CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 4454	**Date: November 8, 2019**
	Change Request 11380

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

I. SUMMARY OF CHANGES: Through this instruction, the Centers for Medicare & Medicaid Services (CMS) is creating a new Part B psychotherapy claims inclusion option. The new option will permit carve-out managed care organizations (MCOs) that are under contract with State Medicaid Agencies to provide Title XIX Medicaid coverage for services to uniquely receive Part B psychotherapy claims only via the Coordination of Benefits Agreement (COBA) crossover process. The possibility of allowing base COBA trading partners to exclude Part B psychotherapy claims is also introduced through this instruction.

EFFECTIVE DATE: April 1, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 6, 2020

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	Table of Contents
R	27/80.5/ Claims Crossover Disposition and Coordination of Benefits Agreement Bypass Indicators
N	27/80.10/ Inclusion and Exclusion of Specified Part B Claims for Coordination of Benefits Agreement (COBA) Crossover Purposes

III. FUNDING:
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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 4454	Date: November 8, 2019	Change Request: 11380

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

EFFECTIVE DATE: April 1, 2020
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I. GENERAL INFORMATION

A. Background: For the national Coordination of Benefits Agreement (COBA) crossover process to work effectively, the Benefits Coordination & Recovery Center (BCRC) must send the Common Working File (CWF) system two files: the Health Utilization Other Beneficiary Insurance (HUBO) maintenance transaction and the Coordination of Benefits Agreement Insurance File (COIF). The BCRC transmits the COIF to CWF weekly as a full-file replacement file. CWF uses the information from the COIF in deciding whether to select or exclude a particular Medicare Fee-For-Service (FFS) claim for COBA crossover purposes.

Effective January 5, 2009, CMS introduced the possibility for COBA trading partners to "include" only Medicare Part A and B adjustment claims via the COBA crossover process. Under this logic, if CWF receives claims that are not denoted as "adjustments," CWF excludes the claims from crossing over and marks the claim with crossover disposition indicator "AD"--defined as "Adjustment inclusion criteria not met."

Recently, CMS has identified an operational need among State Medicaid Agency carve-out managed care organizations (MCOs) to receive only Part B psychotherapy claims via the COBA crossover process. CMS has determined it would not be viable for CWF to attempt to read a comprehensive listing of all potential Common Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes for purposes of selecting only Part B psychotherapy claims to be crossed over. An easier approach would be to have CWF read the 2-byte Medicare provider specialty code that is included in the Health Utilization Part B Claim (HUBC) transaction and compare that specialty code with information included on the COIF. As part of this solution, when a base COBA trading partner contractually carves out the processing and payment of mental health services to another organization, CMS needs to ensure that is does not send Part B psychotherapy claims to the base COBA trading partner.

B. Policy: Through this instruction, the CWF maintainer shall revise the COIF to support the new Part B psychotherapy claims inclusion option in accordance with the business requirements below. When CWF determines through reading the COIF that a COBA trading partner wants to receive Part B psychotherapy claims only, CWF shall select the claim for crossover under the following circumstances:

- The claim's Part B psychotherapy provider specialty code, as received from the HUBC claims transaction, matches the inclusion specifications on the COIF; **and**
- The claim does not otherwise meet other exclusion logic specified on the COIF; **and**
- As applicable, the corresponding original claim was not previously excluded from crossing over. (Note: This relates to the CWF crossover disposition code "R" logic and applies to adjustment claims.)

In determining whether a base COBA trading partner wishes to exclude Part B psychotherapy claims from the COBA process, CWF shall:

- Verify if the claim's Part B psychotherapy provider specialty code matches the COBA trading partner's exclusion criteria per the COIF; and
- Exclude the claim if a match is found.

As part of the COIF changes, CWF shall modify the CWF/Health Insurance Master Record (HIMR) COBA Insurance File Summary (COBS) screen as well as the Heath Utilization COBA Other Insurance (HCOI) transaction.

CWF shall create a new COBA crossover disposition indicator "AG" (defined as "Part B psychotherapy claims inclusion criteria not met") that it will apply when a claim does not meet the provider specialty code inclusion criteria. In addition, CWF shall create a new COBA crossover disposition indicator "AH" (defined as "Part B psychotherapy claims excluded") that it will apply when a claim meets the COBA trading partner's claims exclusion criteria. As applicable, CWF shall display the new AG and AH crossover disposition indicators on page 2 of the PTBH claims detail screen on the Health Insurance Master Record (HIMR). The Next Generation Desktop (NGD) contractor shall modify its application and documentation to capture the new AG and AH crossover disposition indicators, along with their descriptions. Additionally, our Medicare Administrative Contractors (MACs) shall update their documentation regarding the new AG and AH crossover disposition indicators, together with their descriptions, for purposes of addressing provider and supplier inquiries.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11380.1	Through this instruction, the CWF maintainer shall revise the COIF to create 11 bytes that may be used for purposes of including a 1-byte Part B Psychology Therapy Claims Indicator (valid values= "I" (for include), "E" (for exclude), and space) and for specifying up to five (5), 2-byte provider specialty codes (i.e., specialty codes 26, 62, 68, 80, and 89). [See Attachment A for revised COIF changes.]								X	BCRC, MSPSC
11380.1.1	In modifying the COIF, CWF shall ensure that 50 bytes will remain for "Filler" for future use.								X	BCRC, MSPSC
11380.2	When CWF determines through reading the COIF that a COBA trading partner wants to receive Part B psychotherapy claims only, CWF shall select the claim for crossover under the following circumstances: • The claim's Part B psychotherapy provider specialty code matches what the COIF								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	specifies; **and** • The claim does not otherwise meet other exclusion logic specified on the COIF; **and** • As applicable, the corresponding original claim was not previously excluded from crossing over. (Note: This relates to the CWF crossover disposition code "R" logic and applies to adjustment claims.)									
11380.2.1	CWF shall code its logic to allow COBA trading partners to include some or all Part B psychotherapy provider specialty codes.								X	
11380.2.2	The CWF maintainer shall share a copy of the revised COIF with the BCRC prior to beta testing of the requirements in this change request.								X	BCRC, MSPSC
11380.3	In determining whether a base COBA trading partner wishes to exclude Part B psychotherapy claims through the COBA process, CWF shall: • Verify if the claim's Part B psychotherapy provider specialty code matches the COBA trading partner's exclusion criteria per the COIF; and • Exclude the claim if a match is found.								X	
11380.3.1	CWF shall code its logic to allow COBA trading partners to exclude some or all Part B psychotherapy provider specialty codes.								X	
11380.4	The CWF maintainer shall implement the new COIF processing requirements in association with the claim's processing date as opposed to date of service.								X	
11380.5	As part of the COIF changes, CWF shall modify the CWF/HIMR COBS screen as well as the HCOI transaction.								X	
11380.6	CWF shall create a new COBA crossover disposition indicator "AG" (defined as "Part B psychotherapy claims inclusion criteria not met") that it will apply when a claim does not meet the provider specialty code inclusion criteria.								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11380.6.1	CWF shall create a new COBA crossover disposition indicator "AH" (defined as "Part B psychotherapy claims excluded") that it will apply when a claim meets the COBA trading partner's claims exclusion criteria.								X	
11380.6.2	As applicable, CWF shall display the new "AG" and "AH" crossover disposition indicators on page 2 of the PTBH claims detail screen on the HIMR.								X	
11380.6.3	The NGD contractor shall modify its application and documentation to capture the new "AG" and "AH" crossover disposition indicators, along with their descriptions.									NGD
11380.6.4	Our MACs shall update their documentation to include the new AG and AH crossover disposition indicators, together with their descriptions, for purposes of addressing provider and supplier inquiries.	X	X	X	X					RRB-SMAC

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

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

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: 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.

ATTACHMENTS: 1

Medicare Claims Processing Manual

Chapter 27 - Contractor Instructions for CWF

Table of Contents

(Rev.: 4454, Issued: 11-08-19)

Transmittals for Chapter 27

80.10 - Inclusion and Exclusion of Specified Part B Claims for Coordination of Benefits Agreement (COBA) Crossover Purposes

80.5 - Claims Crossover Disposition and Coordination of Benefits Agreement Bypass Indicators

(Rev. 4454, Issued: 11-08-19, Effective: 04-01-20, Implementation: 04-06-20)

1. Claims Crossover Disposition Indicators

Effective with the October 2004 systems release, when a COBA trading partner is in production mode (Test/Production Indicator sent via the COIF submission=P), CWF shall annotate each processed claim on detailed history in the HIMR with a claims crossover disposition indicator after it has applied the COBA trading partner's claims selection criteria. (See the table below for a listing of the indicators.) In addition, when a COBA trading partner is in production mode, CWF shall annotate each processed claim with a 10-position COBA ID (5-digit COBA ID preceded by 5 zeroes) to identify the entity to which the claim was crossed or not crossed, in accordance with the terms of the COBA.

Effective with October 2006, the CWF maintainer updated its data elements/documentation to capture the revised descriptor for crossover disposition indicators "E," as reflected below. In addition, the CWF maintainer shall update its data elements/documentation to capture the newly added "R," "S," "T," "U," and "V" crossover disposition indicators, as reflected in the Claims Crossover Disposition Indicators table below.

Effective with July 2007, the CWF maintainer updated its data elements/ documentation to capture the newly added "W," "X," and "Y" crossover disposition indicators, as well as all other changes, reflected in the table directly below.

As reflected in the table below, the CWF maintainer created crossover disposition indicators "Z" and "AA" to be effective October 1, 2007. The CWF maintainer created a new "AC" crossover disposition indicator as part of its COBA claims selection processing effective April 1, 2008.

Effective January 5, 2009, the CWF maintainer created crossover disposition indicators "AD" and "AE," as indicated in the table below. The CWF shall utilize the "AD" indicator when an incoming claim does not meet any of the new adjustment, mass adjustment, or recovery audit contractor (RAC)-initiated adjustment inclusion criteria, as specified in §80.8 of this chapter. The CWF shall utilize the "AE" indicator when the COBA trading partner specifies that it wishes to exclude RAC-initiated adjustments and CWF does **not** otherwise exclude the claim for some other reason identified higher within its crossover exclusion logic hierarchy.

Effective with the July 2009 release, the CWF maintainer shall display all auto-exclude/COBA by-pass events, as detailed below, in association with an adjudicated claim within the COBA bypass field on page 3 of the HIMR intermediary claim detail screen and on page 2 of the HIMR Part B and DMEL detail screen.

The CWF shall, in addition, create and display a new "BT" crossover disposition exclusion indicator on pages 2 and 3 of the HIMR claim detail screens, as appropriate, effective with July 2009.

Additionally, the CWF maintainer shall create additional fields within claim page 3 of the HIMR intermediary claim detail screen and page 2 of the Part B and DMEL claim detail screens to allow for the reporting of crossover disposition indicators in association with "test" COBA crossover claims. The CWF maintainer shall 1) create additional fields for displaying "test" crossover disposition indicators within both the eligibility file-based and claim-based crossover portions of the claim detail screens on HIMR; and 2) display the "test" crossover disposition indicators so that they mirror all such indicators used for "production" claims in association with the following four (4) claim versions: 4010A1, 5010, National Council for Prescription Drug Programs (NCPDP)-5.1, and NCPDP-D.0.

IMPORTANT: If the BCRC transmits a COIF that contains a COBA ID within the range 79000 through 79999 (Medicaid quality project), CWF shall post an "MQ" disposition indicator in association with the claim instead of the traditional "A" indicator when it selects the claim for crossover. (**NOTE:** "MQ" shall

designate that Medicare is transferring the claim for Medicaid quality project purposes only.) CWF shall annotate claims whose COBA ID is 79000 through 79999 with "MQ" regardless of the claim version indicator in those instances where it selects the claims for crossover to the BCRC. CWF shall also annotate the claims with MQ if the COBA ID is marked on the COIF as being in test (T) or production (P) mode. If CWF excludes from crossover a claim where the COBA ID equals 79000 through 79999, CWF shall continue to post the crossover disposition indicator that corresponds to the reason for the exclusion on the appropriate HIMR claim detail screen.

Effective January 4, 2010, CWF shall apply the newly developed crossover disposition indicator "AF" (see below) to incoming Part B original and adjustment fully paid claims, without deductible and co-insurance, when those claims contain denied service lines where the beneficiary has no liability.

Effective April 6, 2020, CWF shall apply the newly developed crossover disposition indicator "AG" (see below) to incoming Part B claims that do not meet the Part B psychotherapy claims inclusion criteria. In addition, CWF shall apply the newly developed crossover disposition indicator "AH" (see below) to incoming Part B claims that meet a COBA trading partner's Part B psychotherapy claims exclusion criteria.

Claims Crossover Disposition Indicator	**Definition/Description**
A	This claim was selected to be crossed over.
B	This Type of Bill (TOB) excluded.
C	Non-assigned claim excluded.
D	Original Fully Paid Medicare claims without deductible and co-insurance remaining excluded.
E	Original Medicare claims paid at greater than 100% of the submitted charges without deductible or co-insurance remaining excluded (Part A). **Also covers the exclusion of Original Medicare claims paid at greater than 100% of the submitted charges excluded for Part B ambulatory surgical center (ASC) claims, even if deductible or co-insurance applies.
F	100% denied claims, with no additional beneficiary liability excluded.
G	100% denied claims, with additional beneficiary liability excluded.
H	Adjustment claims, monetary, excluded (not representative of mass adjustments).
I	Adjustment claims, non-monetary/statistical, excluded (not representative of mass adjustments).
J	MSP claims excluded.
K	This claim contains a provider identification number (ID) or provider state that is excluded by the COBA trading partner.
L	Claims from this A/B MAC or DME MAC ID excluded.
M	The beneficiary has other insurance (such as Medigap, supplemental, TRICARE, or other) that pays before Medicaid. Claim excluded by Medicaid.
N	NCPDP claims excluded.
O	All Part A claims excluded.

P	All Part B claims excluded.
Q	All DME MAC claims excluded.
R	Adjustment claim excluded because original claim was not crossed over.
S	Adjustment fully paid claims with no deductible or co-Insurance remaining excluded.
T	Adjustment Claims, 100% Denied, with no additional beneficiary liability excluded.
U	Adjustment Claims, 100% Denied, with additional beneficiary liability excluded.
V	MSP cost-avoided claims excluded.
W	Mass Adjustment Claims—Medicare Physician Fee Schedule (MPFS) excluded.
X	Mass Adjustment Claims—Other excluded.
Y	Archived adjustment claim excluded.
Z	Invalid Claim-based Medigap crossover ID included on the claim.
AA	Beneficiary identified on Medigap insurer eligibility file; duplicate Medigap claim-based crossover voided
AB	**Not Used**; already utilized in another current CWF application or process.
AC	All adjustment claims excluded.
AD	Adjustment inclusion criteria not met.
AE	Recovery audit A/B MAC or DME MAC (RAC)-initiated adjustment excluded.
BT	Individual COBA ID did **not** have a matching COIF.
MQ	Claim transferred for Medicaid quality project purposes only.
AF	Fully reimbursable claim containing denied lines with no beneficiary liability excluded.
AG	*Part B psychotherapy claims inclusion criteria not met.*
AH	*Part B psychotherapy claims excluded.*
AV	Void/cancel claim suppressed because the original claim was excluded

2. COBA Bypass Indicators

Effective with the October 2008 release, the CWF maintainer shall display COBA bypass indicators in association with claims posted on HIMR. These indicators will appear on page 2 of the PTBH and DMEH screens and on page 3 of the INPH, OUTH, HHAH, or HOSH screens. The COBA Bypass Indicators appear in the table directly below.

Effective with the July 2009 release, the CWF maintainer shall additionally display bypass indicators BA, BB, BC, BD, BE, BF, BP, and BR on the appropriate detailed screens (PTBH or DMEH; INPH, OUTH, HHAH, or HOSH) on HIMR.

Effective with the October 2010 release, the CWF maintainer shall display the new “BG” COBA bypass indicator on the appropriate claim detail screens (PTBH, DMEH, INPH, OUTH, HHAH, or HOSH) on HIMR.

Effective April 1, 2013, the CWF maintainer shall display the new “BX” COBA bypass indicator on the appropriate claim detail screens (PTBH, DMEH, INPH, OUTH, HHAH, or HOSH) on HIMR.

Effective July 1, 2019, the CWF maintainer shall display the new "BY" COBA bypass indicator on the appropriate claim detail screens (PTBH, DMEH, INPH, OUTH, HHAH, or HOSH) on HIMR.

Claims Crossover Bypass Indicator	**Definition/Description**
BA	Claim represents an "Add History" only (action code 7 on HUOP claims; entry code 9 on HUBC and HUDC claims). Therefore, the claim is bypassed and not crossed over.
BB	Claim falls into one of two situations: 1) there is no eligibility record (exception: if HUBC or HUDC claim has a Medigap claim-based COBA ID); **or** 2) the only available eligibility record contains a "Y" delete indicator. Therefore, the claim is bypassed and not crossed over.
BC	Claim represents an abbreviated encounter record (TOB=11z; condition code=04 or 69); therefore, the claim is bypassed and not crossed over.
BD	Claim contains a Part B/DME MAC CWF claim disposition code other than 01, 03, or 05; therefore, the claim is bypassed and not crossed over.
BE	Submission of Notice of Elections [NOEs] (Hospice—TOB= 8xA through 8xE on HUHC; CEPP—TOB=11A through 11D on HUIP; Religious Non-Medical Care—TOB=41A, 41B, and 41D on HUIP; Medicare Coordinated Care – TOB=89A and 89B on HUOP). Therefore, the submission is bypassed and not crossed over.
BF	Claim represents an excluded demonstration (DEMO) project; therefore, the claim is bypassed and not crossed over.
BG	CWF auto-excluded the claim because it was adjudicated with an "OA" Claim Adjustment Segment (CAS) Group code for **all** denied lines or services.
BN	CWF auto-excluded the claim because it contained a placeholder provider value.
BP	Sanctioned provider claim during service dates indicated; therefore, the claim is bypassed and not crossed over.
BQ	CWF auto-excluded the claim because it contained only PQRS codes.
BR	Submission for Request for Anticipated Payment [RAP] claims (TOB=322 and 332); therefore, the submission is bypassed and not crossed over.
BX	Non-compliant ICD DX code on claim; therefore, the claim is by-passed and not crossed over.
BY	A BOI record exists, but there are no active BOI

Claims Crossover Bypass Indicator	Definition/Description
	entries that correspond to the claim's service dates. Therefore, the claim is bypassed and not crossed over.

80.10 - Inclusion and Exclusion of Specified Part B Claims for Coordination of Benefits Agreement (COBA) Crossover Purposes

(Rev. 4454, Issued: 11-08-19, Effective: 04-01-20, Implementation: 04-06-20)

*Effective April 6, 2020, CWF shall begin to support the **inclusion** and **exclusion** of Part B psychotherapy claims via the COBA crossover process.*

Inclusion of Part B Psychotherapy Claims

When CWF determines through reading the modified COBA Insurance File (COIF) that a COBA trading partner wants to receive Part B psychotherapy claims only, it shall select the claim for crossover purposes under the following circumstances:

- *The claim's Part B psychotherapy provider specialty code (i.e., code 26, 62, 68, 80, or 89), as received via the Health Utilization Part B claim (HUBC) transaction, matches the COIF specifications for inclusion of Part B psychotherapy claims; **and***
- *The claim does not otherwise meet other exclusion logic specified on the COIF; **and***
- *As applicable, the corresponding original claim was not previously excluded from crossing over. (**Note:** This relates to the CWF crossover disposition code "R" logic and applies to adjustment claims. See Section 80.5 for more information regarding crossover disposition code R.)*

Exclusion of Part B Psychotherapy Claims

In determining whether a base COBA trading partner (i.e., an insurer or other health benefit organization that carves out the processing and payment of mental health claims to another organization) wishes to exclude Part B psychotherapy claims through the COBA process, CWF shall:

- *Verify if the claim's Part B psychotherapy provider specialty code matches the COBA trading partner's exclusion criteria per the COIF; and*
- *Exclude the claim if a match is found.*

***Important:** The CWF maintainer shall permit the inclusion or exclusion of some or all Part B psychotherapy provider specialty codes in accordance with the information specified on the COIF.*

Crossover Disposition Indicators

CWF shall create a new COBA crossover disposition indicator "AG" (see Section 80.5 for further details regarding this crossover disposition indicator) that it will apply when the HUBC claim does not meet the provider specialty code inclusion criteria.

In addition, CWF shall create a new COBA crossover disposition indicator "AH" (see Section 80.5) that it will apply when the base COBA trading partner specifies it wishes to exclude Part B psychotherapy claims from crossing over.

As applicable, CWF shall display the new "AG" and "AH" crossover disposition indicators on page 2 of the PTBL claims detail screen on HIMR.