

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2215	Date: May 13, 2011
	Change Request 7393

SUBJECT: Modifications to the COBA Process For Other Federal Payer Payment Order and Other Issues

I. SUMMARY OF CHANGES: Through this instruction, the Centers for Medicare and Medicaid Services (CMS) is making changes to ensure that it only crosses over Medicare beneficiary claims to TRICARE for Life and the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) program when other sources of supplemental insurance coverage are unavailable. Title XIX Medicaid will remain payer of last resort after these entities.

In addition, through this instruction, CMS directs the Part A shared system to always display the value 8 within the 2300 CLM05-3 element on outbound 837 institutional crossover claims.

Lastly, CMS directs the Common Working File (CWF) system to apply consistency edits when the Medicare contractors generate invalid values for the newly created Claim Adjustment Segment (CAS) Group Code indicator within the HUIP, HUOP, HUUH, HUHC, HUBC, and HUDC claims transactions.

EFFECTIVE DATE: October 1, 2011

IMPLEMENTATION DATE: October 3, 2011

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged.

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	27/80.14/ Consolidated Claims Crossover Process
R	28/70.6/ Consolidation of the Claims Crossover Process

III. FUNDING:

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

For Medicare Administrative Contractors (MACs):

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

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2215	Date: May 13, 2011	Change Request: 7393
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SUBJECT: Modifications to the COBA Process For Other Federal Payer Payment Order and Other Issues

Effective Date: October 1, 2011

Implementation Date: October 3, 2011

I. GENERAL INFORMATION

A. Background: Through its Coordination of Benefits Contractor (COBC), the Centers for Medicare & Medicaid Services (CMS) crosses over claims in excess of 800 insurance or benefit plan lines of business. Recipients of crossover claims include employer retiree plans, Medigap issuers, TRICARE for Life, the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), and State Medicaid Agencies. Through ongoing discussions with TRICARE and CHAMPVA, CMS has identified the importance of ensuring that these payers only receive cross over claims to the extent to which other commercial insurance, such as Blue Cross and Blue Shield plans and Medigap issuers, pays first. CMS addresses this issue through this change request.

Through CR 6741, Transmittal 2138, dated January 21, 2011, CMS required the Common Working File (CWF) to create space within its HUBC, HUDC, HUIP, HUOP, HUUH, and HUHHC claims transactions for an "Other Adjustment Claim" indicator to accommodate situations where contractors deny all services or service detail lines using a claim adjustment segment (CAS) group code of "OA." This instruction ensures that 1) CWF consistency editing will be applied to incoming claims whose value within the newly established Claim Adjustment Segment (CAS) Group Code Indicator field is something other than "G" or spaces; and 2) the shared systems will react to the CWF-generated edits to allow for the correct reporting of the appropriate value.

B. Policy: 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 (COBA ID range 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 the revised "Other Insurance" logic, CWF shall interpret "additional supplemental coverage" as including entities whose COBA identifiers fall in any of the following ranges: 00001-29999 (Supplemental), 30000-59999 (Medigap eligibility and claim-based), and 80000-80213 and 80215-88999 (Other Health Insurance). **IMPORTANT:** CWF shall also include TRICARE (60000-69999) and CHAMPVA (80214) within its "Other Insurance" logic deployed 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.

Additionally, CWF shall sort the COBA IDs and trading partner names in the following order on the returned Beneficiary Other Insurance (BOI) reply trailer (29): 1) Eligibility-based Medigap (30000-54999); 2) Medigap claim-based (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).

The Part A shared system shall henceforth reflect the 2300 CLM05-3 value as "8" in lieu of alpha codes (e.g., G, H, I) in association with version 4010A1 and 5010 void/cancel 837 institutional crossover claims.

Number	Requirement	Responsibility									
		A / B	D M E	F I	C A R R I E R	R H I	Shared-System Maintainers				Other
							F I S S	M C S	V M S	C W F	
7393.3.1	<p>Upon receipt of this consistency edit, the indicated shared systems shall take the following actions:</p> <p>1) Modify the value reported in the CAS Group Code Indicator either to “G,” if appropriate, or spaces; and 2) Retransmit the claim to CWF.</p> <p>(NOTE: MCS has hard-coded the possible values as G or spaces and thus is exempt from this requirement.)</p>						X		X		

II. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility									
		A / B	D M E	F I	C A R R I E R	R H I	Shared-System Maintainers				Other
							F I S S	M C S	V M S	C W F	
	N/A										

IV. SUPPORTING INFORMATION

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

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

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

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

VI. FUNDING

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

Not applicable.

Section B: For *Medicare Administrative Contractors (MACs)*, include the following statement:

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

80.14 - Consolidated Claims Crossover Process

(Rev.2215, Issued: 05-13-11, Effective: 10-01-11, Implementation: 10-03-11)

A. The Mechanics of the CWF Claims Selection Process and BOI and Claim-based Reply Trailers

1. CWF Receipt and Processing of the Coordination of Benefits Agreement Insurance File (COIF)

Effective July 6, 2004, the COBC will begin to send copies of the Coordination of Benefits Agreement Insurance File (COIF) to the nine CWF host sites on a weekly basis. The COIF will contain specific information that will identify the COBA trading partner, including name, COBA ID, address, and tax identification number (TIN). It will also contain each trading partner's claims selection criteria exclusions (claim or bill types that the trading partner does not want to receive via the crossover process) along with an indicator (Y=Yes; N=No) regarding whether the trading partner wishes its name to be printed on the Medicare Summary Notice (MSN). During the COBA parallel production period, which is estimated to run from July 6, 2004, to October 1, 2004, CWF will exclusively return an "N" MSN indicator to the Medicare contractor.

The CWF shall load the initial COIF submission from COBC as well as all future weekly updates.

Upon receipt of a claim, the CWF shall take the following actions:

- a. Search for a COBA eligibility record on the BOI auxiliary record for each beneficiary, unless there is a COBA ID in range 55000 through 55999 present on the incoming HUBC or HUDC claim (which identifies Medigap claim-based crossover), and obtain the associated COBA ID(s) **NOTE:** There may be multiple COBA IDs;
- b. Refer to the COIF associated with each COBA ID (NOTE: CWF shall pull the COBA ID from the BOI auxiliary record) to obtain the COBA trading partner's name and claims selection criteria;
- c. Apply the COBA trading partner's selection criteria; and
- d. Transmit a BOI reply trailer 29 to the Medicare contractor only if the claim is to be sent, via 837 COB flat file or National Council for Prescription Drug Programs (NCPDP) file, to the COBC to be crossed over. (See Pub.100-04, Chap. 28, §70.6 for more information about the claim file transmission process involving the Medicare contractor and the COBC.)

Effective with the October 2004 systems release, CWF shall read the COIF submission to determine whether a Test/Production Indicator "T" (test mode) or "P" (production mode) is present. CWF will then include the Test/Production Indicator on the BOI reply trailer 29 that is returned to the Medicare contractor. (See additional details below.)

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

2. BOI Reply Trailer 29 Processes

For purposes of eligibility file-based crossover, if CWF selects a claim for crossover, it shall return a BOI reply trailer 29 to the Medicare contractor. The returned BOI reply trailer 29 shall include, in addition to COBA ID(s), the COBA trading partner name(s), an "A" crossover indicator that specifies that the claim has been selected to be crossed over, the insurer effective and termination dates, and a 1-digit indicator ["Y"=Yes; "N"=No] that specifies whether the COBA trading partner's name should be printed on the beneficiary MSN. Effective with the October 2004 systems release, CWF shall also include a 1-digit Test/Production Indicator "T" (test mode) or "P" (production mode) on the BOI reply trailer 29 that is returned to the Medicare contractor.

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

B. MSN Crossover Messages

As specified above, during the COBA parallel production period (July 6, 2004, to October 1, 2004), CWF will exclusively return an "N" MSN indicator via the BOI reply trailer, in accordance with the information received via the COIF submission. If a Medicare contractor receives a "Y" MSN indicator during the parallel production period, it shall ignore it.

Beginning with the October 2004 systems release, when a contractor receives a BOI reply trailer 29 from CWF that contains a Test/Production Indicator "T" (test mode), it shall ignore the MSN Indicator provided on the trailer. Instead, the Medicare contractor shall follow its existing procedures for inclusion of trading partner names on MSNs for those trading partners with whom it has existing Trading Partner Agreements (TPAs).

Beginning with the October 2004 systems release, when a contractor receives a BOI reply trailer 29 from CWF that contains a Test/Production Indicator "P" (production mode), it shall read the MSN indicator (Y=Yes, print trading partner's name; N=Do not print trading partner's name) returned on the BOI reply trailer 29. (Refer to Pub.100-4, chapter 28, §70.6 for additional details.)

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

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

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

Beginning with the October 2004 release, when CWF returns a BOI reply trailer (29) that contains a "T" Test/Production Indicator to the Medicare contractors, they shall not print information received from the BOI reply trailer (29) in the required crossover fields on the 835 Electronic Remittance Advice or other provider remittance advice(s) that is/are in production. Contractors shall, however, populate the 835 ERA (or provider remittance advice(s) in production) with required crossover information when they have existing agreements with trading partners.

Beginning with the October 2004 release, when CWF returns a BOI reply trailer (29) that contains a "P" Test/Production Indicator to the Medicare contractors, they shall use the returned BOI trailer information to take the following actions on the provider's 835 Electronic Remittance Advice:

1. Record code 19 in CLP-02 (Claim Status Code) in Loop 2100 (Claim Payment Information) of the 835 ERA (v. 4010-A1). [**NOTE:** Record "20" in CLP-02 (Claim Status Code) in Loop 2100 (Claim Payment Information) when Medicare is the secondary payer.]

2. Update the 2100 Loop (Crossover Carrier Name) on the 835 ERA as follows:

- NM101 [Entity Identifier Code]—Use "TT," as specified in the 835 Implementation Guide.
- NM102 [Entity Type Qualifier]—Use "2," as specified in the 835 Implementation Guide.
- NM103 [Name, Last or Organization Name]—Use the COBA trading partner's name that accompanies the first sorted COBA ID returned to you on the BOI reply trailer.
- NM108 [Identification Code Qualifier]—Use "PI" (Payer Identification.)
- NM109 [Identification Code]—Use the first COBA ID returned to you on the BOI reply trailer. (See line 24 of the BOI aux. file record.)

If the 835 ERA is not in production and the contractor receives a "P" Test/Production Indicator, it shall use the information provided on the BOI reply trailer (29) to populate the existing provider remittance advices that it has in production.

Effective January 5, 2009, if CWF returns **only** a COBA ID range 89000 through 89999 on a BOI reply trailer (29) to a Medicare contractor, the contractor's system shall suppress all crossover information (the entire 2100 loop) on the 835 ERA.

Effective **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.

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 HUHH and HUHA claims. (See items J and K within this section for more specifics regarding revised logic for exclusion of fully denied HUIP and HUOP adjustment claims.)

If CWF determines that the COBA trading partner wishes to exclude the claim, as per the COIF, it shall suppress the claim from the crossover process.

CWF shall post the appropriate crossover disposition indicator in association with the adjudicated claim on the HIMR detailed history screen (see §80.15 of this chapter).

In addition, the CWF maintainer shall create and display the new 1-byte beneficiary liability indicator field within the HIMR detailed history screens (INPL, OUTL, HHAL, and HOSL), to illustrate the indicator ('L' or 'N') that appeared on the incoming HUIP, HUOP, HUHH, or HUHC claim transaction.

CWF Editing for Incorrect Values

If a Part A contractor sends values other than 'L' or 'N' in the newly defined beneficiary liability field in the header of its HUIP, HUOP, HUHH, or HUHC claim, CWF shall reject the claim back to the Part A contractor for correction. Following receipt of the CWF rejection, the Part A contractor shall change the incorrect value placed within the newly defined beneficiary liability field and retransmit the claim to CWF.

5. Modification to the CWF Inclusion or Exclusion Logic for the COBA Crossover Process

Beginning with the October 2006 release, the CWF or its maintainer shall modify its COBA claims selection logic and processes as indicated below. The CWF shall continue to include or exclude all other claim types in accordance with the logic and processes that it had in place prior to that release.

D. New Part B Contractor Inclusion or Exclusion Logic

The CWF shall read the first two (2) positions of the Business Segment Identifier (BSI), as reported on the HUBC claim, to uniquely include or exclude claims from state-specific Part B contractors, as indicated on the COBA Insurance File (COIF).

E. Exclusion of Fully Paid Claims

The CWF shall continue to exclude Part B claims paid at 100 percent by checking for the presence of claims entry code '1' and determining that each claim's allowed amount equals the reimbursement amount and confirming that the claim contains no denied services or service lines.

The CWF shall continue to read action code '1' and determine that there are no deductible or co-insurance amounts for the purpose of excluding Part A original claims paid at 100 percent. In addition, CWF shall determine that the Part A claim contained a reimbursement amount before excluding a claim with action code '1' that contained no deductible and co-insurance amounts and that the claim contained no denied services or service lines.

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

New HUBC Line-Level Indicator Field

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

Part B Shared System Requirements

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

- 1) Input a "B" value in the newly created 1-byte LIAB IND field for each denied service line where the beneficiary has payment liability (NOTE: there may be multiple instances where the "B" value will be applied, contingent upon whether the beneficiary is liable for each of the denied service lines);
- 2) Input spaces in the newly created 1-byte LIAB IND field for each denied service line where the provider, rather than the beneficiary, is contractually liable for the denied service; and
- 3) Transmit the HUBC claim to CWF for normal verification and validation processing.

CWF Requirements

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

- 1) Continue to verify the claim's entry or action code for confirmation that the claim is an original;
- 2) Confirm that the claim contains service lines where the amount allowed per line equals the amount paid per line;
- 3) Check for the presence of a "B" line LIAB IND in association with any of the denied service lines on the claim;
- 4) Suppress the claim from the crossover process if the claim does not contain a "B" line LIAB IND for any of the denied service lines; and
- 5) Select the claim for crossover if even one of the denied lines contains a "B" line LIAB IND.

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

F. Claims Paid at Greater than 100 Percent of the Submitted Charge

The CWF shall modify its current logic for excluding Part A original Medicare claims paid at greater than 100 percent of the submitted charges as follows:

In addition to meeting the CWF exclusion criteria for Part A claims paid at greater than 100 percent of the submitted charges, CWF shall exclude these claims only when there is no deductible or co-insurance amounts remaining on the claims.

NOTE The current CWF logic for excluding Part B original Medicare claims paid at greater than 100 percent of the submitted charges/allowed amount (specifically, type F ambulatory surgical center claims, which typically carry deductible and co-insurance amounts) shall remain unchanged.

G. Claims with Monetary or Non-Monetary Changes

The CWF shall check the reimbursement amount as well as the deductible and co-insurance amounts on each claim to determine whether a monetary adjustment change to an original Part A, B, or DMAC claim occurred.

To exclude non-monetary adjustments for Part A, B, and DMAC claims, the CWF shall check the reimbursement amount as well as the deductible and co-insurance amounts on each claim to confirm that there were no monetary changes on the adjustment claim as compared to the original claim.

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

H. Excluding Adjustment Claims When the Original Claim Was Also Excluded

When the CWF processes an adjustment claim, it shall take the following action when the COIF indicates that the "production" COBA trading partner wishes to receive adjustment claims, monetary **or** adjustment claims, non-monetary:

- Return a BOI reply trailer 29 to the contractor if CWF locates the original claim that was marked with an 'A' crossover disposition indicator **or** if the original claim's crossover disposition indicator was blank/non-existent;
- Exclude the adjustment claim if CWF locates the original claim and it was marked with a crossover disposition indicator other than 'A,' meaning that the original claim was excluded from the COBA crossover process.

CWF shall **not** be required to search archived or purged claims history to determine whether an original claim had been crossed over.

The CWF maintainer shall create a new 'R' crossover disposition indicator, as referenced in a chart within §80.15 of this chapter, to address this exclusion for customer service purposes. The CWF maintainer shall ensure that adjustment claims that were excluded because the original claim was not crossed over shall be marked with an 'R' crossover disposition indicator after they have been posted to the appropriate Health Insurance Master Record (HIMR) detailed history screen.

I. Excluding Part A, B, and DMAC Contractor Fully Paid Adjustment Claims Without Deductible and Co-Insurance Remaining

The CWF shall apply logic to exclude Part A and Part B (including DMAC) adjustment claims (identified as action code '3' for Part A claims and entry code '5' for Part B and DMAC claims) when the COIF indicates that a COBA trading partner wishes to exclude adjustment claims that are fully paid and without deductible or co-insurance amounts remaining.

Effective with October 1, 2007, the CWF shall develop logic as follows to exclude fully paid Part A adjustment claims without deductible and co-insurance remaining:

- 1) Verify that the claim contains action code '3';
- 2) Verify that there are no deductible and co-insurance amounts on the claim;
- 3) Verify that the reimbursement on the claim is greater than zero; and

- 4) Confirm that the claim contains no denied services or service lines.

Special Note: Effective with October 1, 2007, CWF shall cease by-passing the logic to exclude Part A adjustment claims fully (100 percent) paid in association with home health prospective payment system (HPPS) 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, HUHHC, 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 HUHC claims transaction. For instances where a match is found, CWF either includes or excludes the claim from the national crossover process, in accordance with the "I" or "E" indicator that precedes the provider ID value reported beginning with field 225 of the COIF.

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

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

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

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, HUUH, 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, HUUH, 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, HUUH, 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.)

70.6 - Consolidation of the Claims Crossover Process

(Rev. 2215, Issued: 05-13-11, Effective: 10-01-11, Implementation: 10-03-11)

Background – Medicare Claims Crossover Process--General

Through the Coordination of Benefits Contractor (COBC), Medicare transmits outbound 837 Coordination of Benefit (COB) and Medigap claims COB trading partners and Medigap plans, collectively termed “trading partners,” on a post-adjudicative basis. This type of transaction, originating at individual Medicare contractors following their claims adjudication activities, includes incoming claim data, as modified during adjudication if applicable, as well as payment data. All Medicare contractors are required to accept all 837 segments and data elements permitted by the in-force applicable guides on an initial 837 professional or institutional claim from a provider, but they are not required to use every segment or data element for Medicare adjudication. Segments and data elements determined to be extraneous for Medicare claims adjudication shall, however, be retained by the Medicare contractor within its store-and-forward repository (SFR). Incoming claims data shall be subjected to standard syntax and applicable implementation guide (IG) edits prior to being deposited in the SFR to assure non-compliant data will not be forwarded on to another payer as part of the Medicare crossover process. SFR data shall be re-associated with those data elements used in Medicare claim adjudication, as well as with payment data, to create an 837 IG-compliant outbound COB/Medigap transaction. The shared systems shall always retain the data in the SFR for a minimum of 6 months.

The 837 version institutional and professional implementation guides require that claims submitted for secondary payment contain standard claim adjustment reason codes (CARCs) to explain adjudicative decisions made by the primary payer. For a secondary claim to be valid, the amount paid by the primary payer plus the amounts adjusted by the primary payer shall equal the billed amount for the services in the claim. A tertiary payer to which Medicare may forward a claim may well need all data and adjustment codes Medicare receives on a claim. A tertiary payer could reject a claim forwarded by Medicare if the adjustment and payment data from the primary payer or from Medicare did not balance against the billed amounts for the services and the claim. As a result, shared systems shall reject inbound Medicare Secondary Payer (MSP) claims if the paid and adjusted amounts do not equal the billed amounts and if the claims lack standard CARCs to identify adjustments to the total amount billed.

As a rule, the shared system maintainers shall populate an outbound COB/Medigap file as an 837 flat file with the Employer Identification Number (EIN)/Tax ID or SSN (for a sole practitioner) present in the provider’s file, unless otherwise specified within §70.6.5 or §70.6.6 of this chapter. With the adoption of the National Provider Identifier (NPI), the shared system shall report qualifier XX in NM108 and the NPI value in NM109. The shared system shall report the provider’s EIN/TAX ID within the REF segment of the billing provider loop, as appropriate. In addition, unless otherwise stated within §70.6.5 or §70.6.6 of this chapter, the shared systems shall populate the provider loops on outbound 837 claims with the provider’s first name, last name, middle initial, address, city, state and zip code as contained in the Medicare provider files, the information for which is derived from the Provider Enrollment Chain and Ownership System (or PECOS)

Background—Specific COBA Crossover Process

The CMS has now streamlined the claims crossover process to better serve its customers. Under the new consolidated claims crossover process, trading partners execute national agreements called Coordination of Benefits Agreements (COBAs) with CMS' Coordination of Benefits Contractor. Through the COBA process, each COBA trading partner will send one national eligibility file that includes eligibility information for each Medicare beneficiary that it insures to the COBC. The COBC will transmit the beneficiary eligibility file(s) to the Common Working File (CWF) via the HUBO maintenance transaction. The transaction is also termed the "Beneficiary Other Insurance (BOI)" auxiliary file. (See Pub.100-4, chapter 27, §80.14 for more details about the contents of the BOI auxiliary file.)

During August 2003, the CMS modified CWF to accept both the HUBO (BOI) transaction on a regular basis and COBA Insurance File (COIF) as a weekly file replacement. Upon reading both the BOI and the COIF, CWF applies each COBA trading partner's claims selection criteria against processed claims with service dates that fall between the effective and termination date of one or more BOI records.

Upon receipt of a BOI reply trailer (29) that contains (a) COBA ID (s) and other crossover information required on the Health Insurance Portability and Accountability Act (HIPAA) 835 Electronic Remittance Advice (ERA), Medicare contractors will send processed claims via an 837 COB flat file or National Council for Prescription Drug Programs (NCPDP) file to the COBC. The COBC, in turn, will cross the claims to the COBA trading partner in the HIPAA American National Standards Institute (ANSI) X12-N 837 or NCPDP formats, following its validation that the incoming Medicare claims are formatted correctly and pass HIPAA or NCPDP compliance editing.

In addition, CMS shall arrange for the invoicing of COBA trading partners for crossover fees.

For more information regarding the COBA Medigap claim-based crossover process, which was enacted on October 1, 2007, consult §70.6.4 of this chapter.

I. Contractor Actions Relating to CWF Claims Crossover Exclusion Logic

A. Determination of Beneficiary Liability for Claims with Denied Services

Effective with the January 2005 release, the Part B and Durable Medical Equipment Regional Carrier (DMERC)/DME Medicare Administrative Contractor (DME MAC) contractor shared systems will 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.

For purposes of applying the liability indicator L or N at the header/claim level and, in turn, including such indicators in the HUBC or HUDC query to CWF, the Part B and DMERC/DME MAC contractor shared systems shall follow these business rules:

- The L or N indicators are not applied at the header/claim level if any service on the claim is payable by Medicare;
- The “L” indicator is applied at the header/claim level if the beneficiary is liable for any of the denied services on a fully denied claim; and
- The “N” indicator is applied at the header/claim level if the beneficiary is not liable for all of the denied services on a fully denied claim.

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 HUHC Part A claims transactions (valid values for the field=“L,” “N,” or space).

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 HUHC claims that they transmit to CWF. In addition, as Part A contractors adjudicate claims and determine that the beneficiary has no payment liability for any of the fully denied services or service lines—that is, the provider must absorb all costs for the fully denied claims—they shall include an “N” beneficiary indicator within the designated field in the header of their HUIP, HUOP, HUUH, and HUHC claims that they transmit to CWF. **NOTE:** Part A contractors shall not set the “L” or “N” indicator on partially denied/partially paid claims.

Upon receipt of an HUIP, HUOP, HUUH, or HUHC claim that contains an “L” or “N” beneficiary liability indicator, CWF shall read the COBA Insurance File (COIF) to determine whether the COBA trading partner wishes to receive “original” fully denied claims with beneficiary liability (crossover indicator “G”) or without beneficiary liability (crossover indicator “F”) or “adjustment” fully denied claims with beneficiary liability (crossover indicator “U”) or without beneficiary liability (crossover indicator “T”).

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,” “N,” or space 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.

B. Developing a Capability to Treat Entry Code “5” and Action Code “3” Claims As Recycled “Original” Claims For Crossover Purposes

Effective with July 2007, in instances when CWF returns an error code 5600 to a contractor, thereby causing it to reset the claim’s entry code to “5” to action code to “3,” the contractor shall set a newly developed “N”(non-adjustment) claim indicator (“treat as an original claim for crossover purposes”) in the header of the HUBC, HUDC, HUIP, HUOP, HUHH, HUIP, HUOP, HUHH, and HUHC claim in the newly defined field before retransmitting the claim to CWF. The contractor’s system shall then resend the claim to CWF.

Upon receipt of a claim that contains entry code “5” or action code “3” with a non-adjustment claim header value of “N,” the CWF shall treat the claim as if it were an “original” claim (i.e., as entry code “1” or action code “1”) for crossover inclusion or exclusion determinations. If CWF subsequently determines that the claim meets all other inclusion criteria, it shall mark the claim with an “A” (“claim was selected to be crossed over”) crossover disposition indicator.

Following receipt of a Beneficiary Other Insurance (BOI) reply trailer (29) for the recycled claim, the contractors’ systems shall ensure that, as part of their 837 flat file creation processes, they populate the 2300 loop CLM05-3 (Claim Frequency Type Code) segment with a value of “1” (original). In addition, the contractors’ systems shall ensure that, as part of their 837 flat file creation process, they do not create a corresponding 2330 loop REF*T4*Y segment, which typically signifies “adjustment.”

C. Developing a Capability to Treat Claims with Non-Adjustment Entry or Action Codes as Adjustment Claims For Crossover Purposes

Effective with July 2007, in instances where contractors must send adjustment claims to CWF as entry code “1” or as action code “1” (situations where CWF has rejected the claim with edit 6010), they shall set an “A” indicator in a newly defined field within the header of the HUBC, HUDC, HUIP, HUOP, HUHH, or HUHC claim.

If contractors send a value other than “A” or spaces within the newly designated header field within their HUBC, HUDC, HUIP, HUOP, HUHH, and HUHC claims, CWF shall apply an edit to reject the claim back to the contractor. Upon receipt of the CWF rejection edit, the contractors’ systems shall correct the invalid value and retransmit the claim to CWF for verification and validation.

Upon receipt of a claim that contains entry code “1” or action code “1” with a header value of “A,” the CWF shall take the following actions:

- Verify that, as per the COIF, the COBA trading partner wishes to exclude **either** adjustments, monetary or adjustments, non-monetary, **or both**; and

- Suppress the claim if the COBA trading partner wishes to exclude **either** adjustments, monetary or adjustments, non-monetary, **or both**.

NOTE: The expectation is that such claims do not represent mass adjustments tied to the MPFS or mass adjustments-other.

If contractors receive a BOI reply trailer (29) on a claim that had an “A” indicator set in its header, the contractors’ systems shall ensure that, as part of their 837 flat file creation processes, they populate the 2300 loop CLM05-3 (“Claim Frequency Type Code”) segment with a value that designates “adjustment” rather than “original” to match the 2330B loop REF*T4*Y that they create to designate “adjustment claim.”

If a contractor’s system does not presently create a loop 2330B REF*T4*Y to designate adjustments, it shall not make a change to do so as part of this instruction.

Correcting Invalid Claim Header Values Sent to CWF

If contractors send a value other than “A,” “N,” or spaces within the newly designated header field within their HUBC, HUDC, HUIP, HUOP, HUUH, and HUHHC claims, CWF shall apply an edit to reject the claim back to the contractor. Upon receipt of the CWF rejection edit, the contractors’ systems shall correct the invalid value and retransmit the claim to CWF for verification and validation.

D. CWF Identification of National Council for Prescription Drug Claims

Currently, the DMERC/DME MAC contractor 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. Effective with January 2005, the DMERC/DME MAC contractor 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” should be included in a field on the HUDC that is separate from the fields used to indicate whether a beneficiary is liable for all services that are completely denied on his/her claim.

The CWF shall read the new indicators passed via the HUBC or HUDC queries for purposes of excluding 100 percent denied claims with or without beneficiary liability and NCPDP claims. After applying the claims selection options, CWF will return a BOI reply trailer (29) to the Medicare contractor only in those instances when the COBA trading partner expects to receive a Medicare processed claim from the COBC.

Effective with July 2007, CWF shall reject claims back to DMERCs/DME MACs if their HUDC claim contains a value other than “P” in the established field used to identify NCPDP claims.

E. CWF Identification and Auto-Exclusion of 837 Professional Claims That Contain Only Physician Quality Reporting Initiative (PQRI) Codes

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 and DME MAC claim detail screens.

Prior to October 6, 2008, all Medicare contractors shall update any of their provider customer service materials geared towards crossover claims related inquiries to reflect the newly developed "BQ" by-pass value, which designates that CWF auto-excluded the claim because it only contained PQRI codes.

The Next Generation Desktop (NGD) contractor shall also modify its user screens and documentation to reflect the new "BQ" code.

F. CWF Identification and Exclusion of Claims Containing Placeholder National Provider Identifiers (NPIs)

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." (See Pub. 100-04, chapter 27, §80.15 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, HUH, 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 screen and on page 3 of the HIMR intermediary claim detail screen. (See Pub.100-04, chapter 27, §80.14 for more details.)

Prior to October 6, 2008, all Medicare contractors shall update any of their provider customer service materials geared towards crossover claims related inquiries to reflect the newly developed “BN” by-pass value, which designates that CWF auto-excluded the claim because it contained a placeholder provider value.

The Next Generation Desktop (NGD) contractor shall also modify its user screens and documentation to reflect the new “BN” code.

G. New CWF 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.)

II. Contractor Actions Relating to CWF Claims Crossover Inclusion or Inclusion/Exclusion Logic

A. Inclusion of Two Categories of Mass Adjustment Claims for Crossover Purposes

All Medicare contractors shall continue to identify mass adjustment claims—MPFS and mass adjustment claims—other by including an “M” (mass adjustment claims—MPFS) or “O” (mass adjustment claims—other) within the header of the HUIP, HUOP, HUUH, HUH, HUBC, and HUDC claim transactions, as specified in Pub.100-04, chapter 27, §80.16. (Refer to Pub.100-04, chapter 27, §80.18 for CWF specific requirements relating to the unique inclusion of mass adjustment claims for crossover purposes.)

Effective January 5, 2009, the COBC, at CMS’s direction, will modify the COIF to allow for the unique **inclusion** of mass adjustment claims—MPFS updates and mass adjustment claims—other. The CWF maintainer shall 1) create these new fields, along with accompanying 1-byte file displacement, within its version of the COIF; and 2) accept and process these new fields when the COBC transmits them as part of its regular COIF updates.

Upon receipt of a HUIP, HUOP, HUUH, HUH, HUBC, or HUDC claim transaction that contains an “M” or “O” mass adjustment indicator, CWF shall undertake all additional actions with respect to determination as to whether the claim should be included or excluded for crossover purposes as specified in chapter 27, §80.18.

Contractor Flat File Requirements

Before the Part A and Part B shared systems send “mass adjustment claims—MPFS” to the COBC via an 837 flat file transmission, they shall take the following actions with respect to the fields that correspond to the loop 2300 NTE01 and NTE02 segments on the 837 COB flat file only if there was not a pre-existing 2300 NTE segment on the incoming Medicare claim:

- 1) Populate “ADD” in the field that corresponds to NTE01; and
- 2) Populate “MP,” utilizing bytes 01 through 02, in the field that corresponds to NTE02.

Before the contractors’ shared systems send “mass adjustment claims—other” to the COBC via an 837 flat file transmission, they shall take the following actions with respect to the fields that correspond to the loop 2300 NTE01 and NTE02 segments on the 837 COB flat file only if there was not a pre-existing 2300 NTE segment on the incoming Medicare claim:

- 1) Populate “ADD” in the field that corresponds to NTE01; and
- 2) Populate “MO,” utilizing bytes 01 through 02, in the field that corresponds to NTE02.

B. Inclusion and Exclusion of Recovery Audit Contractor (RAC)-Initiated Adjustment Claims

Effective January 5, 2009, at CMS’s direction, the COBC will modify the COIF to allow for the unique **inclusion** and exclusion of RAC-initiated adjustment claims. The CWF maintainer shall 1) create these new fields, along with accompanying 1-byte file displacement, within its version of the COIF; and 2) accept and process these new fields when the COBC transmits them as part of its regular COIF updates. In addition, the CWF maintainer shall create a 1-byte RAC adjustment value in the header of its HUIP, HUOP, HUUH, HUHC, HUBC, and HUDC claims transactions (valid values=“R” or spaces).

Through this instruction, all contractor systems shall develop a method for uniquely identifying all varieties of RAC-requested adjustments, which occur as the result of post-payment review activities.

NOTE: Currently, fewer than five (5) contractors process RAC adjustments.

Prior to sending its processed 11X and 12X type of bill RAC-initiated adjustment transactions to CWF for normal verification and validation, the Part A shared system shall input the “R” indicator in the newly defined header field of the HUIP claim transaction if the RAC adjustment claim meets either of the following conditions:

- 1) The claim resulted in Medicare changing its payment decision from paid to denied (i.e., Medicare paid \$0.00 as a result of the adjustment performed); **or**
- 2) The claim resulted in a Medicare adjusted payment that falls below the amount of the inpatient hospital deductible.

Prior to sending RAC-initiated adjustment claims **with all other type of bill designations to CWF** for normal processing, the Part A shared system shall input an “R” indicator in the newly defined header field of the HUOP, HUUH, and HUHHC claim.

Prior to sending their processed RAC adjustment transactions to CWF for normal verification and validation, the Part B and Durable Medical Equipment Medicare Administrative Contractor (DMAC) shared systems shall input the “R” indicator in the newly defined header field of the HUBC and HUDC claim transactions.

Unique COBA ID Assignment to Trading Partners That Accept RAC-Initiated Adjustment Claims Only and Attendant Contractor Responsibilities

The COBC will assign a unique COBA ID range (88000-88999) to COBA trading partners that elect to “include” RAC-initiated adjustment claims for crossover purposes and will **not**, at CMS’s direction, charge the trading partner the standard crossover fee for that category of adjustment claims. Therefore, when contractors receive a BOI reply trailer (29) on a claim that contains **only** a COBA ID in the range 88000 through 88999 (which designates RAC adjustment), the contractor shall not establish an accrual or expect payment for the claim.

Before the contractor systems send “tagged” RAC-initiated adjustment claims to the COBC via an 837 flat file transmission, they shall take the following actions with respect to the fields that correspond to the loop 2300 NTE01 and NTE02 segments on the 837 COB flat file only if there was **not** a pre-existing 2300 NTE segment on the incoming Medicare claim:

- 1) Populate “ADD” in the field that corresponds to NTE01; and
- 2) Populate “RA,” utilizing bytes 01 through 02, in the field that corresponds to NTE02.

III. CWF Crossover Processes In Association with the Coordination of Benefits Contractor

A. CWF Processing of the COBA Insurance File (COIF) and Returning of BOI Reply Trailers

Effective July 6, 2004, the COBC will begin to send initial copies of the COBA Insurance File (COIF) to the nine CWF host sites. 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 along with an indicator (Y=Yes or N=No) of whether the trading partner wishes its name to be printed on the Medicare Summary Notice (MSN). Effective with the October 2004 systems release, the COIF will also contain a 1-digit Test/Production Indicator that will identify whether a COBA trading partner is in test (T) or production (P) mode. The CWF will be required to return that information as part of the BOI reply trailer (29) to Medicare contractors.

Upon receipt of a claim, CWF shall take the following actions:

- Search for a COBA eligibility record on the BOI auxiliary record for each beneficiary and obtain the associated COBA ID(s) [NOTE: There may be multiple COBA IDs associated with each beneficiary.];
- Refer to the COIF associated with each COBA ID **NOTE:** The CWF shall pull the COBA ID from the BOI auxiliary record to obtain the COBA trading partner's name and claims selection criteria;
- Apply the COBA trading partner's selection criteria; and
- Transmit a BOI reply trailer to the Medicare contractor only if the claim is to be sent, via 837 COB flat file or NCPDP file, to the COBC to be crossed over.

B. BOI Reply Trailer and Claim-based Reply Trailer Processes

1. BOI Reply Trailer Process

For eligibility file-based crossover, Medicare contractors shall send processed claims information to the COBC for crossover to a COBA trading partner in response to the receipt of a CWF BOI reply trailer (29). Medicare contractors will only receive a BOI reply trailer (29) under the consolidated crossover process for claims that CWF has selected for crossover after reading each COBA trading partner's claims selection criteria as reported on the weekly COIF submission.

When a BOI reply trailer (29) is received, the COBA assigned ID will identify the type of crossover (see the Data Elements Required for the BOI Aux File Record Table in Chapter 27, §24). Although each COBA ID will consist of a five-digit prefix that will be all zeroes, Medicare contractors are only responsible for picking up the last five digits within these ranges, which will be right justified in the COBA number field. In addition to the trading partner's COBA ID, the BOI reply trailer shall also include the COBA trading partner name (s), an "A" crossover indicator that specifies that the claim has been selected to be crossed over, and a one-digit indicator ["Y"=Yes; "N"=No] that specifies whether the COBA trading partner's name should be printed on the beneficiary MSN. As discussed above, effective with the October 2004 systems release, CWF shall also include a 1-digit Test/Production Indicator on the BOI reply trailer (29) that is returned to the Medicare contractor.

Larger-Scale Implementation of the COBA Process

Medicare contractors should note that the larger-scale COBA process, where additional trading partners are first identified as testing participants with the COBC and then are moved to crossover production with the COBC following the successful completion of testing, may be activated at any time during the COBA smaller-scale parallel production period. Activation of the larger-scale COBA process will most likely not occur before the early months of calendar year 2005.

MSN Crossover Messages

Effective with the October 2004 systems release, the Medicare contractor will begin to receive BOI reply trailers (29) that contain an MSN indicator “Y” (Print trading partner name on MSN) or “N” (Do not print trading partner name on MSN).

Also, effective with the October 2004 systems release, when a Medicare contractor receives a BOI reply trailer (29) that contains a Test/Production Indicator of “T,” it shall ignore the MSN indicator 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 TPAs.

When a COBA trading partner is in full production (Test/Production Indicator=P), the Medicare contractor shall read the MSN indicator returned on the BOI reply trailer (29). If the Medicare contractor receives an MSN indicator “N,” it shall print its generic crossover message(s) on the MSN rather than including the trading partner’s name. Examples of existing generic MSN messages include the following:

(For all COBA ID ranges other than Medigap)

MSN #35.1 - “This information is being sent to private insurer(s). Send any questions regarding your benefits to them.”

(For the Medigap COBA ID range)

MSN#35.2- “We have sent your claim to your Medigap insurer. Send any questions regarding your Medigap benefits to them.”

Beginning with the October 2004 systems release, contractors shall follow these procedures when determining whether to update its claims history to show that a beneficiary’s claim was selected by CWF to be crossed over.

- If the Medicare contractor receives a BOI reply trailer (29) that contains a Test/Production Indicator “T,” it shall not update its claims history to show that a beneficiary’s claim was selected by CWF to be crossed over.
- If the Medicare contractor receives a BOI reply trailer (29) that contains a Test/Production Indicator “P,” it shall update its claims history to show that a beneficiary’s claim was selected by CWF to be crossed over.

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.

Contractors shall **not** update their claims histories to reflect transference of “tagged” claims with COBA ID range 89000 through 89999 to the COBC. Contractors shall, however, accrue for credit (expect payment) on such claims.

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 advices that 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:

- a. 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.]
- b. 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 with January 5, 2009, if CWF returns **only** 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.

CWF Sort Routine for Multiple COBA IDs

Effective with 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 pays after Medicare), CWF shall sort the COBA IDs and trading partner names in the following order on the returned BOI reply trailer (29): 1) Eligibility-based Medigap (30000-54999); 2) Medigap claim-based (55000-59999); 3) Supplemental (00001-29999); 4) Other Insurer (80000-80213); 5) **Other Insurance (80215-88999)**; 6) **TRICARE (60000-69999)**; 7) **CHAMPVA (80124)**; 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 element 24 of the "Data Elements Required for the BOI Aux File Record" Table in chapter 27, §80.14 for more details), CWF shall sort numerically within the same range.

2. Medicare Summary Notice (MSN) and Electronic Remittance Advice (ERA) Crossover Messages During the Parallel Production Period

During the COBA parallel production period, which began July 6, 2004: 1) CWF will only return an "N" MSN indicator on the BOI reply trailer (29), in accordance with information received via the COIF submission; 2) If a "Y" indicator is returned, the Medicare contractor shall ignore it; and 3) the Medicare contractor shall follow its existing procedures for the printing of MSN crossover messages.

During the COBA parallel production period, Medicare contractors shall follow their current procedures for the reporting of crossover claims information in CLP-02 (Claim Status Payment) and in the NM101, NM102, NM103, NM108, and NM109 segments of Loop 2100 of the provider ERA. They shall also continue with their current procedure for inclusion of COB trading partner names on other kinds of provider remittance advices that you have in production.

3. Business Rules for Receipt of a CWF BOI Reply Trailer When Other Indicators of Crossover Are Present

COBA Parallel Production Period

During the COBA parallel production period, which began July 6, 2004, the Medicare contractor shall observe the following business rules when it receives a BOI reply trailer 29 and some other indication of crossover eligibility:

If the Medicare contractor receives a BOI reply trailer 29 with COBA IDs that fall in the ranges of 00001-89999, it shall continue to cross over claims a) per its existing TPAs and b) when Medigap or Medicaid information is reported on the claim.

NOTE: The preceding claim-based scenario does not apply to Part A contractors. In addition, the Medicare contractor shall send claims for which it receives BOI reply trailers to the COBC on the 837 v4010A1 flat file or National Council for Prescription Drug Programs (NCPDP) file.

NOTE: The COBA trading partner will only be charged for the claims that the Medicare contractor continues to cross to it during the parallel production period.

During the parallel production period, the Medicare contractor shall not change its current procedures regarding suppression of Medicaid claims when a beneficiary has non-Medigap and/or Medigap insurance. The Medicare contractor's Medicaid suppression logic should remain the same as today with its existing trading partners, even when it receives a BOI reply trailer that includes a Medicaid COBA ID.

Larger-Scale Implementation of the COBA Process

Beginning with the October 2004 release, Medicare contractors shall follow these rules when they receive a BOI reply trailer (29) that contains Test/Production Indicator "T" and there is some other indication of crossover eligibility:

If the Medicare contractor receives a BOI reply trailer (29) with COBA IDs that fall in the ranges of 00001-89999 (See Attachment A, element 24), it shall cross over claims 1) per its existing TPAs or 2) when Medigap or Medicaid information is reported on the claim (if that is how the Part B or DMERC contractor currently crosses over claims to Medicaid).

NOTE: Claim-based crossover scenarios only apply to Part B and DMERC/ DME MAC contractors.

In addition, the contractor shall send claims for which it receives BOI reply trailer to the COBC on the 837 v4010A1 flat file or National Council for Prescription Drug Programs (NCPDP) file.

When a COBA trading partner is in test mode, the contractor shall not change its current procedures regarding suppression of Medicaid claims when a beneficiary has non-Medigap and/or Medigap insurance. The contractor's Medicaid suppression logic should remain the same as with current existing trading partners, even when you receive a BOI reply trailer (29) that includes a Medicaid COBA ID.

Beginning with the October 2004 release, contractors shall follow these rules when they receive a BOI reply trailer (29) that contains Test/Production Indicator "P" and there is some other indication of crossover eligibility:

- a. If the Medicare contractor receives a BOI reply trailer (29) with a COBA ID that falls in the Medigap eligibility-based range (30000-54999), it shall not cross over

claims based on an existing Medigap TPA or when Medigap information is reported on the claim. Instead, the Medicare contractor shall send the claim to the COBC (based on the BOI reply trailer 29) on the 837 v4010A1 flat file or NCPDP file for crossover by the COBC to the COBA trading partner.

NOTE: The assumption is that a beneficiary will have only one true Medigap insurer.

- b. If the Medicare contractor receives a COBA ID via a BOI reply trailer (29) that falls in the Supplemental range (00001-29999) and it has an existing TPA with a supplemental insurer for the beneficiary, it shall transmit the claim to the COBC for crossover to the COBA trading partner and cross the claim to your existing trading partner.
- c. If the Medicare contractor receives a COBA ID via a BOI reply trailer (29) that falls in the Supplemental range (00001-29999), and it also receives Medigap crossover information on the claim, it shall cross the claim to the Medigap insurer identified on the claim and transmit the claim to the COBC for crossover to the COBA trading partner based on the Supplemental COBA ID.
- d. If the Medicare contractor receives a COBA ID via a BOI reply trailer (29) that falls in the Medicaid range (70000-77999), it shall not cross over claims based on an existing Medicaid TPA or when Medicaid information is reported on the claim (if that is how the Part B or DMERC contractor currently crosses over claims to Medicaid). Instead, the Medicare contractor shall send the claim to the COBC (based on the BOI reply trailer 29) on the 837 v4010A1 flat file or NCPDP file for crossover by the COBC to the COBA trading partner.
- e. If the Medicare contractor receives a BOI reply trailer (29) that contains a Medicaid COBA ID (70000-77999) and it has an existing TPA with a supplemental insurer or Medigap insurer, it shall suppress the Medicaid claim from inclusion on the COB 837 flat file or NCPDP file and cross the claim to the supplemental insurer.
- f. If the Medicare contractor receives a BOI reply trailer (29) that contains a Supplemental COBA ID (00001-29999) or a Medigap eligibility-based COBA ID (30000-54999) and it has an existing TPA with Medicaid, it shall suppress its crossover to Medicaid but send the claim to the COBC.

NOTE: For the scenarios above, the trading partner shall be responsible for canceling any existing TPA that it has with the Medicare contractor once it has signed a COBA with the Coordination of Benefits Contractor (COBC).

Contractor Actions Relating to the Transition from HIPAA 837 4010-A1 to 5010 and NCPDP 5.1 batch standard 1.1 to NCPDP D.O

1. CWF COIF and BOI Reply Trailer (29) Processes

Effective January 5, 2009, the COBC will, at CMS's direction, create a new 1-byte "5010 Test/Production Indicator" and a new 1-byte "NCPDP D.0 Test/Production Indicator" on the COBA Insurance File [COIF] (valid values= "N"—not applicable or not ready as yet; "T"—test; "P"—production). In addition, the CWF maintainer shall add a new "5010 Test/Production Indicator" and an "NCPDP D.0 Test/Production Indicator" to the BOI reply trailer (29) format. (See Pub.100-04 chapter 27, §80.17 for additional details regarding CWF requirements relating to the new crossover claim formats.)

The CWF shall not post crossover disposition indicators in association with claims whose 5010 and NCPDP D.0 indicators are "N" or "T." (See Pub.100-04 chapter 27, §80.15 for more details regarding claims crossover disposition indicators.)

2. Contractor Actions Regarding Claim Format to Send to COBC

Prior to the initiation of HIPAA 837 5010 or NCPDP D.0 testing with COB trading partners, if CWF returns to a Medicare contractor a BOI reply trailer (29) that contains an "N" 5010 Test/Production indicator or NCPDP D.0 indicator, the contractor's shared system shall 1) ignore the indicator; and 2) continue to send the existing 837 flat file and NCPDP file formats to the COBC.

NOTE: CMS will issue a future instruction that addresses contractor and contractor shared system requirements for receipt of "T" or "P" 5010 and NCPDP D.0 indicators.

C. Transmission of the COB Flat File or NCPDP File to the COBC

Regardless of whether a COBA trading partner is in test mode (Test/Production Indicator returned via the BOI reply trailer 29=T) or production mode (Test/Production Indicator returned via the BOI reply trailer 29=P), Medicare contractors shall transmit all non-NCPDP claims received with a COBA ID via a BOI reply trailer to the COBC in an 837 v.4010A1 flat file, as described in Transmittal AB-03-060. In a separate transmission, DMERCs shall send the claims received in the NCPDP file format to the COBC. Medicare contractors shall enter the 5-digit COBA ID picked up from the BOI reply trailer (29) in the 1000B loop of the NM1 segment in the NM109 field. In a situation where multiple COBA IDs are received for a claim, Medicare contractors shall send a separate 837 or NCPDP transaction to the COBC for each COBA ID. Medicare contractors shall perform the transmission at the end of their regular batch cycle, when claims come off the payment floor, to ensure crossover claims are not processed by the COBA trading partner prior to Medicare's final payment. Transmission should occur via Network Data Mover (NDM) over AGNS (AT&T Global Network Services).

Effective with October 4, 2005, when contractor systems transfer processed claims to the COBC as part of the COBA process, they shall include an additional 1-digit alpha character ("T"—test or "P"—production) as part of the BHT03 identifier (Beginning of the Hierarchical Transaction Reference Identification) that is included within the 837 flat file or NCPDP submissions. The contractor shared systems shall determine that a COBA trading partner is in test or production

mode by referring to the BOI reply trailer (29) originally received from CWF for the processed claim. (See §70.6.1 of this chapter for further details about the BHT03 identifier.)

Effective with October 2, 2006, the contractors or their Data Centers shall transmit a combined COBA “test” and “production” 837 flat file and a combined “test” and “production” NCPDP file to the COBC.

NOTE: This requirement changes the direction previously provided in October 2005 through the issuance of Transmittal 586.

Flat File Conventions for Transmission to the COBC

With respect to 837 COB flat file submissions to the COBC, Part B contractors, including MACs, and DME MACs shall observe these process rules:

The following segments shall not be passed to the COBC:

1. ISA (Interchange Control Header Segment);
2. IEA (Interchange Control Trailer Segment);
3. GS (Functional Group Header Segment); and
4. GE (Functional Group Trailer Segment).

The 1000B loop of the NM1 segment denotes the crossover partner. If multiple COBA IDs are received via the BOI reply trailer, the contractor system shall ensure that a separate 837 transaction should be submitted for each COBA ID received. As the crossover partner information will be unknown to the standard systems, the following fields should be formatted as indicated for the NM1 segment:

NM103—Use spaces; and

NM109—Include COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29).

The 2010BA loop denotes the subscriber information. If available, the subscriber name, address, and policy number should be used to complete the NM1, N3, and N4 segments. If unknown, the segments should be formatted as follows, with COBC completing any missing information:

NM1 segment—For NM103, NM104, NM105, and NM107, use spaces;

NM1 segment—For NM109, include HICN;

N3 segment—Use all spaces; and

N4 segment—Use all spaces.

The 2010BB loop denotes the payer name. Per the HIPAA Implementation Guide (IG), this loop should define the secondary payer when sending the claim to the second destination payer. Consequently, given that the payer related to the COBA ID will be unknown by the standard

systems, the NM1, N3, and N4 segments should be formatted as follows, with COBC completing any missing information:

- NM1 segment—For NM103, use spaces;
- NM1 segment—For NM109, include the COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29);
- N3 segment—Use all spaces; and
- N4 segment—Use all spaces.

The 2330B loop denotes other payers for the claim. If multiple COBA IDs are returned via the BOI reply trailer, payer information for the additional COBA IDs will be unknown. As with the 2010BB loop, the NM1 segment should be formatted as follows, with COBC completing any missing information:

- NM103—Use spaces; and
- NM109—Include COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29).

The 2330B loop shall be repeated to allow for the inclusion of the name (NM103) and associated Trading Partner ID (NM109) for each existing trading partner.

The 2320 loop denotes other subscriber information. Within the SBR segment, the SBR03 and SBR04 segments are used to define the group/policy number and insured group name, respectively. If the information is available for these fields, those values should be propagated accordingly for both current trading partners and COBA trading partners. The COBC will inspect these values for COBA related eligibility based claims and overlay as appropriate. Spaces should only be used for COBA-related situations.

- SBR01—Treat as normally do.

With respect to 837 COB flat file submissions to the COBC, Part A contractors shall observe these process rules:

- As the ISA, IEA, and GS segments are included in the “100” record with other required segments, the “100” record must be passed to the COBC. However, as the values for these segments will be recalculated, spaces may be placed in all of the fields related to the ISA, IEA, and GS segments.

The 1000B loop of the NM1 segment denotes the crossover trading partner. If multiple COBA IDs are received via the BOI reply trailer, the contractor system shall ensure that a separate 837 transaction should be submitted for each COBA ID received. As the crossover trading partner information will be unknown to the standard systems, the following fields should be formatted as follows for the NM1 segment on the “100” record:

- NM103—Use spaces; and
- NM109—Include COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29).

The 2010BA loop denotes the subscriber information. If available, the subscriber name, address, and policy number should be used to complete the NM1, N3, and N4 segments. If unknown, the segments should be formatted as follows for the “300” record, with COBC completing any missing information:

NM1 segment – For NM103, NM104, NM105, and NM107, use spaces;
NM1 segment—For NM109, include HICN;
N3 segment—Use all spaces; and
N4 segment—Use all spaces.

The 2010BC loop denotes the payer name. Per the HIPAA IG, this loop should define the secondary payer when sending the claim to the second destination payer. Consequently, since the payer related to the COBA ID will be unknown to the standard systems, the NM1, N3, and N4 segments should be formatted as follows for the “300” record, with COBC completing any missing information:

M1 segment—For NM103, use spaces;
NM1 segment—For NM109, include COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29);
N3 segment—Use all spaces; and
N4 segment—Use all spaces.

The 2330B loop of the “575” record denotes other payers for the claim. If multiple COBA IDs are returned via the BOI reply trailer, payer information for the additional COBA IDs will be unknown. As with the 2010BC loop, the NM1 segment should be formatted as follows, with COBC completing any missing information:

NM103—Use spaces; and
NM109—Include COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29).

The 2330B loop shall be repeated to allow for the inclusion of the name (NM103) and associated Trading Partner ID (NM109) for each existing trading partner.

The 2320 loop denotes other subscriber information. Within the SBR segment, the SBR03 and SBR04 segments are used to define the group/policy number and insured group name, respectively. If the information is available for these fields, those values should be propagated accordingly for both current trading partners and COBA trading partners. The COBC will inspect these values for COBA related eligibility based claims and overlay as appropriate. Spaces should only be used for COBA-related situations.

SBR01—Treat as normally do.

D. COBC Processing of COB Flat Files or NCPDP Files

When a Medicare contractor receives the reject indicator “R” via the Claims Response File, it is to retransmit the entire file to the COBC. If the Medicare contractor receives an acceptance

indicator “A,” this confirms that its entire COB flat file or NCPDP file transmission was accepted. Once COB flat files or NCPDP files are accepted and translated into the appropriate outbound format(s), COBC will cross the claims to the COBA trading partner. The format of the Claims Response File that will be returned to each Medicare contractor by the COBC, following its COB 837 flat file or NCPDP file transmission, appears in the table below. (See §70.6.1 for specifications regarding the receipt and processing of the COBC Detailed Error Reports.)

Claims Response File Layout (80 bytes)				
Field	Name	Size	Displacement	Description
1.	Contractor Number	5	1-5	Contractor Identification Number
2.	Transaction Set Control Number/Batch Number	9	6-14	Found within the ST02 data element from the ST segment of the X12N 837 flat file or in field 806-5C from the batch header of the NCPDP file.
3.	Number of claims	9	15-23	Number of Claims contained in the X12N 837 flat file or NCPDP file. This is a numeric field that will be right justified and zero-filled.
4.	Receipt Date	8	24-31	Receipt Date of X12N 837 flat file or NCPDP file in CCYYMMDD format
5.	Accept/Reject indicator	1	32	Indicator of either the acceptance or rejection of the X12N 837 flat file or NCPDP file. Values will either be an “A” for accepted or “R” for rejected.
6.	Filler	48	33-80	Spaces

Claims response files will be returned to contractors after receipt and initial processing of a claim file. Thus, for example, if a Medicare contractor sends a COB flat file daily, the COBC will return a claim response file to that contractor on a daily basis.

COB 837 flat files and NCPDP files that will be transmitted by the Medicare contractor to the COBC will be assigned the following file names, regardless of whether a COBA trading partner is in test or production mode:

PCOB.BA.NDM.COBA.Cxxxxx.PARTA(+1) [Used for Institutional Claims]
 PCOB.BA.NDM.COBA.Cxxxxx.PARTB(+1) [Used for Professional Claims]
 PCOB.BA.NDM.COBA.Cxxxxx.NCPDP(+1). [Used for Drug Claims]

Note that “xxxxx” denotes the Medicare contractor number.

Medicare contractors shall perform the 837 flat file and NCPDP file transmission at the end of the regular batch cycle, when claims come off the payment floor, to ensure crossover claims are not processed by the COBA trading partner prior to Medicare's final payment.

Files transmitted by the Medicare contractor to the COBC shall be stored for 51 business days from the date of transmission.

The file names for the Claims Response File returned to the Medicare contractor will be created as part of the NDM set-up process.

Outbound COB files transmitted by COBC to the COBA trading partners will be maintained for 50 business days following the date of transmission.

E. The COBA Medigap Claim-Based Process Involving CWF

Refer to §70.6.4 of this chapter for more information regarding this process.

F. COBA Customer Service Issues

1. Customer Service

- a. Medicare Contractors shall use the COBC and CMS COBA Problem Inquiry Request Form to identify and send COBA related problems and issues to the COB contractor for research.

In order to track trading partner requests for research of 837 X12 issues, CMS requires contractors to submit a COBA Problem Inquiry Request Form to the COBC or CMS. This process is being implemented to reduce the number of duplicate issues being researched and to ensure your requests are processed timely. The standard form enables CMS and COBC to track issues through completion and manage the process of addressing post-COBA production issues. Upon receipt the submitter shall receive a response from the COBC with the assigned contact information.

CMS is also requiring Medicare contractors to use the COBA Problem Inquiry Request Form when requesting a COBC representative to research a COBA issue. The combined COBC-CMS COBA Problem Inquiry Request Form appears below.

MEDICARE CONTRACTOR: COBA PROBLEM INQUIRY REQUEST FORM

(Completed by Submitter – control number if applicable Write in this column only

Contractor ID# (Enter the Contractor ID # assigned by CMS)		
Contractor Reference ID (If applicable - BHT03)		
Reported By (Enter submitter's last name, first name)		
Date Submitted (Enter current date – MM/DD/YR)		
Contact # (Enter submitter's phone #)		
E-mail Address (Enter submitter's e-mail address)		
COBA ID #		
Description of Problem (Check applicable category)		
<input type="checkbox"/>	HIPAA Error Code	
	ICN Date (Date file was transmitted to the COBC)	
	HIPAA Error Code(s)	
	Part A/Part B/NCPDP Claim	
<input type="checkbox"/>	Technical Issue (Claims file transmission failures)	
	File Name	
	Transmission Date	
<p>Summary of Issue- Provide detail of problem and note if back-up information will be faxed, e.g., Sample Claims to be Faxed on MM/DD/YR. Indicate whether you would like your issue on the next HIPAA issues log – do not include any PHI information on this form if sent via email. All PHI information must be submitted via fax to the COBC contractor to the attention of your COBC representative at 646-458-6761. Do not include PHI information on the fax cover sheet. Claim examples of issues to be addressed must include the beneficiary HICN and the claim ICN/DCN.</p>		
COBC USE ONLY. Date:		Ticket #:

IV. Identification of Mass Adjustments for COBA Crossover Purposes

All contractors and their systems shall develop a method for differentiating “mass adjustments tied to the Medicare Physician Fee Schedule (MPFS) updates” and “all other mass adjustments” from all other kinds of adjustments and non-adjustment claims.

NOTE: For appropriate classification, all adjustments that do not represent “mass adjustments-MPFS” or “mass adjustments-other” shall be regarded as “other adjustments.”) DMERCs/DME MACs and their shared system shall only be required to identify mass adjustments-other, which represents a current functionality available within VMS. This is because DMERCs/DME MACs do not use pricing from the MPFS when processing their claims.

Working Definition of “Mass Adjustment”

For COBA crossover purposes, a “mass adjustment” refers to an action that a contractor undertakes using special software (e.g., Super-Op Events or Express Adjustments) to pull claims with the anticipated purpose of making monetary changes to a high number of those claims. If, however, contractors do not have special software to perform high volume adjustments (i.e., typically adjustments to 100 or more claims), but instead must perform their high volume adjustments manually, this action also fulfills the definition of a “mass adjustment.”

Inputting a One-Byte Header Value on Claim Transactions to Designate Mass Adjustment and Associated Processes

Before contractors cable their claims to CWF for verification and validation, they shall populate a 1-byte “mass adjustment” indicator in the header of their HUBC, HUDC, HUIP, HUOP, HUHH, or HUHC entry code “5” or action code “3” claim transactions. The CWF maintainer shall create a new 1-byte field within the header of its HUBC, HUDC, HUIP, HUOP, HUHH, or HUHC claims transactions for this purpose.

Contractors shall determine whether the “M” or “O” indicator applies in relation to a given claim at the point that they initiate a mass adjustment action on that claim using a manual process or an automated adjustment process; e.g., Super Op Events or Express Adjustments. Upon making this determination, the contractors and their shared systems shall populate one (1) of the following mass adjustment claim indicators, specific to the particular claim situation, within the header of the contractors’ processed claims that they will cable to CWF for verification and validation:

“M”—if mass adjustment claim tied to an MPFS update; **or**

“O”—if mass adjustment claim-other.

If contractors send values other than “M” or “O” within the newly designated field within the header of their HUBC, HUDC, HUIP, HUOP, HUHH, or HUHC entry code “5” or action code “3” claims, CWF shall apply an edit to reject the claims back to the contractor. Upon receipt of

the CWF rejection edit, the contractors' systems shall correct the invalid value and retransmit the claims to CWF for verification and validation.

V. Special 835 ERA and MSN 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.

Upon receipt of a BOI reply trailer (29) that contains **only** a COBA ID in the range 89000 through 89999, the contractor's shared system shall suppress **all** crossover information (including name of the insurer; generic message; and specific code (for 835 ERA, code MA-18; for MSN, code 35.1) indicating that the claim will be crossed over) from the associated 835 ERA and beneficiary MSN. (See §70.6.1 of this chapter for contractor requirements relating to the COBC Detailed Error Report processes and receipt of claims that contain COBA ID range 89000 through 89999.)

VI. Special Suppression Requirements for Part A Credit Claim Portion of Debit-Credit Claim Pairing

Effective with the April 2009 release, the Part A shared system shall suppress sending the credit claim portion of the debit-credit pairing (that transaction which cancels the original claim) associated with each affiliated contractor's adjustment claims to the COBC. Upon suppressing the credit claim, the Part A contractor system shall mark the claims history of its affiliate contractor to reflect this action.