 3404, there are times when the Part B shared system will adjust incoming claims so that the amount billed per detail line is off-set in its entirety by an adjustment in that same amount. The adjustment is denoted by Claim Adjustment Segment (CAS) Group Code "CO" and Claim Adjustment Reason Code (CARC) 45. Such claims technically are not denied and are not subject to Correct Coding Initiative (CCI) logic. However, to the outside world, these claims appear to be fully denied, with the responsibility charged to the provider. CMS provides a remedy for this situation through this instruction.

B. Policy: The shared systems maintainers shall develop a methodology for grouping together high volumes of claims that will need to be mass adjusted/reprocessed in accordance with a CMS directive, as opposed to a directive arising from specific legislation or a Congressional mandate that would warrant such action. The shared systems shall ensure that their associated A/B MACs, Carriers, and DME MACs have the ability to execute an action that will result in transmission of mass adjusted claims to the COBC under a BHT03 file identifier whose 23rd byte value is "C" (CMS-directed mass adjustment action (use specified by CMS)) when so directed.

Additionally, the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) shared system shall develop a methodology for grouping together National Council for Prescription Drug Programs (NCPDP) version D.0 batch coordination of benefits (COB) claims that are reprocessed either due to CMS directive or because of a Congressional or legislative mandate. Further DME MAC shared system maintainer requirements unique to the NCPDP D.0 COBA claims crossover process are provided below.

The Part A shared system maintainer shall develop a methodology for grouping together all void/cancel claims that it will transmit to the COBC. Additionally, the Part A shared system shall ensure that its associated A/B MACs (A) and A/B MACs (HH) have the ability to execute an action that will result in the transmission of "void/cancel only" claims to the COBC under a BHT03 file identifier whose 23rd byte value is "V" (void/cancel only claims).

For situations where the Part B shared system logic considers a claim to have service details that are related to a larger service and thus applies a CAS*CO*45 to each detail line for the full monetary amount of each line, the Part B system shall: 1) create an "N" beneficiary liable indicator in the header of the HUBC claim; and 2) transmit the claim to the CWF for normal processing.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility											
		A/B MAC			DME	F I	C A R R I E R	R H I	Shared-System Maintainers				Other
		A	B	H H H					F I S S	M C S	V M S	C W F	
8454.1	The shared systems maintainers shall develop a methodology for grouping together high volumes of claims that will need to be mass adjusted or reprocessed in accordance with a CMS directive, as opposed to a directive arising from specific legislation or a Congressional mandate that would warrant such action.								X	X	X		
8454.1.1	In addition, the shared systems shall ensure that their associated A/B MACs, Carriers, and DME MACs have the ability to execute an action that will result in the transmission of mass adjusted claims to the COBC under a BHT03 file identifier whose 23rd byte value is "C" (CMS-directed mass adjustment action (use specified by CMS)) when so directed.								X	X	X	COBA	
8454.2	The Durable Medical Equipment Medicare Administrative Contractor (DME MAC) shared system shall develop a methodology for grouping together National Council for Prescription Drug Programs (NCPDP) version D.0 batch coordination of benefits (COB) claims that are reprocessed either due to CMS directive or because of a Congressional or legislative mandate.										X		
8454.2.1	The DME MAC shared system shall ensure that its affiliate DME MACs have the ability to 1) execute actions that will result in the transmission of their HUDC claims to CWF with Mass Adjustment Indicator set to "O"; and 2) transmit mass adjusted NCPDP D.0 COB claims to the COBC under a 504-F04 (Message) field identifier of "C" (CMS-directed mass adjustment action) or "P" (mass adjustments tied to Affordable Care Act or Congressional/legislative mandate, as created through CR 7136) as appropriate to the situation.										X	COBA	
8454.2.2	In addition, the DME MAC shared system shall ensure that all NCPDP D.0 crossover claims will now be sent to the COBC with the 23rd byte 504-F04 (Message) field indicator completed, as appropriate, as follows:										X	COBA	

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
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Section B: All other recommendations and supporting information: N/A

V. CONTACTS

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

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) 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's 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 do 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.2810, Issued: 11-07-13, Effective: 04-01-14, Implementation: 04-07-14)

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 “NCPDP0 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 October 3, 2011, 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) Other Insurer (80000-80213); 5) Other Insurer (80215-88999); 6) CHAMPVA (80214); 7) TRICARE (60000-69999); 8) Medicaid (70000-79999); and 9) 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, HUUH, HUH, 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.

Effective with the April 2014 release,

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, HUUH, and HUH 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, HUUH, and HUH 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, HUUH, and HUH claims that they transmit to CWF.

Upon receipt of an HUIP, HUOP, HUUH, or HUH 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 HUUH 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, HUUH, 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, HUUH, 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 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, HUUH, 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, HUUH, 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, HUUH, or HUHHC 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, HUUH, or HUHHC 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, HUUH, or HUHHC 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.)

S. Excluding Fully Denied Claims Adjudicated With An “Other Adjustment” (OA”) Claim Adjustment Segment Group Code

Effective October 4, 2010, the CWF maintainer shall create space within the header of its HUIP, HUOP, HUHH, HUHC, HUBC, and HUDC claims transactions for a 1-byte Claim Adjustment Segment (CAS) Group Code Indicator field (valid values=G or space). In addition, CWF shall develop a new 2-byte “BG” COBA By-pass indicator, which designates that CWF auto-excluded the claim because it was adjudicated with an “OA” CAS group code for all denied lines or services.

Prior to transmitting their adjudicated claims to CWF for normal processing, all shared systems shall input the value “G” in the newly defined 1-byte CAS Group Code Indicator field in the header of their HUIP, HUOP, HUHH, HUHC, HUBC, or HUDC claims when all services or claim detail service lines on the affected claims are denied with Group Code “OA.”

Upon receipt of a claim that contains a “G” in the newly defined CAS Group Code Indicator field, CWF shall auto-exclude the claim from the national COBA eligibility file-based and Medigap claim-based crossover processes. (NOTE: CWF shall not be required to read the COIF to determine COBA trading partner preferences for claims containing either an “L” or “N” beneficiary liability indicator when the incoming claim contains a “G” in the newly defined CAS Group Code Indicator field.)

Following auto-exclusion of the claim, CWF shall take the following actions:

- 1) Annotate the claim with a “BG” COBA bypass indicator; and
- 2) Display the “BG” indicator as part of the COBA Bypass segment on page 3 of the appropriate HIMR claim detail screen.

Effective with October 3, 2011, CWF shall create a consistency edit that will activate when the shared systems send HUBC, HUDC, HUIP, HUOP, HUHH, and HUHC claims to CWF that contain a value in the CAS Group Code Indicator field other than G or spaces.

Upon receipt of this consistency edit, the shared system shall take the following actions:

- 1) Modify the value reported in the CAS Group Code Indicator either to a “G,” if appropriate, or spaces; and
- 2) Retransmit the claim to CWF.

T. New Requirements for Other Federal Payers

Effective with October 3, 2011, the CWF maintainer shall expand its logic for “Other Insurance,” which is COIF element 176, to include TRICARE for Life (COBA ID 60000-69999) and CHAMPVA (COBA ID 80214), along with State Medicaid Agencies (70000-79999), as entities eligible for this exclusion.

Through these changes, if either TRICARE for Life or CHAMPVA wishes to invoke the “Other Insurance” exclusion, and if element 176 is marked on the COIF for these entities, CWF shall suppress claims from the national COBA crossover process if it determines that the beneficiary has active additional supplemental coverage.

As part of this revised “Other Insurance” logic for TRICARE and CHAMPVA, CWF shall interpret “additional supplemental coverage” as including entities whose COBA identifiers fall in any of the following ranges:

00001-29999 (Supplemental);

30000-54999 (Medigap eligibility-based);
80000-80213 (Other Insurer); and
80215-88999 (Other Insurer).

The “Other Insurance” logic for State Medicaid Agencies includes all of the following COBA ID ranges:

00001-29999 (Supplemental);
30000-54999 (Medigap eligibility-based);
60000-69999 (TRICARE);
80000-80213 (Other Insurance)
80214 (CHAMPVA)
80215-88999 (Other Insurer).

NOTE: As of October 3, 2011, CWF shall now omit COBA ID range 89000-89999 as part of its Other Insurance logic for State Medicaid Agencies.

CWF shall mark claims that it excludes due to “Other Insurance” with crossover disposition indicator “M” when storing them within the CWF claims history screens. (See §80.15 of this chapter for additional information concerning this indicator.)

U. CWF and Shared Systems Handling of Claims Where Principal Diagnosis Is “E” Code or Equivalent Code in Successive ICD Diagnosis Versions

Effective April 1, 2013, CWF shall create a new 1-byte “First Reported DX Code Indicator” field within the header of incoming HUBC and HUDC claims transactions. CWF shall **only** accept “Y” or spaces as valid values for the newly created First Reported DX Code Indicator within the header of incoming HUBC and HUDC claims and shall develop consistency edits to address invalid values submitted in the newly created field.

For applicable situations where claims having a principle (first-listed) “E” ICD-9 code or, when ICD-10 diagnosis coding is implemented, equivalent V00-Y99 ICD-10 diagnosis code are either **not** rejected due to front-end editing or are returned as unprocessable, the Part B and DME MAC shared systems shall:

- Input a “Y” indicator in the First Reported DX Code field (header) of the HUBC and HUDC claims; and
- Transmit the affected claims to CWF for normal processing.

The shared systems shall have the ability to react to CWF consistency edits received when invalid values are entered in the newly created DX Code Indicator field.

Upon receipt of claims that contain a “Y” in First Reported DX Code Indicator field, CWF shall by-pass the claims from crossing over. CWF shall create a new “BX” COBA by-pass indicator that it will apply to claims where a “Y” is present within the DX Code Indicator field (See §80.15 of this chapter for more information regarding the new indicator). Additionally, CWF shall display the new by-pass indicator on the appropriate page(s) of the HIMR claims detail screens.

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

(Rev.2810, Issued: 11-07-13, Effective: 04-01-14, Implementation: 04-07-14)

Effective with the July 2005 release, CMS implemented 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 *now* 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.

Effective with April 1, 2013, CMS has added a new 1-byte Original versus Adjustment indicator to the suite of possible 1-byte options for position 23 of the BHT03 identifier, as reflected below.

Effective with April 7, 2014, CMS has added 3 new 1-byte Original versus Adjustment indicators to the suite of possible options for position 23 of the BHT03 identifier, as reflected below.

A. Inclusion of the Unique 23-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 23-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=50 (for 5010 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:

E—for reprocessed claims that formerly included an electronic prescribing (e-RX) negative adjustment amount (effective April 1, 2013);

O—for original claims;

P—for Affordable Care Act or other *Congressional/legislative mandate* 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;

A—for routine adjustment claims, not previously classified;

C--CMS-directed mass adjustment action (use specified by CMS).

The following indicator is only applicable to FISS-generated claims:

V—Void/cancel only claim.

The 23-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 23-Digit Unique Identifier

Effective with April 3, 2011, the DME Medicare Administrative Contractor (DME MAC) *shared* system shall also adopt a unique 23-digit format, referenced directly above under “Populating the BHT 03 Portion of the 837 Flat File.” However, *prior to April 7, 2014*, the system shall populate the unique 23-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.

Effective April 7, 2014, the DME MAC shared system shall ensure that its DME MACs have the ability to 1) execute actions that will result in the transmission of their HUDC claims to CWF with Mass Adjustment Indicator set to “O”; and 2) transmit mass adjusted NCPDP D.0 COB claims to the COBC under a 504-F04 (Message) field identifier of "C" (CMS-directed mass adjustment action) or "P" (mass adjustments tied to Affordable Care Act or Congressional/legislative mandate) as appropriate to the situation.

In addition, the DME MAC shared system shall ensure that all NCPDP D.0 crossover claims will now be sent to the COBC with the 23rd byte 504-F04 (Message) field indicator completed, when appropriate, as indicated below.

O -- for all "original" NCPDP D.0 claims transmitted;

A-- for "routine adjustment claims" transmitted; and

R-- for recovery audit claims (RAC) adjustment claims transmitted.

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.