CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1110	**Date: NOVEMBER 9, 2006**
	Change Request 5353

Subject: Excluding Sanctioned Provider Claims from the Coordination of Benefits Agreement (COBA) Crossover Process

I. SUMMARY OF CHANGES: Through this change request, the CMS will ensure that sanctioned provider claims will not be crossed over to COBA trading partners.

New / Revised Material
Effective Date: April 1, 2007
Implementation Date: April 2, 2007

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

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

R/N/D	Chapter / Section / Subsection / Title
R	27/80.14/ Consolidated Claims Crossover Process
R	28/70/ Coordination of Medicare With Medigap and Other Complementary Health Insurance Policies

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1110	Date: November 9, 2006	Change Request: 5353

SUBJECT: Excluding Sanctioned Provider Claims from the Coordination of Benefits Agreement (COBA) Crossover Process

Effective Date: **April 1, 2007**

Implementation Date: April 2, 2007

I. GENERAL INFORMATION

A. Background: Currently, in accordance with existing requirements from the Centers for Medicare & Medicaid Services (CMS), all Medicare contractors, including Program Safeguards Contractors, maintain a listing of those physicians (including practitioners and specialists) and suppliers whose Medicare provider privileges have been suspended, per direction from the Office of the Inspector General (OIG). Such physicians and suppliers are deemed to be "suspended" or "sanctioned" due to their past fraudulent billing practices.

Part A contractors and Durable Medical Equipment Regional Carriers (DMERCs)/ DME Medicare Administrative Contractors (DME MACs) already have shared system edits in place to ensure that claims for suspended or sanctioned providers and suppliers will **not** be selected for crossover. This holds true even if these contractors' shared systems receive a Beneficiary Other Insurance (BOI) reply trailer (29) for a claim that would otherwise be transmitted to the Coordination of Benefits Contractor (COBC) as part of the COBA crossover process. CMS has recently learned that, although Part B contractors had the ability to apply system control facility (SCF) rules to suppress sanctioned physician and supplier claims from being crossed over under their former crossover processes, they have not developed a similar capability with respect to COBA crossover claims.

B. Policy: Effective with this instruction, the Common Working File (CWF) systems maintainer shall create space within its HUBC claim transaction for a newly developed 'S' (sanctioned provider) indicator. Contractors, including Medicare Administrative Contractors (MACs), that process Part B claims from physicians (e.g., practitioners and specialists) and suppliers (e.g., independent laboratories and ambulance companies) whose Medicare billing privileges have been suspended or sanctioned shall set the newly developed 'S' indicator within the header of the fully denied HUBC claim. Before setting the 'S' indicator in the header of a claim, the contractor shall first split the claim if 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 a HUBC claim that contains a 'S' indicator, the CWF shall exclude the claim from the COBA crossover process (not return a BOI reply trailer 29 to the Part B contractor).

Contractors that submit mandatory Medigap ('claim-based') crossovers to Medigap insurers, under the authority of §4081(a)(B) of the Omnibus Budget Reconciliation Act of 1987 [Public Law 100-203] and §1842(h)(3)(B) of the Social Security Act, shall suppress fully denied sanctioned provider claims from their submissions to such entities. (**NOTE:** This requirement should **not** represent a systems change, since fully denied claims, as well as fully paid claims, are to be automatically excluded from the mandatory Medigap crossover process, in accordance with previous CMS guidance.)

II. BUSINESS REQUIREMENTS

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5353.1	The CWF maintainer shall create space within the HUBC claim transaction for a newly developed 'S' indicator, which designates sanctioned provider.										X	
5353.2	Contractors that process Part B claims from physicians (e.g., practitioners and specialists) and suppliers (independent laboratories and ambulance companies) shall set an 'S' indicator within the header of a fully denied claim if the physician or supplier that is billing is suspended/sanctioned.	X			X				X			
5353.2.1	As noted above in the "Background" section, such physicians or suppliers will have been identified by the OIG and will have had their Medicare billing privileges suspended.	X			X				X			
5353.2.2	Before setting the 'S' indicator in the header of a claim, the Part B contractor shall first split the claim if 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.	X			X							
5353.3	Upon receipt of an HUBC claim that contains an 'S' indicator, which designates sanctioned provider claim, the CWF shall exclude the claim from the COBA crossover process.										X	
5353.3.1	The CWF therefore shall **not** return a BOI reply trailer 29 to the										X	

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	multi-carrier system (MCS) Part B contractor for any HUBC claim that contains an 'S' indicator.											
5353.4	The contractor shall suppress fully denied sanctioned provider claims from its mandatory Medigap ('claim-based') crossover process with Medigap insurers.	X	X		X	X						

III. PROVIDER EDUCATION

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5353	None.											

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

B. For all other recommendations and supporting information, use the space below:

V. CONTACTS

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

VI. FUNDING

A. ***For TITLE XVIII Contractors*****, use only one of the following statements:**

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY **2007** operating budgets.

B. ***For Medicare Administrative Contractors (MAC)*****, use only one of the following statements:**

The contractor is hereby advised that this constitutes technical direction as defined in your contract. We do not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified 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.1110, Issued: 11-09-06, Effective: 04-01-07, Implementation: 04-02-07)

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 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.)

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 the April 2007 release, CWF shall also include a 1-digit National Provider Identifier (NPI) waiver indicator on the BOI reply trailer (29) that is returned to the Medicare contractor.

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.)

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

Beginning with the October 2004 release, when contractors receive a BOI reply trailer (29) from CWF that contains a "T" Test/Production Indicator, 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 contractors receive a BOI reply trailer (29) from CWF that contains a "P" Test/Production Indicator, 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.

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, 2) Supplemental, 3) TRICARE, 4) Others, and 5) Eligibility-based Medicaid. 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. Claim-Based Medigap and Medicaid Crossover Processes Involving CWF

As with eligibility file-based crossover, the CWF shall load the initial COIF submission from the COBC as well as all future updates that pertain to claim-based Medigap insurers and State Medicaid Agencies.

For claim-based crossover, the CWF shall only search the Coordination of Benefits Agreement Insurance File (COIF) if the Part B or DMERC contractor has included a claim-based Medigap ID (55000—59999) or claim-based Medicaid ID (78000-79999) in field 36 of the HUBC or HUDC query. If claim-based COBA IDs are entered in field 36 of the HUBC or HUDC query, CWF shall:

a. Search the COIF to locate the claim-based Medicaid and/or Medigap COBA ID and corresponding COBA Trading Partner Name;

b. Apply the Medigap claim-based trading partner's claims selection criteria;

c. Return a Claim-based reply trailer 37 to the Part B or DMERC contractor that includes values for claim-based COBA ID (sorted by Medigap, then Medicaid), COBA Trading Partner Name, and MSN Indicator when a claim-based COBA ID is found on the COIF and the claim is to be sent to the COBC to be crossed over;

d. Return an alert code 7704 on the "01" response via a Claim-based alert trailer 21 to the Part B or DMERC, as specified in Requirement 23 above, if a claim-based

COBA ID in the Medigap claim-based range (55000-59999) is not located on the COIF; and

e. Do not return a trailer 37 or alert code 7704 via the "01" response to the Part B or DMERC contractor if a Medicaid claim-based COBA ID (78000-79999) is not found on the COIF.

As established above, the CWF will only return a Claim-based reply trailer 37 if: 1) it locates a claim-based COBA ID on the COIF, and 2) the claim is to be sent to the COBC for crossover.

4. 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 or DMERC 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 or DMERC 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 or DMERC 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 or DMERC contractor if the claim is to be sent to the COBC to be crossed over.

5. Additional Information Included on the HUBC and HUDC Queries to CWF

Effective with the January 2005 release, the Part B and DMERC 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 DMERC 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 DMERC 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.

6. 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.

A. 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).

B. Exclusion of 100 percent 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.

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.

C. 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 that meet this criteria) shall remain unchanged.)

D. 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 DMERC claim occurred.

To exclude non-monetary adjustments for Part A, B, and DMERC 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.

E. 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:

1) 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;
2) 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.

F. Excluding Part A, B, and DMERC Contractor Adjustment Claims Paid at 100 Percent

The CWF shall apply logic to exclude Part A and Part B (including DMERC) adjustment claims (identified as action code '3' for Part A claims and entry code '5' for Part B and DMERC claims) when the COIF indicates that a COBA trading partner wishes to exclude adjustment claims that are paid at 100 percent.

The CWF shall develop logic as follows to **exclude** Part A adjustment claims that are paid at 100 percent:

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

The CWF shall bypass the exclusion logic for Part A adjustment claims that are paid at 100 percent when the type of bill equals 329 or 339 (home health bills, final payment).

The CWF shall develop logic as follows to **exclude** Part B or DMERC adjustment claims that are paid at 100 percent:

1) Verify that the claim contains an entry code '5'; and
2) Verify that the allowed amount equals the reimbursement amount.

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.

G. Excluding Part A, B, and DMERC Contractor Adjustment Claims That Are 100 Percent Denied with No Additional Liability

The CWF shall apply logic to exclude Part A 100 percent and Part B (including DMERC) denied adjustment claims that carry no additional beneficiary liability when the COIF indicates that a COBA trading partner wishes to exclude such claims.

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 follows:

1) Verify that the claim was sent as action code '3'; and
2) Check for the presence of an 'R' non-pay code on the fully denied claim.

The CWF shall apply logic to the Part B and DMERC 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.

H. Excluding Part A, B, and DMERC Contractor Adjustment Claims That Are 100 Percent Denied with No Additional Liability

The CWF shall apply logic to exclude Part A and Part B (including DMERC) 100 percent denied adjustment claims that carry additional beneficiary liability when the COIF indicates that a COBA trading partner wishes to exclude such claims.

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 follows:

1) Verify that the claim was sent as action code '3'; and
2) Check for the presence of an 'N' or 'B' non-pay code on the fully denied claim.

The CWF shall apply logic to exclude Part B and DMERC 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.

I. 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:

a) 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 DMERC MSP cost-avoided claims:

a) 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.

J. 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, 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 is 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.*

70 - Coordination of Medicare With Medigap and Other Complementary Health Insurance Policies

(Rev.1110, Issued: 11-09-06, Effective: 04-01-07, Implementation: 04-02-07)

(B1-4607, B3-4701, B3-4706, A1-1601; A3-3768 - 3769

For applicable policy on information sharing, see Pub 100-1, the Medicare General Information, Eligibility and Entitlement Manual, Chapter 6.

For applicable cost sharing policy, see Pub 100-06, the Medicare Financial Management Manual, Chapter 1.

A formal agreement is a prerequisite for the electronic transfer of such data. (See §80.3, "Medigap Electronic Claims Transfer Agreement").

Part B contractors, including Medicare Administrative Contractors, as well as Durable Medical Equipment Regional Carriers (DMERCs) or DME Medicare Administrative Contractors (DME MACs) should determine the frequency at which they routinely transmit notices to all Medigap insurers but must transmit not less often than monthly. (See §70.4)

Data elements and the formats to be used are described on the CMS EDI Web site, at http://www.cms.hhs.gov/providers/edi/hipaadoc.asp under formats/coordination of benefits. As changes are made that site will be updated.

*During fiscal year 2006, t*he CMS consolidate*d* the *eligibility file-based* claims crossover process*, as it relates to Medigap insurers and other commercial payers,* under the Coordination of Benefits Contractor (COBC). Refer to §70.6 *and succeeding sub-sections* for Medicare contractor requirements and responsibilities *relating to the national Coordination of Benefits Agreement (COBA) consolidated crossover process.*

All contractors shall continue to pursue collection of unpaid debts from Medigap insurers and other existing trading partners, even if such entities have been transitioned to the COBA process.

*Effective with April 2, 2007, all Part B contractors, including MACs, and DMERCs/DME MACs shall suppress fully denied provider sanctioned claims for their mandatory Medigap crossover process with Medigap insurers, as authorized by §1842(h)(3)(B) of the Social Security Act and §4081(a)(B) of the Omnibus Budget Reconciliation Act of 1987 [Public Law 100-230]. (**NOTE:** All such contractors shall continue to suppress 100 percent paid and 100 percent denied claims from their mandatory Medigap crossovers, per previous CMS guidance.)*