CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3115	**Date: November 6, 2014**
	Change Request 8878

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

I. SUMMARY OF CHANGES: Through this change request, the Centers for Medicare & Medicaid Services (CMS) ensures that the Part A shared system will no longer send a particular Internal Payer Only code on the 837 institutional coordination of benefits flat file. Additionally, CMS modifies the Common Working File (CWF) logic that currently suppresses Part B claims that are voided/cancelled. Also, CMS modifies the CWF logic deployed in selecting void/cancel only Part A and B facility claims under the COBA crossover process.

EFFECTIVE DATE: April 1, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 6, 2015

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	27/80.15/ Claims Crossover Disposition and Coordination of Benefits Agreement By-Pass Indicators

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 obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

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I. GENERAL INFORMATION

A. Background: Under the Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification requirements, all "covered entities" must exchange standard electronic transactions in a compliant manner, as directed by the Technical Report Version 3 (TR-3) Implementation Guide and in accordance with external code-set updates and requirements. The National Uniform Billing Committee (NUBC) has updated its guidance manual to specify that a given Occurrence Span Code is now considered "internal payer use only." This code is not being suppressed from the external 837 COB claims that the Part A shared system creates and transmits to the Benefits Coordination and Recovery Center (BCRC). This instruction corrects this issue.

The Common Working File (CWF) currently applies logic under the COBA crossover process to exclude Part B claims and claims for durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) received with entry code '3' (void/cancel). CWF applies the same logic to these claims as it would to claims that are adjusted for non-monetary or statistical reasons (crossover disposition indicator = I). This current logic is contributing to situations where Medicare is not informing COBA trading partners that Medicare took an action to void/cancel a Part B or DMEPOS claim on which a Part B deductible amount had been applied. This leads to confusion among the COBA trading partner community when Medicare subsequently crosses over other Part B or DMEPOS claims with additional Part B deductible amounts on them. CMS addresses this concern through this instruction.

At present, in most cases, CWF automatically selects all "void/cancel only" Part A and B facility claims (original claims that are typically cancelled due to a billing error and that contain no associated adjustment claim) for inclusion in the COBA crossover process. CMS has determined that a CWF logic change is needed to ensure that CWF no longer automatically selects a "void/cancel only" claims for cross over when COBA trading partners did not receive the associated original claim.

B. Policy: The NUBC Manual defines Occurrence Span Code 79 as "for internal payer use only." Therefore, the Part A shared system shall ensure that Occurrence Span Code 79 is no longer included in the outbound 837 institutional COB claims that it creates and transmits to the BCRC daily. (**NOTE:** CMS has addressed suppression of other "internal payer only" codes (e.g., Value and Condition Codes) through earlier instructions.)

CWF shall modify the current exclusion logic that it applies to incoming void/cancel (entry code '3') HUBC [Part B] and HUDC [DMEPOS] claims as follows:

- Cross the claim over if the claim that is to be voided or cancelled previously had a Part B cash deductible amount taken that is greater than zero; and

- The COBA trading partner has not otherwise excluded receipt of the claim on which a void/cancel action is taken (i.e., MSP claim excluded per COBA trading partner claims selection profile).

NOTE: CWF shall keep its logic for void/cancel claims and adjustment and mass adjustment claims separate. Thus, if a COBA trading partner wishes to exclude adjustment claims/monetary, that exclusion shall not prevent CWF from sending that entity a Part B void/cancel claim. **IMPORTANT:** CWF shall continue to post crossover disposition indicators R (Adjustment claim excluded because original claim was not crossed over) and AC (All adjustment claims excluded) on pages 3 and 4 of the Health Insurance Master Record (HIMR) claims detail screens for adjustment claims when the corresponding original claims did not cross over.

CWF shall suppress all HUIP, HUOP, HUHH, HUHC, HUBC, or HUDC void/cancel claims from crossing over if it had previously excluded the associated original claims from crossing over. (For example, if CWF determines the original claim was fully paid and was excluded with crossover disposition code D, it shall also exclude an associated void/cancel only claim from being crossed over.) CWF shall create a new crossover disposition code "AV" (Void/cancel claim suppressed because the original claim was excluded) to cover this situation. In addition, CWF shall post the new "AV" crossover disposition indicator as an override to the previously displayed crossover indicator on pages 3 and 4 of the HIMR claims detail screens.

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	
8878.1	The Part A shared system shall ensure that Occurrence Span Code 79 is no longer included in the outbound 837 institutional COB claims that it creates and transmits to the BCRC daily.					X				
8878.2	CWF shall modify the current exclusion logic that it applies to incoming void/cancel (entry code '3') HUBC and HUDC claims as follows: • Cross the claim over if the claim that is to be voided or cancelled previously had a Part B cash deductible amount taken that is greater than zero; and • The COBA trading partner has not otherwise excluded receipt of the claim on which a void/cancel action is taken (e.g., original MSP claim excluded per COBA trading partner claims selection profile).								X	
8878.2.1	CWF shall keep its logic for void/cancel claims and adjustment and mass adjustment claims separate.								X	
8878.2.1.1	Thus, for example, if COBA trading partner ABC wishes to exclude adjustment claims/monetary from crossing over, CWF shall ignore the COBA Insurance File (COIF) exclusions for adjustment								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	claims/monetary in deciding whether to cross the void/cancel claim over to COBA partner ABC.									
8878.2.2	CWF shall continue to suppress Part B and Durable Medical Equipment Medicare Administrative Contractor (DME MAC) void/cancel claims that are not otherwise addressed in requirement 8878.2 above using its current "I" (non-monetary adjustment) logic.								X	
8878.2.3	CWF shall continue to post crossover disposition indicators R and AC on pages 3 and 4 of the HIMR claims detail screens for adjustment claims when the corresponding original claims did not cross over.								X	
8878.3	CWF shall suppress all void/cancel HUIP, HUOP, HUHH, HUHC, HUBC, and HUDC claims from being crossed if it had previously excluded the associated original claims from being crossed over. (For example, if CWF determines the original claim was fully paid and was excluded with crossover disposition code D, it shall also exclude an associated void/cancel only claim from being crossed over.)								X	
8878.3.1	CWF shall create a new crossover disposition code "AV" (Void/cancel claim suppressed because the original claim was excluded) to cover this situation.								X	
8878.3.2	In addition, CWF shall post the new "AV" crossover disposition indicator as an override to the previously displayed crossover indicator on pages 3 and 4 of the HIMR claims detail screens (PTBL, DMEL, INPL, OUTL, HHAL, HOSL).								X	
8878.3.3	CWF shall modify its copybook and other documentation to include the new "AV" crossover disposition indicator, along with narrative description.								X	
8878.3.4	The Next Generation Desktop (NGD) contractor and A/B MACs (B) shall make changes to accommodate and display the new "AV" crossover disposition indicator.		X							NGD

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: N/A

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: 0

80.15 - Claims Crossover Disposition and Coordination of Benefits Agreement By-Pass Indicators

(Rev.3115. Issued: 11-06-14, Effective: 04-01-15, Implementation: 04-06-15)

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 update*d* 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 update*d* 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 §80.18 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 DME*L* 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 *Benefits Coordination and Recovery Center (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. 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, 2015, CWF shall apply the newly developed crossover disposition indicator "AV" (see below) to HUIP, HUOP, HUHH, HUHC, HUBC, and HUDC claims to which A/B MACs and DME MACs have applied action code 4 or entry code 3 (void/cancel only action) when CWF originally had excluded the claim from being crossed over.

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.
AV	*Void/cancel only claim suppressed because the original claim was not crossed over.*

2. COBA By-Pass 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 by-pass 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 By-pass 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 By-pass indicator on the appropriate claim detail screens (PTBH, DMEH, INPH< OUTH, HHAH, or HOSH) on HIMR.

Claims Crossover By-Pass 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 PQRI 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.