

CMS Manual System

Department of Health & Human Services

Pub 100-20 One-Time Notification

Centers for Medicare & Medicaid Services

Transmittal 170

Date: JULY 29, 2005

Change Request 3976

SUBJECT: Updates to the Coordination of Benefits Agreement Insurance File (COIF) For Use in the National Claims Crossover Program

I. SUMMARY OF CHANGES: Through this change request, the Centers for Medicare & Medicaid Services (CMS) is updating the data elements contained within the COIF. The Coordination of Benefits Contractor (COBC) transmits this national file that contains each COBA trading partner's claims selection options to each of the Common Working File (CWF) host sites on a weekly basis. At present, the CWF is able to include or exclude Part B claims by contractor identification number (ID). To accommodate the requests of crossover trading partners that wish to exclude all Part B claims, the CMS is adding an exclusion option for all Part B claims processed through CWF. This change request will also add two (2) new exclusion categories within the COIF, to allow for greater flexibility in the CWF's claims exclusion logic. The CWF maintainer shall create three (3) new crossover disposition indicators on the Health Insurance Master Record (HIMR) that will be applied to processed claims when all Part A or all Part B or all DMERC claims are to be excluded from the COBA crossover process. In addition, CMS is requiring CWF to automatically exclude home health care Requests for Anticipated Payments (RAPs), types of bills 322 and 332, from the COBA crossover process.

NEW/REVISED MATERIAL :

EFFECTIVE DATE : January 01, 2006

IMPLEMENTATION DATE : January 03, 2006

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
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III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

One-Time Notification

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

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 170	Date: July 29, 2005	Change Request 3976
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SUBJECT: Updates to the Coordination of Benefits Agreement Insurance File (COIF) For Use in the National Crossover Program

I. GENERAL INFORMATION

A. Background: Through Transmittal 138 (Change Request 3218), Medicare contractors were informed that they would receive a Beneficiary Other Insurance (BOI) reply trailer (29) when the Common Working File (CWF) selected their processed claims to be crossed over to the Coordination of Benefits Contractor (COBC). The CWF either selects or excludes a claim for crossover under the national Coordination of Benefits Agreement (COBA) consolidated crossover process based upon the information that is populated in the COIF—a national file that the COBC transmits to all CWF host sites on a weekly basis.

Since the issuance of Transmittal 130 (Change Request 3614), Medicare contractor customer service representatives (CSRs) have been able to view the COIF updates on the Health Insurance Master Record (HIMR) and determine which types of claims a trading partner wishes to include or exclude from the national COBA crossover process. The contractor CSRs' capability to view each COBA trading partner's claims selection options shall be unaffected by the publication of this instruction.

B. Policy: The CWF maintainer shall have the capability to exclude all Part A, all Part B, and all Durable Medical Equipment Regional Carrier (DMERC) claims when the COIF indicates these claims should be excluded from the national COBA crossover process. The CWF maintainer shall also ensure that the new crossover disposition indicators, specified below and in Attachment B, will be reflected on the HIMR detailed history screens as appropriate. In addition, CWF shall always exclude requests for anticipated payments (RAPs) associated with home health care services from the COBA crossover process. Contractors shall continue to use their existing interface to the COIF File Summary (COBS) screen as well as the HIMR detailed history screens for purposes of responding to inquiries from beneficiaries, providers, and suppliers.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement

"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)					
		F	R	C	D	Shared System	Other
		I	H	a	M	Maintainers	
		U	-	E			

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
						F I S S	M C S	V M S	C W F	
3976.5.1	The CWF maintainer shall derive the file maintenance date by reading the 8-byte date value formatted as CCYYMMDD in the COBA TIN field of an otherwise blank COIF record that contains a COBA ID with all zeroes. (NOTE: The 8-byte date value will be left-justified, with the 9 th byte of the COBA TIN field containing a space.)								X	
3976.6	Contractors shall continue to utilize the COBS screen data on HIMR as well as the HIMR detailed history screens for purposes of responding to inquiries from Medicare beneficiaries, providers, and suppliers.	X	X	X	X					
3976.6.1	The CWF maintainer shall create three (3) additional crossover disposition indicators—O, P, Q—for purposes of updating the HIMR detailed history screens when BOI reply (29) trailers are not returned to the Medicare contractors.								X	
3976.6.2	As reflected in the Attachment B, the CWF shall populate the following new crossover disposition indicators on HIMR when <u>all</u> Part A or <u>all</u> Part B or <u>all</u> DMERC claims are to be excluded from the COBA crossover process: “O”—All Part A claims excluded “P”—All Part B claims excluded “Q”—All DMERC claims excluded.								X	
3976.7	When reading the HUUH query, the CWF shall automatically exclude, and thereby not return a BOI reply trailer (29) for, bill types 322 and 332—Requests for Anticipated Payments (RAPs)—which represent interim payments for home health care services.								X	

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
						F I S S	M C S	V M S	C W F	
3976.8	None.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

<p>Effective Date*: January 01, 2006</p> <p>Implementation Date: January 03, 2006</p> <p>Pre-Implementation Contact(s): Brian Pabst (410-786-2487; brian.pabst@cms.hhs.gov)</p> <p>Post-Implementation Contact(s): Brian Pabst (410-786-2487; brian.pabst@cms.hhs.gov)</p>	<p>No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.</p>
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ATTACHMENTS (2)

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

COBA INSURANCE FILE**ATTACHMENT A**

Field	Start	Length	End	Description
COBA ID	1	10	10	Unique identifier for each COB Agreement
COBA TIN	11	9	19	Tax Identification Number of COBA
COBA Name	20	32	51	Name of COBA Partner (Equivalent to Insurer Name on BOI Auxiliary File)
COBA Address 1	52	40	91	Address 1 of COBA
COBA Address 2	92	40	131	Address 2 of COBA
COBA City	132	25	156	Address city of COBA
COBA State	157	2	158	Postal State Abbreviation of COBA
COBA Zip	159	9	167	Zip plus 4 of COBA

Common Claim Exclusions

The following fields are 1 byte indicators dictating type of claim exclusions. A value of 'Y' in any of the following fields indicates those types of claims should be excluded.

Non-assigned	168	1	168	Non-assigned claims
Orig. Claims Paid at 100%	169	1	169	Original claims paid at 100%
Orig. Claims Paid at >100%	170	1	170	Original claims paid at greater than 100% of submitted charge
100% Denied, No Additional Liability	171	1	171	100% denied claims, with no additional beneficiary liability
100% Denied, Additional Liability	172	1	172	100% denied claims, with additional beneficiary liability
Adjustment Claims, Monetary	173	1	173	Adjustments, monetary claims
Adjustment Claims, Non-Monetary/Statistical	174	1	174	Adjustments, non-monetary/statistical claims
Medicare Secondary Payer Claims	175	1	175	Medicare Secondary Payer (MSP) claims
Other Insurance	176	1	176	Claims if other insurance (such as Medigap, supplemental, TRICARE, or other) exists for beneficiary. **Applies to State Medicaid Agencies only.**
NCPDP Claims	177	1	177	National Council Prescription Drug Program Claims
Filler	178	10	187	Future
Hospital Inpatient A	188	1	188	TOB 11 - Hospital: Inpatient Part A
Hospital Inpatient B	189	1	189	TOB 12 - Hospital: Inpatient Part B
Hospital Outpatient	190	1	190	TOB 13 - Hospital: Outpatient
Hospital Other B	191	1	191	TOB 14 - Hospital: Other Part B (Non-patient)
Hospital Swing	192	1	192	TOB 18 - Hospital: Swing Bed
SNF Inpatient A	193	1	193	TOB 21 - Skilled Nursing Facility: Inpatient Part A
SNF Inpatient B	194	1	194	TOB 22 - Skilled Nursing Facility: Inpatient Part B
SNF Outpatient	195	1	195	TOB 23 - Skilled Nursing Facility: Outpatient
SNF Other B	196	1	196	TOB 24 - Skilled Nursing Facility: Other Part B (Non-patient)
SNF Swing Bed	197	1	197	TOB 28 - Skilled Nursing Facility: Swing Bed
Home Health B	198	1	198	TOB 32 - Home Health: Part B Trust Fund
Home Health A	199	1	199	TOB 33 - Home Health: Part A Trust Fund
Home Health Outpatient	200	1	200	TOB 34 - Home Health: Outpatient
Religious Non-Med Hospital	201	1	201	TOB 41 - Christian Science/Religious Non-Medical Services (Hospital)
Clinic Rural Health	202	1	202	TOB 71 - Clinic: Rural Health

Clinic Freestanding Dialysis	203	1	203	TOB 72 - Clinic: Freestanding Dialysis
Clinic Fed Health Center	204	1	204	TOB 73 - Clinic: Federally Qualified Health Center
Clinic Outpatient Rehab	205	1	205	TOB 74 - Clinic: Outpatient Rehabilitation Facility
Clinic CORF	206	1	206	TOB 75 - Clinic: Comprehensive Outpatient Rehabilitation Facility (CORF)
Clinic Comp Mental Health	207	1	207	TOB 76 - Clinic: Comprehensive Mental Health Clinic
Clinic Other	208	1	208	TOB 79 - Clinic: Other
SF Hospice Non-Hospital	209	1	209	TOB 81 - Special Facility: Hospice Non-Hospital
SF Hospice Hospital	210	1	210	TOB 82 - Special Facility: Hospice Special Facility: Hospice Hospital
Ambulatory Surgical Center	211	1	211	TOB 83 - Special Facility: Ambulatory Surgical Center
Primary Care Hospital	212	1	212	TOB 85 - Primary Care Hospital

Claim Header Level Exclusions

The following fields are 1 byte indicators dictating type of claim exclusions. A value of 'Y' in any of the following fields indicates those types of claims should be excluded.

All Part A Claims	213	1	213	Claims identified as Part A in the HUIP, HUOP, HUUH, and HUHHC queries to CWF.
All Part B Claims	214	1	214	Claims identified as Part B in the HUBC query to CWF.
All DMERC Claims	215	1	215	Claims identified as DMERC in the HUDC query to CWF.
Filler	216	7	222	Filler

Part A/RHHI Provider Inclusion/Exclusion

Part A/RHHI claims may be included or excluded by providers by specifying the Inclusion/Exclusion type. Inclusion or exclusion may be limited by either provider ID or provider state.

Inclusion/Exclusion Type	223	1	223	Indicates whether providers are to be included or excluded (I - Inclusion or E - Exclusion)
Provider Qualifier	224	1	224	Indicates whether providers are identified by state or by provider ID (P - Provider number or S - Provider state)
Provider ID (P)	225	650	874	Specific providers IDs to be included or excluded (occurs 50 times--13-digit alpha/numeric provider number.
Provider State (S)	875	100	974	Specific provider states to be included or excluded (occurs 50 times—2-digit code)
Filler	975	10	984	Future

Part B Contractor Inclusion/Exclusion

Specific contractors may be included or excluded on Part B claims by specifying the Inclusion/Exclusion type.

Inclusion/Exclusion Type	985	1	985	Indicates whether contractors are to be included or excluded (I - Inclusion or E - Exclusion)
Contractor ID	986	250	1235	Specific contractors to be included or excluded (occurs 50 times; allows for 5-digit contractor ID).
Filler	1236	10	1245	Future

DMERC Contractor Exclusion

Specific contractors may be excluded on DMERC claims.

Contractor ID	1246	20	1265	Specific contractors to be excluded on DMERC claims (occurs 4 times).
Filler	1266	10	1275	Future

**Medicare Summary Notice
(MSN) Indicator for Trading
Partner Name**

MSN Indicator for Printing of 1276 1
Trading Partner Name

1276 Indicates whether the COBA trading partner wishes its name to appear on the MSN. (Y=Yes N=No).

Test/Production Indicator

Test/Production Indicator 1277 1

1277 One-position indicator that communicates whether a COBA trading partner is in test or full-production mode. (T= Test Mode; P=Production Mode)

ATTACHMENT B

<i>Claims Crossover Disposition Indicator</i>	Definition/Description
A	This claim was selected to be crossed over.
B	This Type of Bill (TOB) excluded.
C	Non-assigned claim excluded.
D	Original Medicare claims paid at 100%.
E	Original Medicare claims paid at greater than 100% of the submitted charges excluded.
F	100% denied claims, with no additional beneficiary liability excluded.
G	100% denied claims, with additional beneficiary liability excluded.
H	Adjustment claims, monetary, excluded.
I	Adjustment claims, non-monetary/statistical, excluded.
J	MSP claims excluded.
K	This claim contains a provider identification number (ID) or provider state that is excluded by the COBA trading partner.
L	Claims from this Contractor ID excluded.
M	The beneficiary has other insurance (such as Medigap, supplemental, TRICARE, or other) that pays before Medicaid. Claim excluded by Medicaid.
N	NCPDP claims excluded.
O	All Part A claims excluded.
P	All Part B claims excluded.
Q	All DMERC claims excluded.