CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 1006

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: JULY 21, 2006

Change Request 5094

SUBJECT: Modification to the Coordination of Benefits Agreement (COBA) Claims Selection Criteria and File Transfer Protocols

NOTE: Transmittal 967 dated May 26, 2006, is rescinded and replaced with Transmittal 1006, dated July 21, 2006. The all Part A, the all Part B and the all DMERC claims exclusion fields (fields 213-215) were added to attachment A of the business requirements. All other information remains the same.

I. SUMMARY OF CHANGES: Through this change request, the CMS is modifying the claims selection criteria logic that the Common Working File (CWF) system applies to processed Medicare claims. The CMS is undertaking this change to more closely approximate in-house systematic logic that Medicare contractors have historically applied as part of their claims crossover processes. The CMS is also modifying its requirements for transmission of 837 test and production claims to the COBC to ensure that both types of claims may be combined within the same file that is transmitted to the COBC. This requirement is limited to the Medicare contractors and their Data Centers, not to the shared system maintainers.

NEW/REVISED MATERIAL
EFFECTIVE DATE: October 1, 2006
IMPLEMENTATION DATE: October 2, 2006

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

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

R/N/D	Chapter / Section / Subsection / Title
R	27/80.14/Consolidated Claims Crossover Process

| R | 28/70.6/Consolidation of the Claims Crossover Process |

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1006	Date: July 21, 2006	Change Request 5094

NOTE: *Transmittal 967 dated May 26, 2006, is rescinded and replaced with Transmittal 1006, dated July 21, 2006. The all Part A, the all Part B and the all DMERC claims exclusion fields (fields 213-215) were added to attachment A of the business requirements. All other information remains the same.*

SUBJECT: **Modification to the Coordination of Benefits Agreement (COBA) Claims Selection Criteria and File Transfer Protocols**

I.   GENERAL INFORMATION

A.   Background:

As part of the COBA consolidated crossover process, the Coordination of Benefits Contractor (COBC) loads each trading partner's claims selection criteria to a file known as the COBA Insurance File (COIF). The COBC transmits an extract of the COIF to each Common Working File (CWF) host site on a weekly basis. As claims are processed through the CWF, that system applies logic to either include or exclude the claims. This occurs after the CWF has read the Beneficiary Other Insurance (BOI) auxiliary file and the COIF extract file. Currently, as stipulated in Transmittal 138, Change Request (CR) 3218, the CWF returns a BOI reply trailer (29) to the Medicare contractor when it finds a matching beneficiary record within the BOI auxiliary file and if the processed claim meets CWF's inclusion selection criteria. As CWF either includes or excludes claims from the COBA crossover process, it then marks each claim with its associated crossover disposition indicator after the claim has been posted on the appropriate Health Insurance Master Record (HIMR) detailed history screen.

Through this instruction, the Centers for Medicare & Medicaid Services (CMS) shall modify CWF's current logic for including or excluding various types of claims. This will ensure that CWF's claims selection logic more closely mirrors the contractors' in-house systematic logic historically deployed as part of the Medicare contractors' crossover processes.

B.   Policy:

Effective with October 1, 2006, the CWF shall accept and process the revised COIF layout, as provided in Attachment A, as part of the national COBA crossover process. As part of the COIF changes, the CMS is changing the name of field 170 from "Original Claims Paid at Greater than 100% of the Submitted Charges" to "Original Claims Paid at Greater than 100% of the Submitted Charges without Deductible or Co-Insurance Remaining." In addition, CMS is reducing the total bytes for the "Contractor ID" selection criterion as part of this change request.

The CWF's claims selection logic used as part of the national COBA crossover process shall be modified as indicated in the business requirements below.

Under its current logic, the CWF includes or excludes Part B contractor states by reading the 5-digit Medicare contractor workload identifier that each contractor includes on the HUBC claim to CWF. In

addition, the CWF reads the first two positions of the Part A assigned Online Survey, Certification, and Reporting (OSCAR) number, as reported via the HUIP, HUOP, HUHH, or HUHC claims to CWF, for purposes of including or excluding provider states for COBA Part A claims crossover purposes.

Effective with October 1, 2006, the CWF shall read the first two (2) positions of the Business Segment Identifier (BSI) as reported via the HUBC claim for the purpose of uniquely including or excluding claims from state-specific Part B contractors. The CWF logic for including or excluding Part A provider states or individual provider identifiers by unique OSCAR identifier shall remain unchanged.

Through this change request, the CWF shall be required to **exclude** adjustment claims, monetary or adjustment claims, non-monetary if the corresponding original claim was **not** crossed over.
This applies even if the trading partner otherwise wishes to receive adjustment, monetary or adjustment, non-monetary claims. The CWF search parameters for this requirement pertain only to claims that are currently available on history.

Additionally, through this instruction, the CWF's logic shall be modified so that adjustment claims that are 100 percent paid, adjustment claims that are 100 percent denied but contain no beneficiary liability, adjustment claims that are 100 percent denied but contain additional beneficiary liability, and Medicare Secondary Payer (MSP) cost-avoided claims may be **excluded** in accordance with each COBA trading partner's selection criteria as reported via the COIF. However, in light of the requirements detailed below, the CWF maintainer shall be responsible for developing and applying five (5) new crossover disposition indicators 'R,' 'S,' 'T,' 'U,' and 'V' that will be displayed on the HIMR detailed history screens in association with the claims that met the newly developed claim exclusion criteria. The CWF maintainer shall also be required to populate and display the newly developed claims exclusions, as specified below, on the COBA Insurance File Summary screen (COBS) for customer service purposes.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5094.1	The CWF maintainer shall accept and process the latest version of the COIF layout (see Attachment A), including all new fields, as received from the COBC on a weekly basis.								X	

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)							
		FI	RHHI	Carrier	DMERC	FISS	MCS	VMS	CWF	Other
5094.2	The CWF shall read the first two (2) positions of the BSI as reported on the HUBC claim to uniquely include or exclude claims from state-specific Part B contractors, as indicated on the COIF.								X	
5094.3	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% (crossover disposition indicator D).								X	
5094.3.1	In addition, the CWF shall determine that the Part A claim contained a reimbursement amount before excluding that same claim when it is reported to CWF with action code '1' and contains no deductible and co-insurance amounts (crossover disposition indicator D).								X	
5094.4	The CWF shall modify its current logic for exclusion of Part A "Original Medicare Claims Paid at Greater than 100% of the Submitted Charges" (crossover disposition indicator E) as follows: In addition to meeting the CWF exclusion criteria for Part A claims paid at greater than 100% of the submitted charges, these claims shall be **excluded only** when there is no deductible or co-insurance remaining on the claims (crossover disposition indicator E).								X	
5094.4.1	The CWF logic for excluding Part B original Medicare claims paid at greater than 100% of the submitted charges/allowed amount (specifically, type F ambulatory surgical center claims that meet this criteria) shall remain unchanged.								X	

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)							
		F I	R H H I	C a r r i e r	D M E R C	Shared System Maintainers			Other
						F I S S	M C S	V M S	C W F	
5094.4.2	The CWF shall modify its data elements so that the naming convention for crossover disposition indicator 'E' is changed to "Original Claims Paid at Greater than 100% of the Submitted Charges Without Deductible or Co-Insurance Remaining" (see Attachment B).								X	
5094.5	The CWF shall check the reimbursement amount as well as the deductible and co-insurance amounts on each claim to determine whether a monetary adjustment change to an original Part A, B, or DMERC claim occurred (crossover disposition indicator H).								X	
5094.5.1	To exclude non-monetary adjustments for Part A, B, and DMERC claims, the CWF shall check the reimbursement amount as well as the deductible and co-insurance amounts on each claim to confirm that there were no monetary changes on the adjustment claim as compared to the original claim (crossover disposition indicator I).								X	

5094.5.2	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**:**
	
	    a) 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**;**
	    b) Exclude the adjustment claim if CWF locates the original claim and it was marked with a crossover disposition indicator other than 'A.'
									X	

Requirement Number	Requirements	FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5094.5.3	The CWF maintainer shall create a new 'R' crossover disposition indicator ("Adjustment claim excluded because original claim was not crossed over." See Attachment B.)								X	
5094.5.4	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 HIMR detailed history screen.								X	
5094.5.5	The Next Generation Desktop (NGD) application and other customer service tools shall be updated so that the new crossover disposition indicator 'R' will be appropriately captured and displayed to fulfill contractor customer service needs.									X
5094.6	The CWF shall apply logic to exclude Part A and Part B (including DMERC) adjustment claims (identified as action code '3' for Part A claims and entry code '5' for Part B and DMERC claims) when the COIF indicates that a COBA trading partner wishes to exclude "Adjustment Claims, 100% Paid."								X	
5094.6.1	The CWF shall develop logic as follows to **exclude** Part A adjustment claims, 100% paid: a) Verify that the claim contains action code '3'; b) Verify that there are no deductible and co-insurance amounts on the claim; and c) Verify that reimbursement on the claim is greater than zero.								X	

Requirement Number	Requirements	FI	RHHI	Carrier	DMERC	FISS	MCS	VMS	CWF	Other
						Shared System Maintainers				
5094.6.2	The CWF shall bypass the exclusion logic for Part A adjustment claims, 100% paid when the type of bill equals 329 or 339 (home health bills, final payment).								X	
5094.6.3	The CWF shall develop logic as follows to **exclude** Part B and DMERC adjustment claims, 100% paid: a) Verify that the claim contains an entry code '5'; and b) Verify that the allowed amount equals the reimbursement amount.								X	
5094.6.4	The CWF maintainer shall create a new 'S' crossover disposition indicator for "Adjustment Claims, 100 % Paid" (see Attachment B).								X	
5094.6.5	The CWF maintainer shall ensure that excluded adjustment claims that were 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.								X	
5094.6.6	The CWF maintainer shall add "Adj. Claims-100% PD" to the COBA Insurance File Summary screen (COBS) on HIMR so that this exclusion will be appropriately displayed for customer service purposes.								X	
5094.6.7	The Next Generation Desktop (NGD) application and other customer service tools shall be updated so that the new crossover disposition indicator 'S' will be appropriately captured and displayed to fulfill contractor customer service needs.									X
5094.7	The CWF shall apply logic to exclude Part A 100% denied adjustment claims, with no additional beneficiary liability, when the COIF indicates that a COBA trading partner wishes to exclude "100% Denied Adjustment Claims, No Additional Liability."								X	

Requirement Number	Requirements	FI	RHHI	Carrier	DMERC	FISS	MCS	VMS	CWF	Other
						Shared System Maintainers				
5094.7.1	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: a) Verify that the claim was sent as action code '3'; and b) Check for the presence of an 'R' Non-Pay Code on the fully denied claim.								X	
5094.7.2	The CWF shall apply logic to exclude Part B (including Durable Medical Equipment Regional Carrier) 100% denied adjustment claims, with no additional beneficiary liability, when the COIF indicates that a COBA trading partner wishes to exclude "100% Denied Adjustment Claims, No Additional Liability."								X	
5094.7.3	The CWF shall apply logic to Part B and DMERC adjustment claims (entry code '5') where the entire claim is denied and the beneficiary has **no** additional liability as follows: a) Verify that the claim was sent as entry code '5'; and b) Check for the presence of an 'N' liability indicator on the fully denied claim.								X	
5094.7.4	The CWF maintainer shall create a new 'T' crossover disposition indicator for "Adjustment Claims, 100 % Denied with No Additional Beneficiary Liability" (see Attachment B).								X	
5094.7.5	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.								X	

Requirement Number	Requirements	FI	RHHI	Carrier	DMERC	FISS	MCS	VMS	CWF	Other
						Shared System Maintainers				
5094.7.6	The CWF maintainer shall add "Denied Adjs-No Liab" to the COBA Insurance File Summary screen (COBS) on HIMR so that this exclusion will be appropriately displayed for customer service purposes.								X	
5094.7.7	The NGD application and other customer service tools shall be updated so that the new crossover disposition indicator 'T' will be appropriately captured and displayed to fulfill contractor customer service needs.									X
5094.8	The CWF shall apply logic to exclude Part A 100% denied adjustment claims, with additional beneficiary liability, when the COIF indicates that a COBA trading partner wishes to exclude "100% Denied Adjustment Claims, Additional Liability."								X	
5094.8.1	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: a) Verify that the claim was sent as action code '3'; and b) Check for the presence of an 'N' or 'B' Non-Pay Code on the fully denied claim.								X	
5094.8.2	The CWF shall apply logic to exclude Part B (including Durable Medical Equipment Regional Carrier) 100% denied adjustment claims, with additional beneficiary liability when the COIF indicates that a COBA trading partner wishes to exclude "100% Denied Adjustment Claims, Additional Liability."								X	
5094.8.3	The CWF shall apply logic to Part B and DMERC adjustment claims (entry code '5') where the entire claim is denied and the beneficiary has additional liability as follows:								X	

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		F I	R H H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
						F I S S	M C S	V M S	C W F	
	a) Verify that the claim was sent as entry code '5'; and b) Check for the presence of an 'L' liability indicator on the fully denied claim.									
5094.8.4	The CWF maintainer shall create a new 'U' crossover disposition indicator for "Adjustment Claims, 100 % Denied with Additional Beneficiary Liability" (see Attachment B).								X	
5094.8.5	The CWF maintainer shall ensure that excluded adjustment claims that were entirely denied and contained additional beneficiary liability shall be marked with a 'U' crossover disposition indicator after they have been posted to the appropriate HIMR detailed history screen.								X	
5094.8.6	The CWF maintainer shall add "Denied Adjs-Liab" to the COBA Insurance File Summary screen (COBS) on HIMR so that this exclusion will be appropriately displayed for customer service purposes.								X	
5094.8.7	The NGD application and other customer service tools shall be updated so that the new crossover disposition indicator 'U' will be appropriately captured and displayed to fulfill contractor customer service needs.									X
5094.9	The CWF shall apply the following logic to **exclude** Part A MSP cost-avoided claims: a) Verify that the claim contains one of the following MSP non-pay codes: E, F, G, H, J, K, Q, R, T, U, V, W, X, Y, Z, 00, 12, 13, 14, 15, 16, 17, 18, 25, and 26.								X	
5094.9.1	The CWF shall apply the following logic to **exclude** Part B and DMERC MSP cost-avoided claims: a) Verify that the claim contains one of the following MSP non-pay codes: E,								X	

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	FISS	MCS	VMS	CWF	Other
	F, G, H, J, K, Q, R, T, U, V, W, X, Y, Z, 00, 12, 13, 14, 25, and 26.									
5094.9.2	The CWF maintainer shall create a new 'V' crossover disposition indicator for "MSP Cost-Avoided Claims" (see Attachment B).								X	
5094.9.3	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.								X	
5094.9.4	The CWF maintainer shall add "MSP Cost-Avoids" to the COBA Insurance File Summary screen (COBS) on HIMR so that this exclusion will be appropriately displayed for customer service purposes.								X	
5094.9.5	The NGD application and other customer service tools shall be updated so that the new crossover disposition indicator 'V' will be appropriately captured and displayed to fulfill contractor customer service needs.								X	
5094.10	The CWF maintainer shall change its data elements to include the newly created crossover disposition indicators 'R,' 'S,' 'T,' 'U,' and 'V,' together with matching descriptions.								X	
5094.10.1	All contractors shall update their customer service training materials to capture the newly developed COBA crossover disposition indicators R through V along with matching descriptions.	X	X	X	X					
5094.11	All contractors/Data Centers shall transmit a combined COBA "test" and "production" 837 flat file and a combined National Council for Prescription Drug Programs (NCPDP) "test" and "production" claim file to the COBC.	X	X	X	X					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	(NOTE: This non-systems requirement changes the direction that CMS had provided via Transmittal 586, Change Request 3906.)									

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5049.12	None.	X	X	X	X					

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E.   Dependencies: N/A

F.   Testing Considerations: N/A

V.   SCHEDULE, CONTACTS, AND FUNDING

2 Attachments

Effective Date*: October 1, 2006 **Implementation Date:** October 2, 2006 **Pre-Implementation Contact(s):** Brian Pabst (brian.pabst@cms.hhs.gov; 410-786-2487) or Brian Johnson (brian.johnson@cms.hhs.gov; 410-786-7601) **Post-Implementation Contact(s):** Brian Pabst (brian.pabst@cms.hhs.gov; 410-786-2487) or Brian Johnson (brian.johnson@cms.hhs.gov; 410-786-7601)	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

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COBA INSURANCE FILE

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 charge*s without deductible or coinsurance remaining*
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.*
Filler	*182*	*6*	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

Field	Start	Len	End	Description
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)
Filler	975	10	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).
Filler	1266	10	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)

CROSSOVER CLAIM DISPOSITION INDICATORS
ATTACHMENT B

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 paid at 100%.
E	Original Medicare claims paid at greater than 100% of the submitted charges *without deductible or co-insurance remaining* excluded.
F	100% denied claims, with no additional beneficiary liability excluded.
G	100% denied claims, with additional beneficiary liability excluded.
H	Adjustment claims, monetary, excluded.
I	Adjustment claims, non-monetary/statistical, excluded
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 Paid at 100 % 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.*

NOTE: In the future, CMS may expand the above list beyond the last indicator provided above. Once all remaining one-digit alpha indicators are committed, CMS will institute the use of two-position claims crossover disposition indicators.

Medicare Claims Processing Manual
Chapter 27 - Contractor Instructions for CWF

(Rev. 1006, 07-21-06)

80.14 - Consolidated Claims Crossover Process

(Rev.1006, Issued: 07-21-06, Effective: 10-01-06, Implementation: 10-02-06)

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* <u>only</u> 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.)

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

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

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

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

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

- NM101 [Entity Identifier Code]—Use "TT," as specified in the 835 Implementation Guide.

- NM102 [Entity Type Qualifier]—Use "2," as specified in the 835 Implementation Guide.

- NM103 [Name, Last or Organization Name]—Use the COBA trading partner's name that accompanies the first sorted COBA ID returned to you on the BOI reply trailer.

- NM108 [Identification Code Qualifier]—Use "PI" (Payer Identification.)

- NM109 [Identification Code]—Use the first COBA ID returned to you on the BOI reply trailer. (See line 24 of the BOI aux. file record.

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

When a beneficiary's claim is associated with more than one COBA ID (i.e., the beneficiary has more than one health insurer/benefit plan that has signed a national COBA), CWF shall sort the COBA IDs and trading partner names in the following order:

1) Eligibility-based Medigap, 2) Supplemental, 3) TRICARE, 4) Others, and 5) Eligibility-based Medicaid. When two or more COBA IDs fall in the same range (see item 24 in the BOI Auxiliary File table above), CWF shall sort numerically within the same range.

3. Claim-Based Medigap and Medicaid Crossover Processes Involving CWF

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

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

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

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

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

d. Return an alert code 7704 on the "01" response via a Claim-based alert trailer 21 to the *Part B* or DMERC , as specified in Requirement 23 above, if a claim-based COBA ID in the Medigap claim-based range (55000-59999) is not located on the COIF; and

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

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

4. CWF Treatment of Non-assigned Medicaid Claims

When CWF receives a non-assigned Medicare claim for a beneficiary whose BOI auxiliary record contains a COBA ID with a current effective date in the Medicaid eligibility-based range (70000-77999), it shall reject the claim by returning edit 5248 to the *Part B* or DMERC *contractor's* system only when the Medicaid COBA trading partner is in production mode (Test/Production Indicator=P) with the COBC. At the same time, CWF shall only return a Medicaid reply trailer 36 to the *Part B* or DMERC *contractor* that contains the trading partner's COBA ID and beneficiary's effective and termination dates under Medicaid when the Medicaid COBA trading partner is in production mode with the COBC. CWF shall determine that a Medicaid trading partner is in production mode by referring to the latest COBA Insurance File (COIF) update it has received.

If, upon receipt of CWF edit 5248 and the Medicaid reply trailer (36), the *Part B* or DMERC *contractor* determines that the non-assigned claim's service dates fall during a period when the beneficiary is eligible for Medicaid, it shall convert the assignment indicator from "non-assigned" to "assigned" and retransmit the claim to CWF. After the claim has been retransmitted, the CWF will only return a BOI reply trailer to the *Part B* or DMERC *contractor* if the claim is to be sent to the COBC to be crossed over.

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

Effective with the January 2005 release, the *Part B* and DMERC systems *shall* be required to include an indicator *'L'* (beneficiary is liable for the denied service[s]) or *'N'* (beneficiary is not liable for the denied service[s]) in an available field on the HUBC and HUDC queries to CWF for claims on which all line items are denied. The liability indicators (L or N) will be at the header or claim level rather than at the line level.

Currently, the DMERC shared system is able to identify, through the use of an internal indicator, whether a submitted claim is in the National Council for Prescription Drug Programs (NCPDP) format. The DMERC shared system shall pass an indicator "P" to CWF in an available field on the HUDC query when the claim is in the NCPDP format. The indicator "P" shall be included in a field on the HUDC query that is separate from the fields used to indicate whether a beneficiary is liable for all services denied on his/her claim.

The CWF shall read the new indicators passed via the HUBC or HUDC queries for purposes of excluding denied *services on* claims with or without beneficiary liability and NCPDP claims.

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

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

   A. New Part B Contractor Inclusion or Exclusion Logic

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

   B. Exclusion of 100 percent Paid Claims

The CWF shall continue to exclude Part B claims paid at 100 percent by checking for the presence of claims entry code '1' and determining that each claim's allowed amount equals the reimbursement amount.

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

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

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

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

*(**NOTE:** The current CWF logic for excluding Part B original Medicare claims paid at greater than 100 percent of the submitted charges/allowed amount (specifically, type F ambulatory surgical center claims that meet this criteria) shall remain unchanged.)*

   D.   Claims with Monetary or Non-Monetary Changes

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

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

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

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

1) Return a BOI reply trailer 29 to the contractor if CWF locates the original claim that was marked with an 'A' crossover disposition indicator **or** if the original claim's crossover disposition indicator was blank/non-existent;

2) Exclude the adjustment claim if CWF locates the original claim and it was marked with a crossover disposition indicator other than 'A,' meaning that the original claim was excluded from the COBA crossover process.

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

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

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

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

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

1) Verify that the claim contains action code '3';

2) Verify that there are no deductible and co-insurance amounts on the claim; and

3) Verify that the reimbursement on the claim is greater than zero.

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

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

1) Verify that the claim contains an entry code '5'; and

2) Verify that the allowed amount equals the reimbursement amount.

The CWF maintainer shall create a new 'S' crossover disposition indicator for adjustment claims that are paid at 100 percent. The CWF maintainer shall ensure that excluded adjustment claims that are paid at 100 percent shall be marked with an 'S' crossover disposition indicator after they have been posted to the appropriate HIMR detailed history screen. In addition, the CWF maintainer shall add "Adj. Claims-100

percent PD" to the COBA Insurance File Summary screen (COBS) on HIMR so that this exclusion will be appropriately displayed for customer service purposes.

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

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

The CWF shall apply logic to the Part A adjustment claim (action code '3') where the entire claim is denied <u>and</u> the beneficiary has no additional liability as follows:

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

    2) Check for the presence of an 'R' non-pay code on the fully denied claim.

*The CWF shall apply logic to the Part B and DMERC adjustment claims (entry code '5') where the entire claim is denied <u>and</u> the beneficiary has **no** additional liability as follows:*

    1) Verify that the claim was sent as entry code '5'; and

    2) Check for the presence of an 'N' liability indicator on the fully denied claim.

The CWF maintainer shall create a new 'T' crossover disposition indicator for adjustment claims that are 100 percent denied with no additional beneficiary liability. The CWF maintainer shall ensure that excluded adjustment claims that were entirely denied and contained no beneficiary liability shall be marked with a 'T' crossover disposition indicator after they have been posted to the appropriate HIMR detailed history screen. In addition, the CWF maintainer shall add "Denied Adjs-No Liab" to the COBS on HIMR so that this exclusion will be appropriately displayed for customer service purposes.

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

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

The CWF shall apply logic to the Part A adjustment claim (action code '3') where the entire claim is denied <u>and</u> the beneficiary has additional liability as follows:

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

    2) Check for the presence of an 'N' or 'B' non-pay code on the fully denied claim.

The CWF shall apply logic to exclude Part B and DMERC adjustment claims (entry code '5') where the entire claim is denied <u>and</u> the beneficiary has additional liability as follows:

    1) Verify that the claim was sent as entry code '5'; and

    2) Check for the presence of an 'L' liability indicator on the fully denied claim.

The CWF maintainer shall create a new 'U' crossover disposition indicator for adjustment claims that are 100 percent denied with additional beneficiary liability. The CWF maintainer shall ensure that excluded adjustment claims that were entirely denied and contained beneficiary liability shall be marked with a 'U' crossover disposition indicator after they have been posted to the appropriate HIMR detailed history screen. In addition, the CWF maintainer shall add "Denied Adjs-Liab" to the COBS on HIMR so that this exclusion will be appropriately displayed for customer service purposes.

I. Excluding MSP Cost-Avoided Claims

*The CWF shall develop logic to **exclude** MSP cost-avoided claims when the COIF indicates that a COBA trading partner wishes to exclude such claims.*

*The CWF shall apply the following logic to **exclude** Part A MSP cost-avoided claims:*

    a) *Verify that the claim contains one of the following MSP non-pay codes: E, F, G, H, J, K, Q, R, T, U, V, W, X, Y, Z, 00, 12, 13, 14, 15, 16, 17, 18, 25, and 26.*

*The CWF shall apply the following logic to **exclude** Part B and DMERC MSP cost-avoided claims:*

    a) *Verify that the claim contains one of the following MSP non-pay codes: E, F, G, H, J, K, Q, R, T, U, V, W, X, Y, Z, 00, 12, 13, 14, 15, 16, 17, 18, 25, and 26.*

The CWF maintainer shall create a new 'V' crossover disposition indicator for the exclusion of MSP cost-avoided claims. The CWF maintainer shall ensure that excluded MSP cost-avoided claims shall be marked with a 'V' crossover disposition indicator after they have been posted to the appropriate HIMR detailed history screen. In addition, the CWF maintainer shall add "MSP Cost-Avoids" to the COBS on HIMR so that this exclusion will be appropriately displayed for customer service purposes.

80.15 - Claims Crossover Disposition Indicators)

(Rev.1006, Issued: 07-21-06, Effective: 10-01-06, Implementation: 10-02-06)

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 chart below.

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 paid at 100% *excluded.*
E	Original Medicare claims paid at greater than 100% of the submitted charges *without deductible or co-insurance remaining* excluded.
F	100% denied claims, with no additional beneficiary

	liability excluded.
G	100% denied claims, with additional beneficiary liability excluded.
H	Adjustment claims, monetary, excluded.
I	Adjustment claims, non-monetary/statistical, excluded.
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 Paid at 100% 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.*

NOTE: In the future, CMS may expand the above list beyond Indicator *'V.'* Once all remaining one-digit alpha indicators are committed, CMS will institute the use of two-position claims crossover disposition indicators.

Medicare Claims Processing Manual
Chapter 28 - Coordination With Medigap, Medicaid, and Other Complementary Insurers

(Rev. 1006, 07-21-06)

70.6 - Consolidation of the Claims Crossover Process
(Rev.1006, Issued: 07-21-06, Effective: 10-01-06, Implementation: 10-02-06)

The CMS has decided to streamline the claims crossover process to better serve our customers. Beginning with July 6, 2004, approximately ten COBA trading partners will participate in the beta-site testing of the consolidated claims crossover or Coordination of Benefits Agreement (COBA) process. During this time, the COBA beta-site testers will participate in a parallel production crossover process (a pilot for only COBA trading partners using production/live data). During the parallel production period, the ten COBA trading partners will receive consolidated crossover claims as part of the COBA process. In addition, if the ten COBA trading partners have individual Trading Partner Agreements (TPAs) executed with Medicare contractors, they will receive crossover claims based on the terms and conditions of those TPAs. The Coordination of Benefits Contractor (COBC) will not charge the COBA beta-testers for crossed over claims during the parallel production period. Medicare contractors will, however, continue to charge these partners for claims that they continue to cross over to them during the beta-testing period.

Under the consolidated claims crossover process, trading partners will be transitioned from the current TPA process with Medicare contractors to new agreements called Coordination of Benefits Agreements (COBAs). These agreements, which will be negotiated on behalf of CMS by the COBC, will be entered into directly between CMS and the COBA trading partners. 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 a maintenance transaction. The transaction is known as the Beneficiary Other Insurance (BOI) auxiliary file. (See Chapter 27, §80.14, of Publication 100-4, Medicare Claims Processing Manual, for more details about the contents of the BOI auxiliary file.)

The CWF is being modified so that it will apply 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.

Determination of Beneficiary Liability for Claims with Denied Services

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

Currently, the DMERC 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 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% 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.

Additional Information Regarding the COBA Process

Upon receipt of a BOI reply trailer (29) that contains (a) COBA ID (s) and other crossover information required on the 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.

The CWF is also being modified in preparation for future receipt of claim-based Medigap and/ or Medicaid COBA IDs in field 36 of the HUBC or HUDC query. For claim-based crossover, CWF will also be equipped to search the Coordination of Benefits Agreement Insurance File (COIF) to locate a matching COBA IDs; apply the Medigap claim-based trading partner's claims selection criteria; and return a claim-based reply trailer 37 to the Part B or DMERC contractor if a claim-based COBA ID has been located and the claim is to be sent to the COBC to be crossed over.

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

The effort to consolidate the claims crossover function will be implemented via a phased-in approach, beginning with a small-scale implementation on July 6, 2004, involving approximately ten COBA trading partners that will serve as beta-site testers.

CMS will not move trading partners into crossover production with the COBC any earlier than December 2004. Consequently, the COBA parallel production period will be

extended until CMS, the Coordination of Benefits Contractor (COBC), and the participating beta-testing trading partners conclude the testing results demonstrate a high-level of confidence.

Contractors shall operate under the assumption that all of their existing eligibility file-based crossover trading partners will at least be in test mode with the COBC by the end of fiscal year 2005 (i.e., by September 30, 2005).

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:

1) 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.];

2) 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;

3) Apply the COBA trading partner's selection criteria; and

4) 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.

> 1.) 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.

> 2.) 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.

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

Beginning with the October 2004 release, when contractors receive a BOI reply trailer (29) that contains a "T" Test/Production Indicator, they shall not print information received from the BOI reply trailer (29) in the required crossover fields on the 835 Electronic Remittance Advice or other provider remittance 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 contractors receive a BOI reply trailer (29) that contains a "P" Test/Production Indicator, they shall use the returned BOI trailer information to take the following actions on the provider's 835 Electronic Remittance Advice:

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

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

>> • NM101 [Entity Identifier Code]—Use "TT," as specified in the 835 Implementation Guide.

>> • NM102 [Entity Type Qualifier]—Use "2," as specified in the 835 Implementation Guide.

- NM103 [Name, Last or Organization Name]—Use the COBA trading partner's name that accompanies the first sorted COBA ID returned to you on the BOI reply trailer.

- NM108 [Identification Code Qualifier]—Use "PI" (Payer Identification)

- NM109 [Identification Code]—Use the first COBA ID returned to you on the BOI reply trailer. (See line 24 of the BOI aux. file record

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

CWF Sort Routine for Multiple COBA IDs

When a beneficiary's claim is associated with more than one COBA ID (i.e., the beneficiary has more than one health insurer/benefit plan that pays after Medicare), CWF shall sort the COBA IDs and trading partner names in the following order on the returned BOI reply trailer (29): 1) Eligibility-based Medigap, 2) Supplemental, 3) TRICARE, 4) Others, and 5) Eligibility-based Medicaid. 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 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:

1. 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.)

2. 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.

3. 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.

4. 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.

5. 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.

6.   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).

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.)

*E*ffective with October *2, 2006,* the contractor*s 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.)* .

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

> The following segments shall not be passed to the COBC:

>> a) ISA (Interchange Control Header Segment);

>> b) IEA (Interchange Control Trailer Segment);

>> c) GS (Functional Group Header Segment); and

>> d) 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 Future COBA Claim-Based Process Involving CWF

The CWF shall load the initial COIF submission from COBC as well as all future updates that pertain to claim-based Medigap insurers and State Medicaid Agencies.

Once claim-based crossover becomes effective in the future, CWF shall only search the COIF if the Part B or DMERC contractor has included a claim-based Medigap ID (55000-59999) or claim-based Medicaid ID (78000-79999) in field 36 of the HUBC or HUDC query. During the parallel production period (July 6, 2004, to October 1, 2004) and until the future implementation date for the claim-based COBA crossover process, CWF shall ignore claim-based COBA ID values if entered in field 36 of the HUBC or HUDC query.

Beginning with the implementation of the COBA claim-based crossover process, if claim-based COBA IDs are entered in field 36 of the HUBC or HUDC query, CWF shall:

> Search the COIF to locate the claim-based Medicaid and/or Medigap COBA ID and corresponding COBA trading partner name;

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

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

> Return an alert code 7704 on the "01" response via a Claim-based alert trailer 21 to the Part B or DMERC contractor if a claim-based COBA ID in the Medigap claim-based range (55000-59999) is not located on the COIF; and

> Return nothing to the Part B and DMERC contractor if a Medicaid claim-based COBA ID (78000-79999) is not found on the COIF.

F. COBA Claim-Based Crossover Process

Until further notice from CMS, Part B and DMERC contractors shall not cease their existing claim-based Medigap and/or Medicaid crossover processes. Part B and DMERC contractors will receive COBA claim-based crossover requirements as part of a future instruction.

G. 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 chapter 27, §80.15 of the Medicare Claims Processing Manual 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 will issue instructions on the use of the new HIMR screens as part of the October 2004 release.