CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1568	**Date: AUGUST 1, 2008**
	Change Request 6103

Subject: Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X12-N 837 version 5010 Changes Necessary for Coordination of Benefits (COB) and other Coordination of Benefits Agreement (COBA) Process Revisions

I. SUMMARY OF CHANGES: Through this instruction, the Centers for Medicare and Medicaid Services (CMS) outlines preliminary changes necessary within the Medicare shared systems to support HIPAA ANSI X12-N 837 version 5010 COB transactions. The instruction also requires that all shared systems uniquely identify mass adjustment claims for COBA crossover "inclusion" purposes and recovery audit contractor (RAC) adjustment claims for COBA crossover "inclusion" and "exclusion" purposes. In addition, through this instruction, all shared systems shall be required to identify claims uniquely targeted for Health Care Pre-Payment Plans (HCPPs) to ensure that contractors will not issue associated crossover information on Medicare Summary Notices (MSNs) and 835 Electronic Remittance Advices (ERAs) or other remittance advices in production.

New / Revised Material
Effective Date: January 1, 2009
Implementation Date: January 5, 2009

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/TOC
R	27/80.14/Consolidated Claims Crossover Process
R	27/80.15/Claims Crossover Disposition and Coordination of Benefits Agreement By-Pass Indicators
N	27/80.18/Inclusion of Specified Categories of Adjustment Claims for Coordination of Benefits Agreement (COBA) Crossover Purposes
N	27/80.19/Health Insurance Portability and Accountability Act (HIPAA) 5010 and National Council for Prescription Drug Programs (NCPDP) D.0 Crossover Requirements
R	28/70.6/Consolidation of the Claims Crossover Process

R	28/70.6.1/ Coordination of Benefits Contractor (COBC) Detailed Error Report Notification Process

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: 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: 1568	Date: August 1, 2008	Change Request: 6103

SUBJECT: **Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X12-N 837 version 5010 Changes Necessary for Coordination of Benefits (COB) and other Coordination of Benefits Agreement (COBA) Process Revisions**

Effective Date: January 1, 2009

Implementation Date: January 5, 2009

I. GENERAL INFORMATION

A. Background: At present, the Medicare contractor shared systems create and transmit 837 flat files and National Council for Prescription Drug Programs (NCPDP) version 5.1 batch standard 1.1 files containing finalized Medicare claims to the Coordination of Benefits Contractor (COBC) for crossover purposes on a daily basis. All Medicare contractors send combined "test" and "production" 837 and NCPDP flat files to the COBC following their shared systems' receipt of a 1-byte "test/production" indicator from the Common Working File (CWF) via the Beneficiary Other Insurance (BOI) reply trailer (29) during normal verification and validation processing. This instruction addresses some of the preliminary Medicare contractor and shared system coordination of benefits (COB) requirements associated with the future implementation of the new HIPAA 5010 and NCPDP D.0 formats.

Currently, COBA trading partners are unable to **include only** adjustment claims, mass adjustment claims, or recovery audit contractor (RAC)-initiated adjustment claims for COBA crossover purposes. This instruction addresses these issues. Prior to activating these "inclusion" options, the COBC will, at CMS's direction, be setting up COBA identifiers (IDs) for the interested COBA trading partners under which they receive only these types of claims and will be directing these entities to exclude receipt of adjustment claims and mass adjustment claims under their pre-existing COBA IDs. This should ensure that the COBA trading partner would **not** receive the same claim twice but under differing COBA IDs.

Through Transmittal 1189, change request (CR) 5472, CMS instructed all contractors systems to develop a method for identifying mass adjustment claims tied to the Medicare Physician Fee Schedule (MPFS) updates as well as mass adjustment claims—other. In addition to requirements involving **inclusion** of mass adjustment claims for crossover purposes, CMS needs to modify the shared systems to include indicators that will identify these two categories of mass adjustments within the 837 COB flat files. This instruction addresses these business needs.

Medicare currently includes the name of health care pre-payment plans (HCPPs), along with other crossover message information, on the 835 Electronic Remittance Advice (ERA) or other provider remittance advices in production prior to the COBC's transference of claims to such entities via the national COBA process. HCPPs utilize crossover claims data to ensure that they do **not** duplicate payments made under the traditional Medicare fee-for-service program. Therefore, any attempt to reflect that Medicare transferred claims to HCPPs within the context of the Medicare crossover process promotes unnecessary confusion that CMS will alleviate through this instruction.

B. Policy: 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). The CWF maintainer shall 1) create these new fields, along with 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. If the COBC transmits a value other than T, P, or N within the newly designated fields, CWF shall ignore the value. 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 Attachment B). 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.) The CWF shall not post crossover disposition indicators in association with claims whose 5010 and NCPDP D.0 indicators are "N" or "T."

At CMS's direction, the Coordination of Benefits Contractor (COBC) will modify the COIF to allow for the unique **inclusion** of adjustment claims (see Attachment A). The CWF maintainer shall 1) create this new field, along with 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 COIF that features a COBA identification number (ID) with specifications to **include** adjustment claims only, the CWF shall select **only** those claims for COBA crossover that meet the following specifications: 1) The claim's action code=3, entry code=5, or adjustment header indicator= "A"—all of which designate an "adjustment" claim; and 2) the claim meets no other **exclusion** criteria, as specified on the COIF, or does not fall under the national provider identifier (NPI) placeholder value logic, as per change request (CR) 6024. With the implementation of this change, the CWF shall continue to select adjustment claims **only** if it previously selected the "original" claims for crossover (logic for crossover disposition indicator "R"). If the incoming HUIP, HUOP, HUHH, HUHC, HUBC, or HUDC claim contains spaces in the new designated RAC adjustment indicator field, CWF shall select the claim in accordance with the COBA trading partner's claims selection criteria specified on the COIF.

Through CR 5472, CMS directed all Medicare contractors systems to develop a method for uniquely identifying mass adjustment claims—MPFS updates, as well as mass adjustment claims—other for CWF claims exclusion purposes. Through this instruction, the COBC will modify the COIF to allow for the unique **inclusion** of mass adjustment claims—MPFS updates and mass adjustment claims—other (see Attachment A). 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, HUHH, HUHC, HUBC, or HUDC claim transaction, CWF shall take the following actions: 1) Verify that the claim transaction contains an "M" or "O" mass adjustment claim header indicator; 2) verify that the claim's action code=3, or entry code=5, or adjustment header indicator=A; 3) check the COIF to determine if the COBA trading partner wishes to **include** mass adjustment claims—MPFS or mass adjustment claims—other; 4) include the claim for crossover, unless the "original" claim was **not** crossed over (logic for crossover disposition indicator "R") **or** the claim meets any claims

exclusion criteria as specified on the COIF. If the incoming HUIP, HUOP, HUHH, HUHC, HUBC, or HUDC claim contains spaces in the mass adjustment indicator field, CWF shall select the claim per the COBA trading partner's claims selection criteria, as specified on the COIF. In addition, the CWF maintainer shall include the 1-byte RAC adjustment indicator in the header of the claim that is posted to history on HIMR, thereby ensuring that CWF displays the indicator when a user accesses the INPH, OUTH, PTBH, DMEH, and related HIMR screens.

At CMS's direction, the COBC will modify the COIF to allow for the unique **inclusion** and **exclusion** of RAC-initiated adjustment claims (see Attachment A). 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.

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.) The CWF maintainer shall create a 1-byte RAC adjustment field in the header of its HUIP, HUOP, HUHH, HUHC, HUBC, and HUDC claims transactions (valid values= "R" or spaces). 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); **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 (**bill types other than 11X and 12X) to CWF for normal processing, the Part A shared system shall input an "R" indicator in the newly defined header field of the HUOP, HUHH, and HUHC 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.

Upon receipt of a claim that contains an "R" in its header in the newly defined field, CWF shall take the additional following actions: 1) Verify that the claim's action code=3, or entry code=5, or adjustment header indicator=A; 2) check the COIF to determine if the COBA trading partner wishes to **include or exclude** RAC-initiated claims; 3) include the claim for crossover, **unless** the "original" claim was **not** crossed over (logic for crossover disposition indicator "R") **or** the claim meets any claims exclusions specified on the COIF; or 4) exclude the claim if the COIF specifies exclusion of RAC-initiated adjustment claims. In addition, if the incoming HUIP, HUOP, HUHH, HUHC, HUBC, or HUDC claim contains spaces in the newly designated RAC adjustment indicator field, CWF shall select the claim per the COBA trading partner's claims selection criteria, as specified on the COIF.

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 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. The contractors' shared systems shall redefine the "Other" trading partner category as COBA ID range 80000-

87999 and 89000 through 89999 within their COBA financial reports. In addition, the shared systems shall designate a separate range covering 88000 through 88999 as "RAC-initiated adjustments" within their COBA financial reports.

Before Part A and Part B contractors transmit claims that they identify as RAC-initiated adjustments or mass adjustments—MPFS, they shall populate the fields on the 837 COB flat file that correspond to the loop 2300 NTE-01 and NTE-02 segments on the 837 outbound crossover claim file in accordance with the requirements below. Before DMACs transmit claims that they identify as RAC-initiated adjustments or mass adjustments—other, they shall populate the fields on the 837 COB flat file that correspond to the loop 2300 NTE-01 and NTE-02 segments on the 837 outbound crossover claim file as indicated in the requirements below.

With this instruction, the CWF maintainer shall develop a new "AD" crossover disposition indicator that it shall apply to the claim when it does not meet the COBA trading partner's adjustment **inclusion** logic. Examples of situations where CWF shall apply this indicator include, but are not limited to, the following: 1) The COIF specifies inclusion of adjustment claims only, but the claim is an "original"; 2) the incoming claim to CWF contains an "RA" indicator, but it is an original; 3) the incoming claim to CWF contains an indicator that designates "mass adjustment," but it is an original. The CWF shall display the new crossover disposition indicator in association with the claim on the appropriate Health Insurance Master Record (HIMR) detailed claims history screen. In addition, the CWF maintainer shall develop a new "AE" crossover disposition indicator that it shall apply when it excludes RAC-initiated claims from the national COBA crossover process. The CWF shall display the new crossover disposition indicator in association with the claim on the appropriate HIMR detailed claims history screen.

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 both on incoming HUBO transactions and on the COIF. Upon receipt of a BOI reply trailer (29) that contains **only** a COBA ID in the range 89000 through 89999, the contractors' shared systems 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. Contractors shall **not** mark their claims histories to reflect transference of HCPP claims (COBA ID range 89000 through 89999) to the COBC. However, contractors shall set accruals (expect payment) for claims whose COBA IDs fall in the range 89000 through 89999. In addition, when the COBC returns claims on the COBC Detailed Error Report whose COBA ID falls in the range 89000 through 89999, the contractors' systems shall 1) suppress generation of the special provider letters; and 2) **not** update their affiliated contractors' claims histories to indicate that the COBC will not be crossing the affected claims over.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)						
		A/B MA	D ME	F I	C AR	R H H	Shared-System Maintainers	Other

							FISS	MCS	VMS	CWF	
6103.1	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 COIF (valid values= "N"—not applicable or not ready as yet; "T"—test; "P"—production; see Attachment A).										X COBC
6103.1.1	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.									X	
6103.1.2	If the COBC transmits a value other than T, P, or N within the newly designated fields, CWF shall ignore the value. (**NOTE:** The default value for this field should be a "space.")									X	
6103.1.3	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 Attachment B).									X	
6103.1.4	The CWF system shall read the COIF to determine which 5010 and NCPDP D.0 Test/Production indicator (valid values=N, T, and P) to return via the BOI reply trailer (29) in association with a given COBA ID.									X	
6103.1.5	Prior to the initiation of HIPAA 837 5010 or NCPDP D.0 testing, 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 shared system shall 1) ignore the indicator**;** and 2) continue to send the existing 837 flat file claims or, as applicable, NCPDP file formats to the COBC. (**NOTE:** The 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.)						X	X	X		
6103.1.6	The CWF system shall **not** post crossover disposition indicators on the Health Insurance Master Record (HIMR) in association with claims whose 5010 and NCPDP D.0 indicators are "N" or "T."									X	
6103.1.7	The CWF system shall ensure that 1) all pre-									X	

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
	existing by-pass logic shall continue to take precedence over inclusion/exclusion logic; and 2) it continues to generate and post all applicable by-pass indicators within HIMR.										
6103.2	At CMS's direction, COBC will modify the COIF to allow for the unique **inclusion** of adjustment claims (see Attachment A).										X COBC
6103.2.1	The CWF system shall 1) create the newly defined **inclusion** of adjustment claims option, along with 1-byte file displacement, within its version of the COIF; and 2) accept and process this new field when the COBC transmits it as part of its regular COIF updates.									X	
6103.3	Upon receipt of a COIF that features a COBA identification number (ID) with specifications to **include** adjustment claims only, the CWF shall select **only** those claims for COBA crossover that meet the following specifications: 1) The claim's action code=3, or entry code=5, or adjustment header indicator="A"—all of which designate an "adjustment" claim; and 2) The claim meets no other **exclusion** criteria, as specified on the COIF, **or** does **not** fall under the NPI placeholder value logic, as per CR 6024.									X	
6103.3.1	With the implementation of this change, the CWF shall continue to select adjustment claims **only** if it previously selected the "original" claim for crossover (logic for claims crossover disposition indicator "R").									X	
6103.4	At CMS's direction, the COBC will modify the COIF to allow for the unique **inclusion** of "mass adjustment claims—MPFS updates" and "mass adjustment claims—other" (see Attachment A).										X COBC
6103.4.1	The CWF system shall 1) create the newly defined **inclusion** of mass adjustment claims—									X	

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
	MPFS updates and mass adjustment claims—other options, along with accompanying 1-byte file displacement indicators, 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.										
6103.4.2	All Medicare contractor systems 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, HUHH, HUHC, HUBC, and HUDC claim transactions, in accordance with CR 5472.						X	X	X		
6103.4.3	The CWF system shall accept the newly defined mass adjustment fields when specified on the COIF.									X	
6103.4.4	Upon receipt of a HUIP, HUOP, HUHH, HUHC, HUBC, or HUDC claim transaction, CWF shall take the following actions: 1) Verify that the incoming claim to CWF contains an "M" or "O" mass adjustment claim header indicator; 2) Verify that the claim's action code=3, or entry code=5, or claim adjustment header indicator=A; 3) Check the COIF to determine if the COBA trading partner wishes to include mass adjustment claims—MPFS or mass adjustment claims--other; and 4) Include the claim for crossover, unless the "original" claim was **not** crossed over (logic for crossover disposition indicator "R") **or** if the claim meets any other exclusion criteria as specified on the COIF. (**NOTE:** The CWF system shall take the same set of actions whether the COIF									X	

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
	specifies to include mass adjustment claims—MPFS update or to include mass adjustment claims—other or both.)										
6103.4.5	In addition, if the incoming HUIP, HUOP, HUHH, HUHC, HUBC, or HUDC claim's header contains spaces in the mass adjustment indicator field, CWF shall select the claim per the COBA trading partner's claims selection criteria, as specified on the COIF.									X	
6103.4.6	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.						X	X			
6103.4.6.1	The COBC will map the values from the incoming 837 COB flat file to loop 2300 NTE01 and NTE02 of the outbound 837 crossover claim.										X COBC
6103.4.7	Before the contractor 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						X	X	X		

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
	corresponds to NTE01; and 2) Populate "MO," utilizing bytes 01 through 02, in the field that corresponds to NTE02.										
6103.4.7.1	Contractor systems shall **not** modify pre-existing 2300 NTE01 and NTE02 segments to fulfill requirements 6103.4.6 and 6103.4.7.						X	X	X		
6103.4.7.2	The COBC will map the values from the incoming 837 COB flat file to loop 2300 NTE01 and NTE02 of the outbound 837 crossover claim.										X COBC
6103.5	At CMS's direction, COBC will modify the COIF to allow for the unique **inclusion and exclusion** of RAC-initiated adjustment claims (see Attachment A).										X COBC
6103.5.1	The CWF maintainer shall 1) create the newly defined inclusion and exclusion of RAC-initiated adjustment options, along with accompanying 1-byte file displacement, on 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.									X	
6103.5.2	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) Medicare contractors process RAC-initiated adjustments.)						X	X	X		
6103.5.3	The CWF maintainer shall create a 1-byte RAC adjustment field in the header of its HUIP, HUOP, HUHH, HUHC, HUBC, and HUDC claims transactions (valid values= "R" or spaces).									X	
6103.5.3.1	The CWF shall ignore any contractor-reported values other than "R" or spaces when included in the newly defined field.									X	
6103.5.4	Prior to sending its processed 11x and 12x type of bill RAC adjustment transactions to CWF for						X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
	normal verification and validation, the Part A shared system shall input the "R" indicator in the newly defined header field of the HUIP claims 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); **or** 2) The claim resulted in a Medicare adjusted payment that falls below the amount of the inpatient hospital deductible.										
6103.5.4.1	Prior to sending RAC-initiated adjustment claims with **all other type of bill designations** (bill types other than 11X and 12X) to CWF for normal processing, the Part A shared system shall input an "R" indicator in the newly defined header field of the HUOP, HUHH, and HUHC claim.						X				
6103.5.4.2	Prior to sending their processed RAC adjustment transactions to CWF for normal verification and validation, the Part B and DMAC shared systems shall input the "R" indicator in the newly defined header field of the HUBC and HUDC claim transactions.							X	X		
6103.5.5	Upon receipt of a claim that contains an "R" in its header in the newly defined HUIP, HUOP, HUBC, HUDC, HUHH, or HUHC field, CWF shall take the additional following actions: 1) Verify that the claim's action code=3, or entry code=5, or claim adjustment header indicator=A; 2) Check the COIF to determine if the COBA trading partner wishes to include or exclude RAC-initiated claims; 3) Include the claim for crossover, unless the "original" claim was **not** crossed over (logic for crossover disposition indicator									X	

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
	"R"); **or** 4) Exclude the claim if the COIF specifies exclusion of RAC-initiated adjustment claims **or** if the claim meets any other claims exclusion, as per the COIF.										
6103.5.6	In addition, if the incoming HUIP, HUOP, HUHH, HUHC, HUBC, or HUDC claim contains spaces in the new designated RAC adjustment indicator field, CWF shall select the claim in accordance with the COBA trading partner's claims selection criteria specified on the COIF.									X	
6103.5.6.1	The CWF maintainer shall include the 1-byte RAC adjustment indicator in the header of the claim that is posted to history on HIMR, thereby ensuring that CWF displays the indicator when a user accesses the INPH, OUTH, PTBH, DMEH, and related HIMR screens.									X	
6103.5.7	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.						X	X	X		
6103.5.7.1	Contractor systems shall **not** modify pre-existing 2300 NTE01 and NTE02 segments to fulfill requirement 6103.5.7.						X	X	X		
6103.5.7.2	The COBC will map the values from the incoming 837 COB flat file to loop 2300 NTE01 and NTE02 of the outbound 837 crossover claim.										X COBC

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
6103.5.8	The COBC will assign all COBA trading partners that wish to include RAC-initiated adjustment claims a new COBA ID that falls within the range 88000 to 88999 and will not, at CMS's direction, charge the insurer the standard crossover fee for such claims.										X COBC
6103.5.9	If contractors receive a BOI reply trailer (29) on a claim that contains a COBA ID in the range 88000 through 88999 (which identifies RAC-initiated adjustment claims), they shall **not** expect payment or accrue for credit on the claim.	X	X	X	X	X	X	X	X		
6103.5.9.1	The contractors' shared systems shall redefine the "Other" trading partner category as COBA ID range 80000-87999 and 89000 through 89999 within their COBA financial reports.						X	X	X		
6103.5.9.2	In addition to the requirement in 6103.5.9.1, the shared systems shall designate a separate range covering 88000 through 88999 as "RAC-initiated adjustments" within their COBA financial reports.						X	X	X		
6103.6	The CWF maintainer shall develop a new "AD" crossover disposition indicator that it shall apply to the claim when it does not meet the COBA trading partner's adjustment inclusion logic for "adjustment" claim, both categories of mass adjustment claims, and RAC-initiated adjustment claims (see attachment C).									X	
6103.6.1	In addition, the CWF maintainer shall develop a new "AE" crossover disposition indicator that it shall apply when it excludes RAC-initiated claims from the national COBA crossover process (see Attachment C).									X	
6103.6.2	The CWF shall display the new "AD" and "AE" crossover disposition indicator in association with the claim on the appropriate HIMR detailed claims history screen.									X	
6103.6.3	The CWF maintainer shall update its system documentation to include the newly defined "AD" and "AE" crossover disposition									X	

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
	indicators, together with indicators AA, AB, and AC, along with accompanying descriptions.										
6103.6.4	The contractors and system maintainers responsible for the Next Generation Desktop (NGD) and MCSDT applications shall update their screens and documentation to reflect the new "AD" and "AE" crossover disposition indicators, together with accompanying descriptions.							X			X NGD
6103.6.5	Contractors shall ensure that their provider customer service materials are updated to reflect the new "AD" and "AE" crossover disposition indicators, together with accompanying descriptions.	X	X	X	X	X					
6103.7	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.										X COBC
6103.7.1	The CWF system shall accept the reporting of this COBA ID range both on incoming HUBO transactions and on the COIF (see Attachment D, element 24).									X	
6103.7.2	The CWF shall modify its sort for inclusion of COBA IDs returned via the BOI reply trailer (29) as follows: 1) Medigap eligibility file-based (30000-54999); 2) Medigap claim-based (55000-59999); 3) Supplemental (00001-29999); 4) Other Insurer (80000-88999); 5) TRICARE (60000-69999); 6) Medicaid (70000-79999); 7) Other—Health Care Pre-Payment Plan (89000-89999).									X	
6103.7.3	Upon receipt a BOI reply trailer (29) that contains a COBA ID in the range 89000 through 89999, the contractors' shared systems shall suppress <u>all</u> crossover information (including name of the insurer; generic						X	X	X		

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
	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.										
6103.7.3.1	Contractors shall not mark their claims histories to reflect transference of HCPP claims (COBA ID range 89000 through 89999) to the COBC.	X	X	X	X	X	X	X	X		
6103.7.3.2	Contractors shall set accruals (expect payment) for claims whose COBA IDs fall in the range 89000 through 89999.	X	X	X	X	X					
6103.7.4	When the COBC returns claims on the COBC Detailed Error Report whose COBA ID falls in the range 89000 through 89999, the contractors' systems shall take the following actions: 1) Suppress generation of the special provider letters; and 2) Not update their affiliated contractors' claims histories to indicate that the COBC will not be crossing the affected claims over.						X	X	X		

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
	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 (brian.pabst@cms.hhs.gov; 410-786-2487)

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

VI. FUNDING

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

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

Section B: *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.

COBA INSURANCE FILE **ATTACHMENT A**

Field	Start	Length	End	Description
COBA ID	1	10	10	Unique identifier for each COB Agreement
COBA TIN	11	9	19	Tax Identification Number of COBA
COBA Name	20	32	51	Name of COBA Partner (Equivalent to Insurer Name on BOI Auxiliary File)
COBA Address 1	52	40	91	Address 1 of COBA
COBA Address 2	92	40	131	Address 2 of COBA
COBA City	132	25	156	Address city of COBA
COBA State	157	2	158	Postal State Abbreviation of COBA
COBA Zip	159	9	167	Zip plus 4 of COBA
Common Claim Exclusions				**The following fields are 1 byte indicators dictating type of claim exclusions. A value of 'Y' in any of the following fields indicates those types of claims should be excluded.**
Non-assigned	168	1	168	Non-assigned claims
Orig. Claims Paid at 100%	169	1	169	Original claims paid at 100%
Orig. Claims Paid at >100% of the submitted.charges w/out deductible or co-ins.	170	1	170	Original claims paid at greater than 100% of the submitted charges without deductible or coinsurance remaining (**NOTE:** Also covers the exclusion of ambulatory surgical center claims, even if deductible or co-insurance applies.)
100% Denied Claims, No Additional Liability	171	1	171	100% denied claims, with no additional beneficiary liability
100% Denied Claims, Additional Liability	172	1	172	100% denied claims, with additional beneficiary liability
Adjustment Claims, Monetary	173	1	173	Adjustments, monetary claims
Adjustment Claims, Non-Monetary/Statistical	174	1	174	Adjustments, non-monetary/statistical claims
MSP Claims	175	1	175	Medicare Secondary Payer (MSP) claims.
Other Insurance	176	1	176	Claims if other insurance (such as Medigap, supplemental, TRICARE, or other) exists for beneficiary. **Applies to State Medicaid Agencies only.**
NCPDP Claims	177	1	177	National Council Prescription Drug Program Claims
Adjustment Claims Paid at 100%	178	1	178	Adjustment claims paid at 100%.
Adjustment Claims, 100% Denied, No Additional Liability	179	1	179	Adjustment Claims, 100% Denied, with no additional beneficiary liability
Adjustment Claims, 100% Denied, Additional Liability	180	1	180	Adjustment Claims, 100% Denied, with additional beneficiary liability

MSP Cost-Avoided Claims	181	1	181 MSP claims that have been cost-avoided.
Mass Adjustment Claim-MPFS	182	1	182 Mass adjustment claim tied to Medicare Physician Fee Schedule (MPFS) updates.
Mass Adjustment Claim-Other	183	1	183 Mass adjustment claim-all other reasons besides MPFS updates.
All Adjustment Claims	184	1	184 All Adjustment Claims (note: does not include credit only adjustments—"true voids"—for Part A)
Recovery Audit Contractor (RAC) Adjustment Claims (RA)	*185*	*1*	*185 Indicates that COBA trading partner wishes to **exclude** all recovery audit contractor (RAC) adjustment claims (acceptable values="Y" or space)*
Filler	186	2	187 Future
Hospital Inpatient A	188	1	188 TOB 11 - Hospital: Inpatient Part A
Hospital Inpatient B	189	1	189 TOB 12 - Hospital: Inpatient Part B
Hospital Outpatient	190	1	190 TOB 13 - Hospital: Outpatient
Hospital Other B	191	1	191 TOB 14 - Hospital: Other Part B (Non-patient)
Hospital Swing	192	1	192 TOB 18 - Hospital: Swing Bed
SNF Inpatient A	193	1	193 TOB 21 - Skilled Nursing Facility: Inpatient Part A
SNF Inpatient B	194	1	194 TOB 22 - Skilled Nursing Facility: Inpatient Part B
SNF Outpatient	195	1	195 TOB 23 - Skilled Nursing Facility: Outpatient
SNF Other B	196	1	196 TOB 24 - Skilled Nursing Facility: Other Part B (Non-patient)
SNF Swing Bed	197	1	197 TOB 28 - Skilled Nursing Facility: Swing Bed
Home Health B	198	1	198 TOB 32 - Home Health: Part B Trust Fund
Home Health A	199	1	199 TOB 33 - Home Health: Part A Trust Fund
Home Health Outpatient	200	1	200 TOB 34 - Home Health: Outpatient
Religious Non-Med Hospital	201	1	201 TOB 41 - Christian Science/Religious Non-Medical Services (Hospital)
Clinic Rural Health	202	1	202 TOB 71 - Clinic: Rural Health
Clinic Freestanding Dialysis	203	1	203 TOB 72 - Clinic: Freestanding Dialysis
Clinic Fed Health Center	204	1	204 TOB 73 - Clinic: Federally Qualified Health Center
Clinic Outpatient Rehab	205	1	205 TOB 74 - Clinic: Outpatient Rehabilitation Facility
Clinic CORF	206	1	206 TOB 75 - Clinic: Comprehensive Outpatient Rehabilitation Facility (CORF)
Clinic Comp Mental Health	207	1	207 TOB 76 - Clinic: Comprehensive Mental Health Clinic
Clinic Other	208	1	208 TOB 79 - Clinic: Other
SF Hospice Non-Hospital	209	1	209 TOB 81 - Special Facility: Hospice Non-Hospital
SF Hospice Hospital	210	1	210 TOB 82 - Special Facility: Hospice Special Facility: Hospice Hospital
Ambulatory Surgical Center	211	1	211 TOB 83 - Special Facility: Ambulatory Surgical Center
Primary Care Hospital	212	1	212 TOB 85 - Primary Care Hospital

Claim Header Level Exclusions

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

All Part A Claims	213	1	213	Claims identified as Part A in the HUIP, HUOP, HUHH, and HUHC queries to CWF.
All Part B Claims	214	1	214	Claims identified as Part B in the HUBC query to CWF.
All DMERC Claims	215	1	215	Claims identified as DMERC in the HUDC query to CWF.
Filler	216	7	222	Filler
Part A/RHHI Provider Inclusion/Exclusion				**Part A/RHHI claims may be included or excluded by providers by specifying the Inclusion/Exclusion type. Inclusion or exclusion may be limited by either provider ID or provider state.**
Inclusion/Exclusion Type	223	1	223	Indicates whether providers are to be included or excluded (I - Inclusion or E - Exclusion)
Provider Qualifier	224	1	224	Indicates whether providers are identified by state or by provider ID (P - Provider number or S - Provider state)
Provider ID (P)	225	650	874	Specific providers IDs to be included or excluded (occurs 50 times--13-digit alpha/numeric provider number.
Provider State (S)	875	100	974	Specific provider states to be included or excluded (occurs 50 times—2-digit provider state code)
Adjustment Claims, Mass Adjustment Claims, and Recovery Audit Contractor Adjustment (RAC) Claims Inclusion				
Inclusion Indicator (used for trading partners wishing to receive adjustment claims only)	*975*	*1*	*975*	*Indicates that COBA trading partner wishes to **include** adjustment claims **ONLY** (acceptable values="I" or space)*
Mass Adjustment Claims-MPFS Updates	*976*	*1*	*976*	*Indicates that COBA trading partner wishes to **include** all mass adjustment claims tied to Medicare Physician Fee Schedule (MPFS) updates (acceptable values="Y" or space)*
Mass Adjustment Claims—Other	*977*	*1*	*977*	*Indicates that COBA trading partner wishes to **include** all mass adjustment claims—other (acceptable values="Y" or space)*
Recovery Audit Contractor (RAC) Adjustment Claims (RA)	*978*	*1*	*978*	*Indicates that COBA trading partner wishes to **include** all recovery audit contractor (RAC) adjustment claims (acceptable values="Y" or space)*
Filler	*979*	*6*	*984*	Future
Part B Contractor Inclusion/Exclusion				**Specific contractors may be included or excluded on Part B claims by specifying the Inclusion/Exclusion type.**
Inclusion/Exclusion Type	985	1	985	Indicates whether contractors are to be included or excluded (I – Inclusion or E - Exclusion)

Contractor ID	986	100	1085 State-specific Part B contractor claims to be excluded (occurs 50 times. First 2 positions of BSI indicator.)
Filler	1086	160	1245 Future

DMERC Contractor Exclusion **Specific contractors may be excluded on DMERC claims.**

Contractor ID	1246	20	1265 Specific contractors to be excluded on DMERC claims (occurs 4 times).

HIPAA 5010 & NCPDP D.0 Test/Production Indicator

5010 Test/Production Indicator	*1266*	*1*	*1266 COBA trading partner status for acceptance of HIPAA 5010 (acceptable values= **N**--not ready or not applicable; **T**--Test mode; **P**--Production mode)*
NCPDP D.0 Test/Production Indicator	*1267*	*1*	*1267 COBA trading partner status for acceptance of NCPDP D.0 (acceptable values= **N**--not ready or not applicable; **T**--Test mode; **P**--Production mode)*
Filler	*1268*	*8*	1275 Future

Medicare Summary Notice (MSN) Indicator for Trading Partner Name

MSN Indicator for Printing of Trading Partner Name	1276	1	1276 Indicates whether the COBA trading partner wishes its name to appear on the MSN. (Y=Yes N=No)

Test/Production Indicator

Test/Production Indicator	1277	1	1277 One-position indicator that communicates whether a COBA trading partner is in test or full-production mode. (T= Test Mode P=Production Mode)

CWF Beneficiary Other Insurance (BOI)
Reply Trailer Requirements **Attachment B**

CWF shall return a *BOI Reply Trailer 29 to the Medicare contractors that displays the following elements as part of the national Coordination of Benefits Agreement (COBA) eligibility file-based and Medigap claim-based crossover processes:*

```
01  :X:-29-TRAILER.
    05  :X:-29-TRLR-CODE        PIC  X(02).
    05  :X:-29-OCCURRENCES     PIC  9(02).
    05  :X:-29-COBA-CROS-IND    PIC  X(01).
    05  :X:-29-DATA             OCCURS 1 TO 10 TIMES,
                                 DEPENDING ON X:-29-OCCURRENCES
                                INDEXED :X:-29-INDEX.


        10 :X:-29-COBA-NUM      PIC  X(10).
        10 :X:-29-COBA-NAME     PIC  X(32).
        10 :X:-29-COBA-MSN-IND  PIC  X(01).
        10 :X:-29-COBA-EFF-DATE PIC S9(07) COMP-3.
        10 :X:-29-COBA-TRM-DATE PIC S9(07) COMP-3.
        10: X:-29-COBA-TEST-PROD-IND PIC X (01)
        10:X:-29-5010-TEST-PROD-IND PIC X (01)
        10:X:-29-NCPDP D.0-TEST-PROD-IND PIC X (01)
        10:X:-filler PIC X(10)
```

CROSSOVER CLAIM DISPOSITION INDICATORS **ATTACHMENT** C

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 Medicare claims fully paid without deductible or co-insurance remaining excluded.
E	Original Medicare claims paid at greater than 100% of the submitted charges without deductible or co-insurance remaining excluded. **Also covers the exclusion of Original Medicare claims paid at greater than 100% of the submitted charges 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 (represents non-mass adjustment claims)
I	Adjustment claims, non-monetary/statistical, excluded (represents non-mass adjustment claims)
J	MSP claims excluded
K	This Claim contains a provider identification number (ID) or provider state that is excluded by the COBA trading partner.
L	Claims from this Contractor ID excluded
M	The beneficiary has other insurance (such as Medigap, supplemental, TRICARE, or other) that pays before Medicaid. Claim excluded by Medicaid.
N	NCPDP claims excluded.
O	All Part A claims excluded.
P	All Part B claims excluded.
Q	All DMERC claims excluded.
R	Adjustment claim excluded because original claim was not crossed over.
S	Adjustment Claims Fully Paid without deductible and co-insurance remaining excluded.
T	Adjustments 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) update 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
AC	All Adjustment Claims excluded
AD	*Adjustment inclusion criteria not met*
AE	*Recovery audit contractor (RAC)-initiated adjustment excluded.*

Attachment D

Data Elements Required for the BOI Aux File Record

DATA ELEMENT	REMARKS
1. Record Type	CWF BOI other insurer maintenance (**Mandatory)**
2. Health Insurance Claim (HIC) Number	Beneficiary's HIC/Railroad Board number (**Mandatory)**
3. Beneficiary's Surname	Beneficiary's surname (**Mandatory)**
4. Beneficiary's First Initial	Initial of first name of beneficiary (**Mandatory)**
5. Beneficiary's Date of Birth	Beneficiary's date of birth (CCYYDDD)
6. Beneficiary's Sex Code	Beneficiary's sex code 0 = Unknown 1 = Male 2 = Female
7. Contractor Number	Identifies COB contractor applying maintenance
8. Creation Date	Date record created (CCYYDDD)
9. Deletion Date	Date record deleted (CCYYDDD)
10. Document control	Document control number
11. Action Type	Identifies type of maintenance (**Mandatory)** 0 = Add insurance data transaction 1 = Change insurance data transaction 2 = Delete insurance data transaction
12. Update Indicator	Date maintenance applied (CCYYDDD)
13. Insurance Code	Insurance coverage type (**Mandatory)** A = Supplemental B = TRICARE C = Medicaid
14. Insurer's Name	Insurer's name
15. Insurer's Address - 1	Insurer's address line 1
16. Insurer's Address – 2	Insurer's address line 2
17. Insurer's City	Insurer's city
18. Insurer's State	Insurer's State

DATA ELEMENT	REMARKS
19. Insurer's Zip Code	Insurer's zip code
20. Policy Number	Insurer's policy number of insured
21. Insurance Effective Date	Effective date of insurance coverage (CCYYDDD) (One or more occurrences) (**Mandatory)**
22. Insurance Termination Date	Termination date of insurance coverage (CCYYDDD) (One or more occurrences) (**Mandatory, if applicable)**
23. Identifier Number Assigned by Supplemental Insurer	Number assigned to insured by supplemental insurer
24. Coordination of Benefits Agreement (COBA) Number	COBA ID assigned to other insurer by the COB Contractor. Numbers will be right justified and will fall into these ranges based on type of COBA trading partner: Supplemental 00001-29999 Eligibility-based Medigap 30000-54999 Medigap Claim-based 55000-59999 TRICARE 60000-69999 Medicaid 70000-79999 *Other-Insurer 80000-88999* *Other Health Care Pre-Pay-Ment Plans (HCPP) 89000-89999* Unassigned 90000-99999 (**Mandatory)**
25. NPlanID	The CMS national plan identifier assigned to the insurer (**Mandatory when available)**
26. Other Insurer Number	Other number assigned to an insurer by an FI or carrier under a former trading partner agreement (One or more occurrences)
27. Filler	Filler (includes 25 characters for future expansion)

Medicare Claims Processing Manual

Chapter 27 - Contractor Instructions for CWF

Table of Contents
(Rev. 1568, 08-01-08)

80.14 - Consolidated Claims Crossover Process

(Rev. 1568; Issued: 08-01-08; Effective Date: 01-01-09; Implementation Date: 01-05-09)

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.

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 *January 5, 2009,* 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) TRICARE *(60000-69999);* 5) Other *Insurer (80000-88999);* 6) Medicaid *(70000-79999); and 7) 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, HUHH, HUHC, 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, HUHH, and HUHC 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, HUHH, 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, HUHH, and HUHC claims that they transmit to CWF.

Upon receipt of an HUIP, HUOP, HUHH, 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').

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.

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.

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 adjustments claims fully (100 percent) paid in association with home health prospective payment system (HHPPS) 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.

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 follows:

1) Verify that the claim was sent as action code '3'; and

2) 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 follows:

1) Verify that the claim was sent as action code '3'; and

2) 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 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.

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, HUHH, 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, HUHH, HUHC, 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.

6. 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.)

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

(Rev. 1568; Issued: 08-01-08; Effective Date: 01-01-09; Implementation Date: 01-05-09)

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 Health Insurance Master Record (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.

CWF shall not annotate processed Medicare claims on the detailed history screens in HIMR when a COBA trading partner is in test mode (Test/Production Indicator sent via the COIF submission=T).

Once the claims crossover process is fully consolidated under the Coordination of Benefits Contractor (COBC), Medicare contractor customer service staff will have access to a CWF auxiliary file that will display the crossover disposition of each beneficiary claim. The crossover disposition indicators that will appear on the HIMR detailed history screens (INPH, OUTH, HOSH, PTBH, DMEH, and HHAH) are summarized below.

Effective with October 2006, the CWF maintainer shall update 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 shall update 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 is creating crossover disposition indicators "Z" and "AA" to be effective October 1, 2007. The CWF maintainer is creating and utilizing 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 is creating 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.

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 Contractor ID excluded.
M	The beneficiary has other insurance (such as Medigap, supplemental, TRICARE, or other) that pays before Medicaid. Claim excluded by Medicaid.
N	NCPDP claims excluded.
O	All Part A claims excluded.
P	All Part B claims excluded.
Q	All DMERC claims excluded.
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 contractor (RAC)-initiated adjustment excluded.*

2. COBA By-Pass Indicators

Effective with the October 2008 release, the CWF maintainer shall begin to 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.

Claims Crossover By-Pass Indicator	**Definition/Description**
BN	CWF auto-excluded the claim because it contained a placeholder provider value.
BQ	CWF auto-excluded the claim because it contained only PQRI codes.

80.18 Inclusion and Exclusion of Specified Categories of Adjustment Claims for Coordination of Benefits Agreement (COBA) Crossover Purposes

(Rev. 1568; Issued: 08-01-08; Effective Date: 01-01-09; Implementation Date: 01-05-09)

1. CWF Inclusion of Adjustment Claims

Effective January 5, 2009, the CWF system shall 1) create the newly defined ***inclusion*** *of adjustment claims option, along with 1-byte file displacement, within its version of the COIF; and 2) accept and process this new field when the COBC transmits it as part of its regular COIF updates.*

Upon receipt of a COIF that features a COBA identification number (ID) with specifications to ***include*** *adjustment claims only, the CWF shall select only those claims for COBA crossover that meet the following specifications:*

1) *The claim's action code=3, entry code=5, or claim adjustment indicator="A"—all of which designate an "adjustment" claim;* ***and***
2) *The claim meets no other exclusion criteria, as specified on the COIF,* ***or*** *does* ***not*** *meet the NPI placeholder value by-pass exclusion logic.*

With the implementation of this change, the CWF shall continue to select adjustment claims only if it previously selected the "original" claim for crossover (logic for adjustment indicator "R"; see §80.14 of this chapter for additional details regarding this logic).

If the incoming HUIP, HUOP, HUHH, HUHC, HUBC, or HUDC claim contains spaces in the new designated RAC adjustment indicator field, CWF shall select the claim in accordance with the COBA trading partner's claims selection criteria specified on the COIF.

2. CWF Inclusion of Two Categories of Mass Adjustment Claims for Crossover Purposes

Effective January 5, 2009, the CWF system shall 1) create the newly defined ***inclusion*** *of mass adjustment claims—MPFS updates and mass adjustment claims—other options, along with accompanying 1-byte file displacement indicators, 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, HUHH, HUHC, HUBC, or HUDC claim transaction, CWF shall take the following actions: 1) Verify that the claim transaction contains an "M" or "O" mass adjustment claim header indicator; 2) verify that the claim's action code=3, or entry code=5, or adjustment header indicator=A; 3) check the COIF to determine if the COBA trading partner wishes to include mass adjustment claims—MPFS or mass adjustment claims--other; 4) ***include*** *the claim for crossover, unless the "original"*

*claim was **not** crossed over (logic for crossover disposition indicator "R") **or** the claim meets any claims exclusion criteria as specified on the COIF.*

If the incoming HUIP, HUOP, HUHH, HUHC, HUBC, or HUDC claim contains spaces in the mass adjustment indicator field, CWF shall select the claim per the COBA trading partner's claims selection criteria, as specified on the COIF.

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

*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 system shall 1) create the newly defined **inclusion** and **exclusion** of RAC-initiated adjustment options, along with accompanying 1-byte file displacement, on 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.*

Effective January 5, 2009, the CWF maintainer shall create a 1-byte RAC adjustment value in the header of its HUIP, HUOP, HUHH, HUHC, HUBC, and HUDC claims transactions (valid values= "R" or spaces.)

The CWF maintainer shall, in addition, include the 1-byte RAC adjustment indicator in the header of the claim that is posted to history on HIMR, thereby ensuring that CWF displays the indicator when a user accesses the INPH, OUTH, PTBH, DMEH, and related HIMR screens.

Contractor Actions

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.

Prior to sending their processed 11X and 12X type of bill RAC adjustment transactions to CWF for normal verification and validation, the Part A shared system shall input an "R" indicator in the newly defined header field of their HUIP claims transactions if the RAC-initiated 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 the 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** (bill types other than 11X and 12X) to CWF for normal processing, the Part A shared system shall input an "R" indicator in the newly defined header field of the HUOP, HUHH, and HUHC claim transaction.*

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 an "R" indicator in the

newly defined header field of their HUBC and HUDC claim transactions. (See chapter 28, §70.6 for more details.)

CWF Actions

Upon receipt of a claim that contains an "R" in its header in the newly defined field, CWF shall take the additional following actions:

1) Verify that the claim's action code=3, entry code=5, or header claim adjustment indicator=A;

2) Check the COIF to determine if the COBA trading partner wishes to ***include*** *RAC-initiated claims;*

3) ***Include*** *the claim for crossover,* ***unless*** *the "original" claim was* ***not*** *crossed over (logic for crossover disposition indicator "R")* ***or*** *the claim meets any other claims exclusions specified on the COIF;* ***or***

4) ***Exclude*** *the claim if the COIF specifies exclusion of RAC-initiated adjustment claims****.***

In addition, if the incoming HUIP, HUOP, HUHH, HUHC, HUBC, or HUDC claim contains spaces in the new designated RAC adjustment indicator field, CWF shall select the claim in accordance with the COBA trading partner's claims selection criteria, as specified on the COIF.

80.19- Health Insurance Portability and Accountability Act (HIPAA) 5010 and National Council for Prescription Drug Programs (NCPDP) D.0 Crossover Requirements

(Rev. 1568; Issued: 08-01-08; Effective Date: 01-01-09; Implementation Date: 01-05-09)

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).

The CWF maintainer shall 1) create these new fields, along with 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. If the COBC transmits a value other than T, P, or N within the newly designated fields, CWF shall ignore the value.

*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. (**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.)*

*The CWF shall **not** post crossover disposition indicators in association with claims whose 5010 and NCPDP D.0 indicators are "N" or "T." (Refer to §80.15 of this chapter for more information regarding claims crossover disposition indicators.)*

70.6 - Consolidation of the Claims Crossover Process

(Rev. 1568; Issued: 08-01-08; Effective Date: 01-01-09; Implementation Date: 01-05-09)

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, HUHH, 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, HUHH, 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, HUHH, 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, HUHH, 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, HUHH, 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, 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.

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, 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.

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, HUHH, 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, HUHH, HUHC, 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.

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, HUHH, HUHC, 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, HUHH, HUHC, 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, HUHH, 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, HUHH, and HUHC 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.*

*I*II. 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 January 5, 2009, w*hen 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)* TRICARE *(60000-69999); 5)* Other *Insurer (80000-88999); 6*) Medicaid *(70000-79999); and 7) 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*. Transition to the National COBA and Customer Service Issues**

1. Maintenance of Current Crossover Processes, Including Entry into New Claims Crossover Agreements (also known as Trading Partner Agreements or TPAs)

   Medicare contractors shall keep their present crossover process in place, including invoicing for claims crossed to current trading partners, as described in Pub. 100-06, Financial Management, chapter 1, §450 and §460, until each of their present trading partners has been transitioned to the COBA process. Once CMS has fully consolidated the claims crossover process under the COBC, the COBC will have exclusive responsibility for the collection of crossover claim fees for those Medigap and non-Medigap claims that are sent to the COBC to be crossed over to trading partners. The COBC will also have responsibility for distribution of the collected crossover fees to Medicare Part A contractors and Part B contractors. (See also Pub.100-06, Chapter 1, §450.)

   As trading partners are signed on to national COBAs, they will be advised that it is their responsibility to simultaneously cancel current agreements with the Medicare contractors and to cease submission of eligibility files.

   NOTE: During the parallel production period, the COBA trading partner will be instructed by CMS to not cancel current TPAs with you.) By current estimates, CMS expects to at least have all current eligibility file-based trading partners in test mode by end of fiscal year 2005 (September 30, 2005.

   Medicare contractors shall execute new TPAs only with trading partners that will be converted to full crossover production by April 1, 2005. Therefore, CMS expects contractors to cease execution of new crossover TPAs by January 31, 2005.

Trading partners that either wish to go into live crossover production after January 31, 2005, or have current questions regarding the COBA process shall be referred to the COBC at 1-646-458-6740.

2. Workload and Crossover Financial Reporting In Light of COBA

For workload reporting purposes, Medicare contractors shall provide counts for those claims that they individually cross to current trading partners (including Medicaid), just as they currently do in CAFM II and in CROWD. Medicare contractors shall separately track claims transmitted to the COBC for crossover to the COBA trading partners for future reporting requirements by COBA ID.

Effective with October 4, 2005, contractors or their shared systems shall report the number of claims submitted to the COBC via the 837 flat files or NCPDP files to their associated contractors' financial management staff only for those BHT03 (Beginning of Hierarchical Transaction Reference Identification) indicators that include a "P" in the final position of the BHT03 (position 22).

Reports generated by the contractors or their shared systems to the contractors' financial management staff shall include like data that are submitted following receipt of the COBC Detailed Error Reports to fulfill the necessary provider notification requirements. NOTE: The Detailed Error Reports shall contain the same BHT03 identifier for purposes of reporting to financial management staff as was included by the contractor shared systems on the 837 flat file and NCPDP claim file submissions sent to the COBC.) [See §70.6.1 of this chapter for more information about the COBC Detailed Error Reports]. Minimum information for each BHT03 shall include claim counts sorted by COBA ID and shall be organized into groupings that allow for separate totals by Medicaid (COBA ID range=70000-77999), Medigap (COBA ID range=30000-54999), Supplemental (COBA ID ranges=00001-29999 and 60000-69999), and Other (COBA ID range 80000-89999), as well as grand totals for all less Medicaid.

3. Customer Service

a. COBA Parallel Production or COBA Testing Process

During the parallel production period, and while a COBA trading partner is in test mode with the COBC (Test/Production Indicator="T"), the Medicare contractor shall proceed with its current claims crossover customer service process. In addition, the Medicare contractor's claims history shall not be updated with crossover information based upon the receipt of a CWF BOI reply trailer (29).

b. Updating of the HIMR Detailed History Screens By CWF and the Larger Scale Implementation of COBA

Effective with the October 2004 release, when a COBA trading partner is in production mode (Test/Production Indicator=P), CWF shall annotate each processed claim on detailed history within the Health Insurance Master Record (HIMR) with an indicator that will inform all users of the claim's crossover status. (See Pub.100-04, Chapter 27, §80.15 for more information.). CWF shall allow for repeating of the application of crossover disposition indicators for up to ten (10) COBA IDs.

In addition, 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 COBA.

CWF shall not annotate processed claims on the detailed history screens in HIMR when a COBA trading partner is in test mode (Test/Production Indicator=T).

Effective with the October 2004 systems release, when a COBA trading partner is in production mode, the Medicare contractor's customer service personnel shall answer provider/supplier and beneficiary questions about a claim's crossover status by referring to your internal claims history. In addition, the Medicare contractor's customer service staff shall access information regarding why a claim did not cross by referring to the detailed history screens on HIMR (e.g., INPH, OUTH, HOSH, PTBH, DMEH, and HHAH). [See Pub. 100-04, chapter 27, §80.15 for a listing of all claims crossover disposition indicators.] These screens will also display indicator "A" when a claim was selected by CWF to be crossed over to the COBA ID shown. The BOI auxiliary file will identify the name associated with the COBA ID. Such information may also be available to contractor customer service staff via the Next Generation Desktop (NGD) application.

The CWF maintainer issued instructions on the use of the new HIMR screens as part of the October 2004 release.

c. 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)

☐ **HIPAA Error Code**

ICN Date (Date file was transmitted to the COBC)	
HIPAA Error Code(s)	
Part A/Part B/NCPDP Claim	

☐ **Technical Issue** (Claims file transmission failures)

File Name	
Transmission Date	

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.

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.)*

70.6.1 - Coordination of Benefits Agreement (COBA) Detailed Error Report Notification Process

(Rev. 1568; Issued: 08-01-08; Effective Date: 01-01-09; Implementation Date: 01-05-09)

Effective with the July 2005 release, CMS will implement an automated process to notify physicians, suppliers, and providers that specific claims that were previously tagged by the Common Working File (CWF) for crossover will not be crossed over due to claim data errors. Claims transmitted via 837 flat file by the Medicare contractor systems to the COBC may be rejected at the flat file level, at an HIPAA ANSI pre-edit validation level, or by trading partners as part of a financial dispute arising from an invoice received. By contrast, claims transmitted via NCPDP file will be rejected only at the flat file and trading partner dispute levels. Effective with the April 2005 release, the contractor systems will have begun to populate the BHT 03 (Beginning of Hierarchical Reference Identification) portion of their 837 COB flat file submissions to the COBC with a unique 22-digit identifier. This unique identifier will enable the COBC to successfully tie a claim that is rejected by the COBC at the flat file or HIPAA ANSI pre-edit validation levels as well as claims disputed by trading partners back to the original 837 flat file submissions.

Effective with October 4, 2005, contractors or their shared systems will receive notification via the COBC Detailed Error Reports, whose file layout structures appear below, that a COBA trading partner is in test or production mode via the BHT 03 identifier that is returned from the COBC.

A. Inclusion of the Unique 22-Digit Identifier on the 837 Flat File and NCPDP File

1. Populating the BHT 03 Portion of the 837 Flat File

The contractor shared systems shall populate the BHT 03 (Beginning of Hierarchical Transaction Reference Identification; **field length=30 bytes**) portion of their 837 flat files that are sent to the COBC for crossover with a 22-digit Contractor Reference Identifier (CRI). The identifier shall be formatted as follows:

a. Contractor number (9-bytes; until the 9-digit contractor number is used, report the 5-digit contractor number, left-justified, with spaces for the remaining 4 positions);

b. Julian date as YYDDD (5 bytes);

c. Sequence number (5 bytes; this number begins with “00001,” so the sequence number should increment for each ST-SE envelope, which is specific to a trading partner, on a given Julian date);

d. Data Center ID (2 bytes; a two-digit numeric value assigned by CMS; see Table below for specific value for each contractor Data Center); and

e. COBA Test/Production Indicator (1-byte alpha indicator; acceptable values = "T" [test] and "P" [production]) or "R" if the claims were recovered for a "production" COBA trading partner (see §70.6.3 of this chapter for more details.

The 22-digit CRI shall be left-justified in the BHT 03 segment of the 837 flat file, with spaces used for the remaining 8 positions.

NOTE: The CRI is unique inasmuch as no two files should ever contain the same combination of numbers.) Special Note: In advance of October 2007, as directed by CMS, DME MACs shall begin to utilize the additional Data Center identification number 17 only in association with their NCPDP claim files transmissions to the COBC for crossover purposes.

Data Center Name	**Data Center Identification Number for BHT 03 Field**
AdminaStar Federal	01
Alabama (Cahaba)	02
Arkansas BCBS	03
CIGNA	04
EDS/MCDC2 (Plano)	05
EDS/MCDC2 (Sacramento)	06
Empire Medicare Services	07
Florida BCBS	08
Highmark	09
IBM/MCDC1 (Southbury, CT)	10
Info Crossing	11
Medicare Northwest/Regence of Oregon	12
Mutual of Omaha	13
South Carolina BCBS (Palmetto GBA)	14
TrailBlazer Health Enterprises	15
Veritus Medicare Services	16
Enterprise Data Center (EDC)-EDS (Used only by DME MACs when sending NCPDP claim transactions to the COBC)	17

2. NCPDP 22-Digit Unique Identifier

The DMERC/DME Medicare Administrative Contractor (DME MAC) contractor system shall also adopt the unique 23-digit format, referenced directly above

under “Populating the BHT 03 Portion of the 837 Flat File.” However, the system shall populate the unique 22-digit identifier in field 504-F4 (Message) within the NCPDP file (field length=35 bytes). The DMERC/DME MAC contractor system shall populate the new identifier, left justified, in the field. Spaces shall be used for the remaining bytes in the field.

B. COBC Institutional, Professional, and NCPDP Detailed Error Reports

The contractor systems shall accept the COBC Institutional, Professional, and NCPDP Detailed Error Reports received from the COBC. The formats for each of the Detailed Error Reports appear below.

Beginning with July 2007, all contractor systems shall no longer interpret the percentage values received for 837 institutional and professional claim “222” and “333” errors via the COBC Detailed Error Reports as if the values contained a 1-position implied decimal (e.g., “038”=3.8 percent). DMERCs/DME MACs shall also no longer interpret the percentage values received for NCPDP claims for “333” errors via the COBC Detailed Error Report for such claims as if the values should contain a 1-position implied decimal.

In addition, contractors and their systems shall now base their decision making calculus for initiation of a claims repair of “111” (flat file) errors upon the number of errors received rather than upon an established percent parameter, as otherwise described within this section.

The Institutional Error File Layout, including summary portion, will be used for Part A claim files.

COBC Detailed Error Report

Institutional Error File Layout
(Detail Record)

1.	**Date**	**8**	**1-8**
2.	**Control Number**	**9**	**9-17**
3.	**COBA-ID**	**10**	**18-27**
4.	**Subscriber ID/HICN**	**12**	**28-39**
5.	**Claim DCN/ICN**	**14**	**40-53**
6.	**Record Number**	**9**	**54-62**
7.	**Record/Loop Identifier**	**6**	**63-68**
8.	**Segment**	**3**	**69-71**
9.	**Element**	**2**	**72-73**
10.	**Error Source Code**	**3**	**74-76 (‘111,’ ‘222,’ or ‘333’)**
11.	**Error/Trading Partner**		
	Dispute Code	**6**	**77-82**

12. Error Description	**100**	**83-182**
13. Field Contents	**50**	**183-232**
14. BHT 03 Identifier	**30**	**233-262**
15. Claim DCN/ICN	**23**	**263-285**
16. Filler	**18**	**286-303**

Institutional Error File Layout – (Summary Record)

1. Date	**8**	**1-8**
2. Total Number of Claims For Processing Date	**10**	**9-18**
3. Number of '111' Errors	**10**	**19-28**
4. Number of '222' Errors	**10**	**29-38**
5. Percentage of '222' Errors	**3**	**39-41**
6. Number of '333' Errors	**10**	**42-51**
7. Percentage of '333' Errors	**3**	**52-54**
8. Filler	**19**	**55-73**
9. Summary Record Id (Error Source Code)	**3**	**74-76 ('999')**
10. Filler	**227**	**77-303**

The Professional Error File Layout, including summary portion, will be used for Part B and DMERC claim files.

COBC Detailed Error Report

Professional Error File Layout
(Detail Record)

1.	**Date**	**8**	**1-8**
2.	**Control Number**	**9**	**9-17**
3.	**COBA-ID**	**10**	**18-27**
4.	**Subscriber ID/HICN**	**12**	**28-39**
5.	**Claim DCN/ICN**	**14**	**40-53**
6.	**Record Number**	**9**	**54-62**
7.	**Record/Loop Identifier**	**6**	**63-68**
8.	**Segment**	**3**	**69-71**
9.	**Element**	**2**	**72-73**
10.	**Error Source Code**	**3**	**74-76 (‘111,’’ 222,’ or’ 333’)**
11.	**Error/Trading Partner**		
	Dispute Code	**6**	**77-82**
12.	**Error Description**	**100**	**83-182**
13.	**Field Contents**	**50**	**183-232**
14.	**BHT 03 Identifier**	**30**	**233-262**
15.	**Claim DCN/ICN**	**23**	**263-285**
16.	**Filler**	**18**	**286-303**

Professional Error File Layout – (Summary Record)

1.	**Date**	**8**	**1-8**
2.	**Total Number of Claims**		
	For Processing Date	**10**	**9-18**
3.	**Number of ‘111’ Errors**	**10**	**19-28**
4.	**Number of ‘222’ Errors**	**10**	**29-38**
5.	**Percentage of ‘222’ Errors**	**3**	**39-41**
6.	**Number of ‘333’ Errors**	**10**	**42-51**
7.	**Percentage of ‘333’ Errors**	**3**	**52-54**
8.	**Filler**	**19**	**55-73**
9.	**Summary Record Id**		
	(Error Source Code)	**3**	**74-76 (‘999’)**
10.	**Filler**	**227**	**77-303**

The NCPDP Error File Layout, including summary portion, will be used for by DMERCs/DME MACs for Prescription Drug Claims

COBC Detailed Error Report

NCPDP Error File Layout
(Detail Record)

1.	**Date**	**8**	**1-8**
2.	**Batch Number**	**7**	**9-15**
3.	**COBA-ID**	**5**	**16-20**
4.	**HICN**	**12**	**21-32**
5.	**CCN**	**14**	**33-46**
6.	**Record Number**	**9**	**47-55**
7.	**Batch Record Type**	**2**	**56-57**
8.	**Segment ID**	**2**	**58-59**
9.	**Error Source Code**	**3**	**60-62 ('111' or '333')**
10.	**Error/Trading Partner Dispute Code**	**6**	**63-68**
11.	**Error Description**	**100**	**69-168**
12.	**Field Contents**	**50**	**169-218**
13.	**Unique File Identifier**	**30**	**219-248**
14.	**CCN**	**23**	**249-271**
15.	**Filler**	**18**	**272-289**

NCPDP Error File Layout – (Summary Record)

1.	**Date**	**8**	**1-8**
2.	**Total Number of Claims For Processing Date**	**10**	**9-18**
3.	**Number of '111' Errors**	**10**	**19-28**
4.	**Number of '333' Errors**	**10**	**29-38**
5.	**Percentage of '333' Errors**	**3**	**39-41**
6.	**Filler**	**18**	**42-59**
7.	**Summary Record Id (Error Source Code)**	**3**	**60-62 ('999')**
8.	**Filler**	**227**	**63-289**

If the COB Contractor has rejected back to the contractor system for 2 or more COBA Identification Numbers (IDs), the contractor system shall receive a separate error record for each COBA ID. Also, if a file submission from a contractor system to the COBC contains multiple provider, subscriber, or patient level errors for one COBA ID, the

system will receive a separate error record for each provider, subscriber, or patient portion of the file on which errors were found.

C. Further Requirements of the COBA Detailed Error Report Notification Process

1. Error Source Code

Contractors, or their shared systems, shall use all information supplied in the COBC Detailed Error Report (particularly error source codes provided in Field 10 of Attachment B) to (1) identify shared system changes necessary to prevent future errors in test mode or production mode (Test/Production Indicator= T or P) and (2) to notify physicians, suppliers, and providers that claims with the error source codes "111," "222," and "333" will not be crossed over to the COBA trading partner.

The DMERC contractors, or their shared system, will only receive error source codes for a flat file error ("111") and for a trading partner dispute ("333"). Both error types shall be used to identify shared system changes necessary to prevent future errors and notify physicians, suppliers, and providers that claims with error source codes of "111" and "333" will not be crossed over to the COBA trading partner.

2. Time frames for Notification of Contractor Financial Management Staff and Providers

Contractors, or their shared systems, shall provide notification to contractor financial management staff for purposes of maintaining an effective reconciliation of crossover fee/ complementary credit accruals within five (5) business days of receipt of the COBC Detailed Error Report.

Effective with the October 2005 release, contractors and their shared systems shall receive COBC Detailed Error Reports that contain BHT03 identifiers that indicate "T" (test) or "P" (production) status for purposes of fulfilling the provider notification requirements. NOTE: The "T" or the P" portion of the BHT03 indicator will be identical to the Test/Production indicator originally returned from CWF on the processed claim.)

a) Special Automated Provider Correspondence

Contractors, or their shared systems, shall also take the following actions indicated below only when they determine via the Beneficiary Other Insurance (BOI) reply trailer (29) that a COBA trading partner is in crossover production mode with the COBC (Test/Production Indicator=P). After a contractor, or its shared system, has received a COBC Detailed Error Report that contains claims with error source codes of "111" (flat file error) "222" (HIPAA ANSI error), or "333" (trading partner dispute), it shall take the following two specified actions within five (5) business days:

1. Notify the physician, supplier, or provider via automated letter from your internal correspondence system that the claim did not cross over. The letter shall include

specific claim information, not limited to, Internal Control Number (ICN)/Document Control Number (DCN), Health Insurance Claim (HIC) number, Medical Record Number (for Part A only), Patient Control Number (only if it is contained in the claim), beneficiary name, date of service, and the date claim was processed.

Effective with July 2007, contractors and their systems shall ensure that, in addition to the standard letter language (the claim(s) was/were not crossed over due to claim data errors and was/were rejected by the supplemental insurer), their contractors' special provider letters/reports, which are generated for '222' and '333' error rejections in accordance with CR 4277, now include the following additional elements, as derived from the COBC Detailed Error Report: 1) Claredi HIPAA rejection code or other rejection code, and 2) the rejection code's accompanying description.

NOTE: Contractors, or their shared systems, are not required to reference the COBA trading partner's name on the above described automated letter, since the original remittance advice (RA)/electronic remittance advice (ERA) would have listed that information, if appropriate.

2. Update its claims history to reflect that the claim(s) did not cross over as a result of the generation of the automated letter.

   Effective with October 1, 2007, all contractors shall modify their special provider notification letters that are generated for "111," "222," and "333" error situations to include the following standard language within the opening paragraph of their letters: "This claim(s) was/were not crossed over due to claim data errors or was/were rejected by the supplemental insurer."

   Contractors shall reformat their provider notification letters to ensure that, in addition to the new standard letter language, they continue to include the rejection code and accompanying description, as derived from the COBC Detailed Error Report, for "222" or "'333" errors in association with each errored claim.

b) Special Exemption from Generating Provider Notification Letters

Effective July 7, 2008, upon their receipt of COBC Detailed Error Reports that contain "222" error codes 000100 ("Claim is contained within a BHT envelope previously crossed; claim rejected") and 00010 ("Duplicate claim; duplicate ST-SE detected"), all contractor systems shall automatically suppress generation of the special provider notification letters that they would normally generate for their associated contractors in accordance with the requirements of this section as well as §70.6.3 of this chapter. In addition, upon receipt of COBC Detailed Error Reports that contain "333" (trading partner dispute) error code 000100 (duplicate claim) or 000110 (duplicate ISA-IEA) or 000120 (duplicate ST-SE), all contractor systems shall automatically suppress generation

of the special provider notification letters, as would normally be required in accordance with this section as well as §70.6.3 of this chapter.

NOTE: When suppressing their provider notification letters for the foregoing qualified situations, the contractors shall also **not** update their claims histories to reflect the non-crossing over of the associated claims. Contractors should, however, continue to take into account the volume of claims that they are suppressing for financial reconciliation purposes.

Effective with October 6, 2008, when the COBC returns the "222" error code "N22225" to Medicare contractors via the COBC Detailed Error Report, the contractors' shared systems shall suppress generation of the special provider notification letters that they would normally issue in accordance with *CRs 3709 and 5472*.

When suppressing their provider notification letters following their receipt of a "N22225" error code, the contractors' shared systems shall also not update their claims histories to reflect the non-crossing over of the associated claims. Contractors should, however, continue to take into account the volume of claims that they are suppressing for financial reconciliation purposes.

Effective with January 5, 2009, when the COBC returns claims on the COBC Detailed Error Report whose COBA ID falls in the range 89000 through 89999 (range designates "Other-Health Care Pre-payment Plan [HCPP]"), the contractors' systems shall take the following actions:

1) Suppress generation of the special provider letters; and

*2) Not update their affiliated contractors' claims histories to indicate that the COBC will **not** be crossing the affected claims over.*