| CMS Manual System | Department of Health & Human Services (DHHS) |
|---|---|
| Pub 100-04 Medicare Claims Processing | Centers for Medicare & Medicaid Services (CMS) |
| **Transmittal 1189** | **Date: February 28, 2007** |
| | **Change Request 5472** |

**NOTE:** ***Transmittal1179, dated February 2, 2007, is rescinded and replaced herewith. The Summary of Changes below corrects the scope of the CR. Business Requirements references within the Policy section and 5472.4.4 are changed from "loop 2330 REF*T4*Y" to "loop 2330B REF*T4*Y." Business Requirement 5472.5.3 modifies "value" with "compliant." Business Requirement 5472.5 clarifies the example provided as to when the "A" adjustment indicator should be set. The identical tables of Crossover Claim Disposition Indicators in Attachment B and Chapter 27§80.15 are corrected. The COBC Detailed Error Report layouts in Chapter 28 §70.6.1 now match those in Attachment C. All other information remains the same.***

**Subject: Differentiating Mass Adjustments From Other Types of Adjustments and Claims for Crossover Purposes and Revising the Detailed Error Report Special Provider Notification Letters**

**I. SUMMARY OF CHANGES:** Through this change request, contractor systems will be changed to enable contractors to differentiate mass adjustment claims from all other kinds of adjustment claims for crossover purposes. In addition, through this instruction, the special provider notification letters that contractors generate to their providers, in accordance with change request 3709, will be modified so that they display the specific reason as to why claims were not crossed over.

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

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

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

| R/N/D | Chapter / Section / Subsection / Title |
|---|---|
| R | 27/ Table of Contents |
| R | 27/80.15/ Claims Crossover Disposition Indicators |
| N | 27/80.16/ Special Mass Adjustment and Other Adjustment Crossover Requirements |
| R | 28/70.6/ Consolidated Claims Crossover Process |
| R | 28/70.6.1/ Coordination of Benefits Agreement (COBA) Detailed |

| | |
|---|---|
| | Error Report Notification Process |
| R | 28/70.6.2/ Coordination of Benefits Agreement (COBA) Full Claim File Repair |

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

**IV. ATTACHMENTS:**

**Business Requirements**

**Manual Instruction**

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

# Attachment - Business Requirements

| Pub. 100-04 | Transmittal: 1189 | Date: February 28, 2007 | Change Request: 5472 |
|---|---|---|---|

**NOTE:** ***Transmittal1179, dated February 2, 2007, is rescinded and replaced herewith. The Summary of Changes below corrects the scope of the CR. Business Requirements references within the Policy section and 5472.4.4 are changed from "loop 2330 REF*T4*Y" to "loop 2330B REF*T4*Y." Business Requirement 5472.5.3 modifies "value" with "compliant." Business Requirement 5472.5 clarifies the example provided as to when the "A" adjustment indicator should be set. The identical tables of Crossover Claim Disposition Indicators in Attachment B and Chapter 27§80.15 are corrected. The COBC Detailed Error Report layouts in Chapter 28 §70.6.1 now match those in Attachment C. All other information remains the same.***

**SUBJECT: Differentiating Mass Adjustments from Other Types of Adjustments and Claims for Crossover Purposes and Revising the Detailed Error Report Special Provider Notification Letters**

**Effective Date**: **July 1, 2007**

**Implementation Date: July 2, 2007**

## I. GENERAL INFORMATION

**A. Background:** All Medicare contractors currently send processed claims for which they receive a Beneficiary Other Insurance (or BOI) reply trailer 29 from the Common Working File (CWF) to the Coordination of Benefits Contractor (COBC) for crossover under the national Coordination of Benefits Agreement (COBA) program. This activity occurs on a daily basis, unless the contractor processes claims on a less frequent batch cycle.

The Centers for Medicare & Medicaid Services (CMS) requires a method whereby its COBC may differentiate among the various categories of adjustment crossover claims: mass adjustments-Medicare physician fee schedule (MPFS), mass adjustments-other, and all other adjustments. This will enable CMS and the COBC to better address the kinds of contingencies that arise with the passage of mandated legislation such as the Deficit Reduction Act. This instruction represents a first step towards fulfilling this objective. All remaining system requirements will be addressed through a future change request.

In addition, CMS has identified a change needed to ensure that CWF will properly exclude adjustment claims, even if they are sent to CWF as entry code '1' or action code '1,' in accordance with contractor shared system procedures. Further, CMS has identified a change needed to ensure that CWF, the Medicare contractors, and their systems will properly classify claims that are recycled to CWF as entry code '5' or action code '3.' Contractor and CWF requirements relating to these changes are detailed below.

CMS will modify the COBC Detailed Error Report process to ensure that the contractor-generated special provider letters, which are created and sent in accordance with Transmittal 474 (change request [CR] 3709), now contain the specific Claredi rejection code returned for the claim along with its description for '222' and '333' error situations. In addition, CMS is further modifying its procedures for '111' errors (flat file errors) in terms of threshold levels and the information that will be reported on the contractor-generated special provider letters/reports for these error situations.

**B. Policy:** All contractors and their systems shall develop a method for differentiating mass adjustments tied to the Medicare Physician Fee Schedule (MPFS) updates and other mass adjustments from all other kinds of adjustments and claims. For purposes of this instruction, a 'mass adjustment' refers to an action that a contractor undertakes using special software (e.g., Super-Op Events or Express Adjustments) to pull claims with the anticipated purpose of making monetary changes to a high number of those claims. If, however, contractors do **not** have special software to perform high volume adjustments (i.e., typically adjustments to 100 or more claims), but instead must perform their high volume adjustments manually, this action also fulfills the definition of a 'mass adjustment.'

Effective with July 2, 2007, the Common Working File (CWF) maintainer shall create a new field for a one (1)-byte mass adjustment indicator within the HUBC, HUDC, HUIP, HUOP, HUHH, and HUHC claims transactions. The valid values for the newly created field shall be 'M'—mass adjustment claim-Medicare Physician Fee Schedule (MPFS) and 'O'—mass adjustment claim-other. Further, effective with July 2007, the Coordination of Benefits Contractor (COBC) shall send the CWF host sites a modified Coordination of Benefits Agreement Insurance File (COIF) that contains two new claims exclusion categories: mass adjustments-MPFS and mass adjustments-other. The CWF shall accept and process the revised COIF and exclude HUBC, HUDC, HUIP, HUOP, HUHH, and HUHC claims that are designated as mass adjustments-MPFS or mass adjustments-other in accordance with the specifications on the COIF.

Through this instruction, all contractors and their systems shall internally classify all mass adjustment crossover claims as either 'mass adjustment claim-MPFS' or 'mass adjustment claim-other' and shall include either an 'M' (mass adjustment claim-MPFS) or 'O' (mass adjustment claim-other) indicator within the header of the HUBC, HUDC, HUIP, HUOP, HUHH, or HUHC claims transactions that they send to CWF for verification and validation. Contractors shall determine whether the 'M' or 'O' indicator applies at the point that they initiate a mass adjustment action through non-manual means.

In instances when CWF returns error code 5600 to a contractor, thereby causing it to reset the claim's entry code to '5' or action code to '3,' the contractor shall set a newly developed 'N' non-adjustment claim indicator ('treat as an original claim for crossover purposes') in the header of the HUBC, HUDC, HUIP, HUOP, HUHH, and HUHC claim in the newly defined field before retransmitting the claim to CWF. To accommodate this change, the CWF maintainer shall create a new header field within its HUBC, HUDC, HUIP, HUOP, HUHH, and HUHC claims transactions for a new 1-byte adjustment indicator (valid values='N'—non adjustment claim; 'A'—adjustment claim; or space). Upon receipt of a claim that contains entry code '5' or action code '3' with an 'N' claim adjustment indicator, the CWF shall treat the claim as if it was an original claim. If CWF determines that the claim meets all other inclusion criteria, it shall mark the claim with an 'A' ('selected to be crossed over') crossover disposition indicator. Upon receipt of a Beneficiary Other Insurance (BOI) reply trailer (29) for the recycled claim, the contractors' systems shall ensure that, as part of their 837 flat file creation processes, they populate the 2300 loop CLM05-3 ('Claim Frequency Type Code') segment with a value of '1' (original). In addition, the contractor systems shall ensure that, as part of their 837 flat file creation process, they do **not** create a corresponding 2330B loop REF*T4*Y segment, which typically signifies 'adjustment.'

In those situations where contractors must send adjustment claims to CWF as entry code '1'or as action code '1'(situations where an accrete claim cannot be processed at CWF), they shall set an 'A' indicator in a newly defined field within the header of the HUBC, HUDC, HUIP, HUOP, HUHH, or HUHC claim. Upon receipt of a claim that contains entry code '1' or action code '1' with an 'A' claim adjustment indicator, the CWF shall 1) check the COIF to determine whether the COBA trading partner wishes to exclude either adjustments, monetary or adjustments, non-monetary, or both, and 2) exclude the claim from COBA crossover if either of these claim types is, or both claim types are, to be excluded. In addition, the CWF maintainer shall create a new crossover disposition indicator 'Y' ("archived

adjustment claim-excluded") to accommodate this unique situation. If contractors receive a BOI reply trailer (29) on a claim that had an 'A' indicator set in its header, this means that CWF has determined that the COBA trading partner wishes to receive adjustment claims. Therefore, the contractors' systems shall ensure that, as part of their 837 flat file creation processes, they populate the 2300 loop CLM05-3 (Claim Frequency Type Code) segment with a value that designates 'adjustment' rather than 'original' to match the 2330B loop REF*T4*Y that they create to designate 'adjustment claim.' **NOTE:** If a contractor's system does **not** presently create a loop 2330B REF*T4*Y to designate adjustments, it shall not make a change to do so as part of this instruction.

CMS is directing its COB Contractor to make minor modifications to the COBC Detailed Error Report (including summary portion) to accommodate an expanded field length for the Internal Control Number (ICN)/Document Control Number (DCN), to remove the '111' percentage field, and to modify the file displacements for a few additional fields.

In an effort to reduce the number of customer service inquiries from providers or their billing agents, contractors shall, effective with this instruction, include the specific Claredi Health Insurance Portability and Accountability Act (HIPAA) rejection code along with description on the special provider notification letters they generate in accordance with CR 3709. Contractors shall advise their providers, via newsletters or other appropriate media, that they should contact their billing vendors/agents to obtain a better understanding of the error code and accompanying description, which, in turn, explains why their patients' claims were not successfully crossed over. .

Contractors shall now base their decision making calculus for initiation of a claims repair of '111' (flat file) errors upon the number of errors received. If a contractor receives even one (1) '111' error via the COBC Detailed Error Report, the contractor, working with its Data Center or shared system as necessary, shall immediately attempt a repair of the claims file. If the file cannot be repaired, only then shall the contractor issue its special provider letter/report, which shall now include a more specific message concerning the reason why the affected claim(s) was/were not crossed over.

## II. BUSINESS REQUIREMENTS TABLE

*"Shall" denotes a mandatory requirement*

| Number | Requirement | Responsibility (place an "X" in each applicable column) | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | DME MAC | FI | CARRIER | DMERC | RHHI | Shared-System Maintainers | | | | OTHER |
| | | | | | | | | FISS | MCS | VMS | CWF | |
| 5472.1 | All contractors and their systems shall develop a method for differentiating 'mass adjustments tied to the Medicare Physician Fee Schedule (MPFS) updates' and 'all other mass adjustments' from all other kinds of adjustments and non-adjustment claims. (**NOTE:** For appropriate classification, all adjustments that do **not** represent 'mass adjustments-MPFS' or 'mass | X | X | X | X | X | X | X | X | X | | |

| Number | Requirement | Responsibility (place an "X" in each applicable column) | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | DME MAC | FI | CARRIER | DMERC | RHHI | Shared-System Maintainers | | | | OTHER |
| | | | | | | | | FISS | MCS | VMS | CWF | |
| | adjustments-other' shall be regarded as 'other adjustments.') | | | | | | | | | | | |
| 5472.1.1 | For purposes of this instruction, a 'mass adjustment' refers to an action that a contractor undertakes using special software (e.g., Super-Op Events or Express Adjustments) to pull claims with the anticipated purpose of making monetary changes to a high number of those claims. | X | X | X | X | X | X | X | X | X | | |
| 5472.1.2 | If, however, contractors do not have special software to perform high volume adjustments (i.e., typically adjustments to 100 or more claims), but instead must perform their high volume adjustments manually, this action also fulfills the definition of a 'mass adjustment.' | X | X | X | X | X | X | X | X | X | | |
| 5472.1.3 | DMERCs/DME MACs and their shared system shall only be required to identify mass adjustments-other, which represents a current functionality available within VMS. (**NOTE:** This is because DMERCs/DME MACs do not use pricing from the MPFS when processing their claims.) | | X | | | X | | | | X | | |
| 5472. 2 | The CWF maintainer shall create a new header field within its HUBC, HUDC, HUIP, HUOP, HUHH, and HUHC claims transactions for a 1-byte mass adjustment indicator ('M' or 'O,' as described below). | | | | | | | | | | X | |
| 5472.2.1 | All contractor systems shall internally classify mass adjustment claims as either 'mass adjustment claim-MPFS' or 'mass adjustment claim-other.' | | | | | | | X | X | X | | |
| 5472.2.2 | Before contractors cable their claims | X | X | X | X | X | X | X | X | X | | |

| Number | Requirement | Responsibility (place an "X" in each applicable column) | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | DME MAC | FI | CARRIER | DME RC | RHHI | Shared-System Maintainers | | | | OTHER |
| | | | | | | | | FISS | MCS | VMS | CWF | |
| | to CWF for verification and validation, they shall populate a 1-byte 'mass adjustment' indicator in the header of their HUBC, HUDC, HUIP, HUOP, HUHH, or HUHC entry code '5' or action code '3'claim transactions. | | | | | | | | | | | |
| 5472.2.3 | Contractors shall determine whether the 'M' or 'O' indicator applies in relation to a given claim at the point that they initiate a mass adjustment action on that claim using a manual process or an automated adjustment process; e.g., Super Op Events or Express Adjustments. | X | X | X | X | X | X | | | | | |
| 5472.2.4 | Following their contractors' completion of requirement 5472.2.3, the contractors' systems shall populate one (1) of the following mass adjustment claim indicators, specific to the particular claim situation, within the header of their contractors' processed claims that they will cable to CWF for verification and validation:<br><br>'M'—if mass adjustment claim tied to an MPFS update; **or**<br>'O'—if mass adjustment claim-other. | | | | | | | X | X | X | | |
| 5472.3 | CMS and the COBC will modify the COIF to include two new claims exclusion options: mass adjustment claim-MPFS and mass adjustment claim-other (see Attachment A for revised COIF layout). | | | | | | | | | | | X<br>CMS and COBC |
| 5472.3.1 | Upon receipt of a claim that contains an 'M' indicator (new field) in the header of an HUBC, HUDC, HUIP, HUOP, HUHH, or HUHC claim, CWF shall read the COIF (Attachment A) to determine | | | | | | | | | | X | |

| Number | Requirement | Responsibility (place an "X" in each applicable column) | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | DME MAC | FI | CARRIER | DME RC | RHHI | Shared-System Maintainers | | | | OTHER |
| | | | | | | | | FISS | MCS | VMS | CWF | |
| | whether the COBA trading partner wishes to exclude the claim. | | | | | | | | | | | |
| 5472.3.2 | If CWF determines that the trading partner wishes to exclude the mass adjustment-MPFS claim, it shall exclude the claim from the COBA crossover process. | | | | | | | | | | X | |
| 5472.3.3 | In relation to its receipt of a claim that has an 'M' header value, the CWF shall create a new crossover disposition indicator 'W' ("mass adjustment claim-MPFS excluded") on the HIMR detailed history screens in association with excluded processed claims for 'production' COBA trading partners (see Attachment B). | | | | | | | | | | X | |
| 5472.3.3.1 | CWF shall display the new 'W' crossover disposition indicator in association with the processed mass adjustment claim-MPFS on the Health Insurance Master Record (HIMR) detailed history screen. | | | | | | | | | | X | |
| 5472.3.4 | Upon receipt of a claim that contains an 'O' indicator in the header of an HUBC, HUDC, HUIP, HUOP, HUHH, or HUHC claim, CWF shall read the COIF to determine whether the COBA trading partner wishes to exclude the claim. | | | | | | | | | | X | |
| 5472.3.4.1 | If CWF determines that the trading partner wishes to exclude the mass adjustment claim-other, it shall exclude the claim from the COBA crossover process. | | | | | | | | | | X | |
| 5472.3.5 | In relation to its receipt of a claim that has an 'O' header value, the CWF shall create a new crossover disposition indicator 'X' ("mass adjustments claim-other excluded") on the HIMR detailed history screens in association with excluded processed claims for 'production' | | | | | | | | | | X | |

| Number | Requirement | Responsibility (place an "X" in each applicable column) | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | DME MAC | FI | CARRIER | DME RC | RHHI | Shared-System Maintainers | | | | OTHER |
| | | | | | | | | FISS | MCS | VMS | CWF | |
| | COBA trading partners (see Attachment B). | | | | | | | | | | | |
| 5472.3.5.1 | The CWF shall display the new 'X' crossover disposition indicator in association with the processed mass adjustment claim-other on the Health Insurance Master Record (HIMR) detailed history screen. | | | | | | | | | | X | |
| 5472.3.5.2 | The CWF maintainer shall develop and display two new exclusion fields within the COBA Inquiry Screen (COBS) for 'mass adj.-M' (mass adjustments-MPFS) and 'mass adj.-O' (mass adjustments-other). | | | | | | | | | | X | |
| 5472.3.5.3 | The Next Generation Desktop application maintainer shall modify its specifications so that the new COBS claim exclusion categories ('mass adj-M' and 'mass adj.-O') and 'W' and 'X' crossover disposition indicators with accompanying descriptions will be displayed for contractor customer service purposes. | | | | | | | | | | | X NGD |
| 5472.3.5.4 | Contractors shall update their customer service applications, such as the MCS Desktop application (MCSDT), to ensure that the two newly developed claim exclusion categories and 'W' and 'X' crossover disposition indicators with accompanying descriptions will be appropriately captured and displayed for contractor customer service purposes. | X | X | X | X | X | X | | X | | | |
| 5472.3.5.5 | If contractors send values other than 'M' or 'O' within the newly designated field within the header of their HUBC, HUDC, HUIP, HUOP, HUHH, or HUHC entry code '5' or action code '3' claims, CWF shall apply an edit to reject the claims | | | | | | | | | | X | |

| Number | Requirement | Responsibility (place an "X" in each applicable column) | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | DME MAC | FI | CARRIER | DME RC | RHHI | Shared-System Maintainers | | | | OTHER |
| | | | | | | | | FISS | MCS | VMS | CWF | |
| | back to the contractor. | | | | | | | | | | | |
| 5472.3.5.6 | Upon receipt of the CWF rejection edit, the contractors' systems shall correct the invalid value and retransmit the claims to CWF for verification and validation. | | | | | | | X | X | X | | |
| 5472.4 | The CWF maintainer shall create a new header field within its HUBC, HUDC, HUIP, HUOP, HUHH, and HUHC claims transactions for a 1-byte adjustment claim indicator (valid values='N'-non-adjustment; 'A'-adjustment; or space). | | | | | | | | | | X | |
| 5472.4.1 | In instances when CWF returns error code 5600 to a contractor, thereby causing it to reset the claim's entry code to '5' or action code to '3,' the contractor shall set an 'N' (non-adjustment claim) indicator ('treat as an original claim for crossover purposes') in the header of the HUBC, HUDC, HUIP, HUOP, HUHH, and HUHC claim in the newly defined field before retransmitting the claim to CWF. | X | X | X | X | X | X | X | X | X | | |
| 5472.4.1.1 | The contractor's system shall then resend the claim to CWF. | X | X | X | X | X | X | X | X | X | | |
| 5472.4.2 | Upon receipt of a claim that contains entry code '5' or action code '3' with a non-adjustment claim header value of 'N,' the CWF shall treat the claim as if it were an 'original' claim (entry code '1' or action code '1') for crossover include or exclude determinations. | | | | | | | | | | X | |
| 5472.4.2.1 | If CWF determines that the claim meets all other inclusion criteria, it shall mark the claim with an 'A' ('selected to be crossed over') crossover disposition indicator. | | | | | | | | | | X | |
| 5472.4.3 | Upon receipt of a Beneficiary Other Insurance (BOI) reply trailer (29) | | | | | | | X | X | X | | |

| Number | Requirement | Responsibility (place an "X" in each applicable column) | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | DME MAC | FI | CARRIER | DME RC | RHHI | Shared-System Maintainers | | | | OTHER |
| | | | | | | | | FISS | MCS | VMS | CWF | |
| | for the recycled claim, the contractors' systems shall ensure that, as part of their 837 flat file creation processes, they populate the 2300 loop CLM05-3 (Claim Frequency Type Code) segment with a value of '1' (original). | | | | | | | | | | | |
| 5472.4.4 | In addition, the contractors' systems shall ensure that, as part of their 837 flat file creation process, they do not create a corresponding 2330B loop REF*T4*Y segment, which typically signifies 'adjustment.' | | | | | | | X | X | X | | |
| 5472.5 | In instances where contractors must send adjustment claims to CWF as entry code '1' or as action code '1' (situations where an accrete claim cannot be processed at CWF), they shall set an 'A' indicator ('treat claim as adjustment for crossover purposes') in a newly defined field within the header of the HUBC, HUDC, HUIP, HUOP, HUHH, or HUHC claim. | X | X | X | X | X | X | X | X | X | | |
| 5472.5.1 | Upon receipt of a claim that contains entry code '1' or action code '1'with an 'A' claim adjustment indicator, the CWF shall take the following initial action:<br>• Verify that, as per the COIF, the COBA trading partner wishes to exclude either adjustments, monetary or adjustments, non-monetary, or both.<br>(NOTE: The expectation is that such claims do not represent mass adjustments tied to the MPFS or mass adjustments-other.) | | | | | | | | | | X | |
| 5472.5.1.1 | In addition, if CWF determines that the COBA trading partner wishes to | | | | | | | | | | X | |

| Number | Requirement | Responsibility (place an "X" in each applicable column) | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | DME MAC | FI | CARRIER | DME RC | RHHI | Shared-System Maintainers | | | | OTHER |
| | | | | | | | | FISS | MCS | VMS | CWF | |
| | exclude either adjustments, monetary or adjustments, non-monetary, or both, it shall exclude the claim from the crossover process. | | | | | | | | | | | |
| 5472.5.2 | For purposes of requirements 5472.5.1 and 5472.5.1.1, CWF shall 1) assume that the 'original' claim that was purged from CWF's online history was crossed over, and 2) bypass to its logic for crossover disposition indicator 'R' (cross the adjustment claim only if the original claim was crossed). | | | | | | | | | | X | |
| 5472.5.3 | If contractors receive a BOI reply trailer (29) on a claim that had an 'A' indicator set in its header, the contractors' systems shall ensure that, as part of their 837 flat file creation processes, they populate the 2300 loop CLM05-3 ('Claim Frequency Type Code') segment with a compliant value that designates 'adjustment' rather than 'original' to match the 2330B loop REF*T4*Y that they create to designate 'adjustment claim.' | | | | | | | X | X | X | | |
| 5472.5.3.1 | If a contractor's system does not presently create a loop 2330B REF*T4*Y to designate adjustments, it shall not make a change to do so as part of this instruction. | | | | | | | X | X | X | | |
| 5472.5.4 | In relation to its receipt of a claim that has an 'A' header value, the CWF shall create a new crossover disposition indicator 'Y' ("archived adjustment claim-excluded") on the HIMR detailed history screens in association with excluded processed claims for 'production' COBA | | | | | | | | | | X | |

| Number | Requirement | Responsibility (place an "X" in each applicable column) | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | DME MAC | FI | CARRIER | DME RC | RHHI | Shared-System Maintainers | | | | OTHER |
| | | | | | | | | FISS | MCS | VMS | CWF | |
| | trading partners (see Attachment B). | | | | | | | | | | | |
| 5472.5.5 | The CWF shall display the new 'Y' crossover disposition indicator in association with the processed claim on the Health Insurance Master Record (HIMR) detailed history screen. | | | | | | | | | | X | |
| 5472.5.6 | The Next Generation Desktop application maintainer shall modify its specifications so that the newly developed 'Y' crossover disposition indicator with its accompanying descriptions will be displayed for contractor customer service purposes. | | | | | | | | | | | X<br>NGD |
| 5472.5.7 | Contractors shall update their customer service applications, such as the MCS Desktop application (MCSDT), to ensure that the newly developed 'Y' crossover disposition indicator with its accompanying description will be appropriately captured and displayed for contractor customer service purposes. | X | X | X | X | X | X | | X | | | |
| 5472.5.8 | If contractors send an adjustment indicator value other than 'N,' 'A,' or space within the newly designated field within the header of their HUBC, HUDC, HUIP, HUOP, HUHH, or HUHC claims, CWF shall apply an edit to reject the claims back to the contractor. | | | | | | | | | | X | |
| 5472.5.9 | Upon receipt of the CWF rejection edit, the contractors' systems shall correct the invalid value and retransmit the claims to CWF for verification and validation. | | | | | | | X | X | X | | |
| 5472.6 | The CMS and the COBC will modify the COBC Detailed Error Reports for the purpose of | | | | | | | | | | | X<br>CMS and COBC |

| Number | Requirement | Responsibility (place an "X" in each applicable column) | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | DME MAC | FI | CARRIER | DME RC | RHHI | Shared-System Maintainers | | | | OTHER |
| | | | | | | | | FISS | MCS | VMS | CWF | |
| | accommodating an extended length (up to 23 bytes) Internal Control Number (ICN)/Document Control Number (DCN), eliminating the '111' percentage field, and further modifying the file displacements for various fields. (See Attachment C for specific changes.) | | | | | | | | | | | |
| 5472.6.1 | The contractor systems shall be modified to accept the revised COBC Detailed Error Report layouts as depicted in Attachment C, including changes for the ICN/DCN, elimination of '111' error percentages, and other file displacement changes. | | | | | | | X | X | X | | |
| 5472.7 | Contractors and their systems shall no longer assume an implied decimal for purposes of determining whether claims that received '222' or '333' errors have met or exceeded the four (4) percent parameter established within CR 4277. | X | X | X | X | X | X | X | X | X | | |
| 5472.7.1 | Contractors and their systems shall now base their decision making calculus for initiation of a claims repair of '111' (flat file) errors upon the number of errors received rather than upon an established percent parameter, as specified in CR 4277. | X | X | X | X | X | X | X | X | X | | |
| 5472.7.2 | If a contractor receives even one (1) '111' error via the COBC Detailed Error Report, the contractor, working with its Data Center or shared system as necessary, shall immediately attempt a repair of the claims file, in accordance with all other requirements communicated via CR 4277. | X | X | X | X | X | X | X | X | X | | |
| 5472.7.3 | If the contractor, its Data Center, or shared system, determines that a | X | X | X | X | X | X | | | | | |

| Number | Requirement | Responsibility (place an "X" in each applicable column) | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | DME MAC | FI | CARRIER | DME RC | RHHI | Shared-System Maintainers | | | | OTHER |
| | | | | | | | | FISS | MCS | VMS | CWF | |
| | claim flat file containing (a) '111' error(s) cannot be repaired, the contractor shall then issue its special provider letter/report, with the modifications specified below in requirement 5472.7.5 | | | | | | | | | | | |
| 5472.7.4 | Contractor systems shall ensure that their contractors' special provider letters/reports, which are generated for '222' and '333' error rejections in accordance with CR 4277, now include the following additional elements, as derived from the COBC Detailed Error Report: 1) Claredi HIPAA rejection code or other rejection code, and 2) the rejection code's accompanying description. | X | X | X | X | X | X | X | X | X | | |
| 5472.7.4.1 | Contractors shall advise their providers, via newsletters or other appropriate media, that they may wish to contact their billing vendors/agents to obtain a better understanding of the error code and accompanying description, which, in turn, explains why their patients' claims were not successfully crossed over. | X | X | X | X | X | X | | | | | |
| 5472.7.4.2 | Contractors shall advise their providers that they shall always inform their billing vendors/agents when they receive special provider notification letters/reports that state why their patients' claims were not crossed over. | X | X | X | X | X | X | | | | | |
| 5472..7.5 | Contractors and their systems shall ensure that their contractors' special provider letters/reports generated for '111' errors contain the following generic message: "Claim was not crossed over because the file in | X | X | X | X | X | X | X | X | X | | |

| Number | Requirement | Responsibility (place an "X" in each applicable column) | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | DME MAC | FI | CARRIER | DMERC | RHHI | Shared-System Maintainers | | | | OTHER |
| | | | | | | | | FISS | MCS | VMS | CWF | |
| | which the claim was contained could not be successfully transmitted from the Medicare contractor to CMS' crossover contractor." | | | | | | | | | | | |
| 5472.7.6 | Contractors and their systems shall ensure that their special provider notification letters/reports are properly formatted and contain all necessary data elements, including the two (2) new elements described in requirement 6 for '222' and '333' error situations, as well as the newly developed language unique to '111' error situations as described in requirement 7.5. | X | X | X | X | X | X | X | X | X | | |
| 5472.8 | If a DMERC/DME MAC contractor sends CWF a value other than 'P' within the designated HUDC header field to identify National Council for Prescription Drug Programs (NCPDP) claims, the CWF shall apply an edit to reject the claims back to the contractor. | | | | | | | | | | X | |
| 5472.8.1 | Upon receipt of the CWF rejection edit, the DMERC/ DME MAC contractor's system shall correct the invalid value and retransmit the claims to CWF for verification and validation. | | X | | | X | | | | X | | |

## III. PROVIDER EDUCATION TABLE

| Number | Requirement | Responsibility (place an "X" in each applicable column) | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | DME MAC | FI | CARRIER | DMERC | RHHI | Shared-System Maintainers | | | | OTHER |
| | | | | | | | | FISS | MCS | VMS | CWF | |
| 5472.9 | A provider education article related | X | X | X | X | X | X | | | | | |

| Number | Requirement | Responsibility (place an "X" in each applicable column) | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | DME MAC | FI | CARRIER | DME RC | RHHI | Shared-System Maintainers | | | | OTHER |
| | | | | | | | | FISS | MCS | VMS | CWF | |
| | to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv.<br>Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin.<br>Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly. | | | | | | | | | | | |

## IV. SUPPORTING INFORMATION

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

| X-Ref Requirement Number | Recommendations or other supporting information: |
|---|---|
| 5472.3.3 | ATTACHMENT A |
| 5472.3.5 & 3.7 | ATTACHMENT B |
| 5472.6 & 5472.6.1 | ATTACHMENT C |

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

## V. CONTACTS

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

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

## VI. FUNDING

**A.** ***For TITLE XVIII Contractors*****:**
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY **2007** operating budgets.

**B.** ***For Medicare Administrative Contractors (MAC*****):**

The contractor is hereby advised that this constitutes technical direction as defined in your contract. We do not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

**COBA INSURANCE FILE**

# ATTACHMENT A

| Field | Start | Length | End | Description |
|---|---|---|---|---|
| COBA ID | 1 | 10 | 10 | Unique identifier for each COB Agreement |
| COBA TIN | 11 | 9 | 19 | Tax Identification Number of COBA |
| COBA Name | 20 | 32 | 51 | Name of COBA Partner (Equivalent to Insurer Name on BOI Auxiliary File) |
| COBA Address 1 | 52 | 40 | 91 | Address 1 of COBA |
| COBA Address 2 | 92 | 40 | 131 | Address 2 of COBA |
| COBA City | 132 | 25 | 156 | Address city of COBA |
| COBA State | 157 | 2 | 158 | Postal State Abbreviation of COBA |
| COBA Zip | 159 | 9 | 167 | Zip plus 4 of COBA |
| **Common Claim Exclusions** | | | | **The following fields are 1 byte indicators dictating type of claim exclusions. A value of 'Y' in any of the following fields indicates those types of claims should be excluded.** |
| Non-assigned | 168 | 1 | 168 | Non-assigned claims |
| Orig. Claims Paid at 100% | 169 | 1 | 169 | Original claims paid at 100% |
| Orig. Claims Paid at >100% of the submitted.charges w/out deductible or co-ins. | 170 | 1 | 170 | Original claims paid at greater than 100% of the submitted charges without deductible or coinsurance remaining ***(NOTE:*** *Also covers the exclusion of ambulatory surgical center claims, even if deductible or co-insurance applies.)* |
| 100% Denied Claims, No Additional Liability | 171 | 1 | 171 | 100% denied claims, with no additional beneficiary liability |
| 100% Denied Claims, Additional Liability | 172 | 1 | 172 | 100% denied claims, with additional beneficiary liability |
| Adjustment Claims, Monetary | 173 | 1 | 173 | Adjustments, monetary claims |
| Adjustment Claims, Non-Monetary/Statistical | 174 | 1 | 174 | Adjustments, non-monetary/statistical claims |
| MSP Claims | 175 | 1 | 175 | Medicare Secondary Payer (MSP) claims. |
| Other Insurance | 176 | 1 | 176 | Claims if other insurance (such as Medigap, supplemental, TRICARE, or other) exists for beneficiary. **Applies to State Medicaid Agencies only.** |
| NCPDP Claims | 177 | 1 | 177 | National Council Prescription Drug Program Claims |
| Adjustment Claims Paid at 100% | 178 | 1 | 178 | Adjustment claims paid at 100%. |
| Adjustment Claims, 100% Denied, No Additional Liability | 179 | 1 | 179 | Adjustment Claims, 100% Denied, with no additional beneficiary liability |
| Adjustment Claims, 100% Denied, Additional Liability | 180 | 1 | 180 | Adjustment Claims, 100% Denied, with additional beneficiary liability |
| MSP Cost-Avoided Claims | 181 | 1 | 181 | MSP claims that have been cost-avoided. |
| *Mass Adjustment Claim-MPFS* | *182* | *1* | *182* | *Mass adjustment claim tied to Medicare Physician Fee Schedule (MPFS) updates.* |
| *Mass Adjustment Claim-Other* | *183* | *1* | 183 | *Mass adjustment claim-all other reasons besides MPFS updates.* |
| Filler | *184* | *4* | 187 | Future |
| Hospital Inpatient A | 188 | 1 | 188 | TOB 11 - Hospital: Inpatient Part A |
| Hospital Inpatient B | 189 | 1 | 189 | TOB 12 - Hospital: Inpatient Part B |
| Hospital Outpatient | 190 | 1 | 190 | TOB 13 - Hospital: Outpatient |
| Hospital Other B | 191 | 1 | 191 | TOB 14 - Hospital: Other Part B (Non-patient) |
| Hospital Swing | 192 | 1 | 192 | TOB 18 - Hospital: Swing Bed |
| SNF Inpatient A | 193 | 1 | 193 | TOB 21 - Skilled Nursing Facility: Inpatient Part A |
| SNF Inpatient B | 194 | 1 | 194 | TOB 22 - Skilled Nursing Facility: Inpatient Part B |
| SNF Outpatient | 195 | 1 | 195 | TOB 23 - Skilled Nursing Facility: Outpatient |
| SNF Other B | 196 | 1 | 196 | TOB 24 - Skilled Nursing Facility: Other Part B (Non-patient) |
| SNF Swing Bed | 197 | 1 | 197 | TOB 28 - Skilled Nursing Facility: Swing Bed |

| | | | | |
|---|---|---|---|---|
| Home Health B | 198 | 1 | 198 | TOB 32 - Home Health: Part B Trust Fund |
| Home Health A | 199 | 1 | 199 | TOB 33 - Home Health: Part A Trust Fund |
| Home Health Outpatient | 200 | 1 | 200 | TOB 34 - Home Health: Outpatient |
| Religious Non-Med Hospital | 201 | 1 | 201 | TOB 41 - Christian Science/Religious Non-Medical Services (Hospital) |
| Clinic Rural Health | 202 | 1 | 202 | TOB 71 - Clinic: Rural Health |
| Clinic Freestanding Dialysis | 203 | 1 | 203 | TOB 72 - Clinic: Freestanding Dialysis |
| Clinic Fed Health Center | 204 | 1 | 204 | TOB 73 - Clinic: Federally Qualified Health Center |
| Clinic Outpatient Rehab | 205 | 1 | 205 | TOB 74 - Clinic: Outpatient Rehabilitation Facility |
| Clinic CORF | 206 | 1 | 206 | TOB 75 - Clinic: Comprehensive Outpatient Rehabilitation Facility (CORF) |
| Clinic Comp Mental Health | 207 | 1 | 207 | TOB 76 - Clinic: Comprehensive Mental Health Clinic |
| Clinic Other | 208 | 1 | 208 | TOB 79 - Clinic: Other |
| SF Hospice Non-Hospital | 209 | 1 | 209 | TOB 81 - Special Facility: Hospice Non-Hospital |
| SF Hospice Hospital | 210 | 1 | 210 | TOB 82 - Special Facility: Hospice Special Facility: Hospice Hospital |
| Ambulatory Surgical Center | 211 | 1 | 211 | TOB 83 - Special Facility: Ambulatory Surgical Center |
| Primary Care Hospital | 212 | 1 | 212 | TOB 85 - Primary Care Hospital |
| **Claim Header Level Exclusions** | | | | **The following fields are 1 byte indicators dictating type of claim exclusions. A value of 'Y' in any of the following fields indicates those types of claims should be excluded.** |
| All Part A Claims | 213 | 1 | 213 | Claims identified as Part A in the HUIP, HUOP, HUHH, and HUHC queries to CWF. |
| All Part B Claims | 214 | 1 | 214 | Claims identified as Part B in the HUBC query to CWF. |
| All DMERC Claims | 215 | 1 | 215 | Claims identified as DMERC in the HUDC query to CWF. |
| Filler | 216 | 7 | 222 | Filler |
| **Part A/RHHI Provider Inclusion/Exclusion** | | | | **Part A/RHHI claims may be included or excluded by providers by specifying the Inclusion/Exclusion type. Inclusion or exclusion may be limited by either provider ID or provider state.** |
| Inclusion/Exclusion Type | 223 | 1 | 223 | Indicates whether providers are to be included or excluded (I - Inclusion or E - Exclusion) |
| Provider Qualifier | 224 | 1 | 224 | Indicates whether providers are identified by state or by provider ID (P - Provider number or S - Provider state) |
| Provider ID (P) | 225 | 650 | 874 | Specific providers IDs to be included or excluded (occurs 50 times--13-digit alpha/numeric provider number. |
| Provider State (S) | 875 | 100 | 974 | Specific provider states to be included or excluded (occurs 50 times—2-digit provider state code) |
| 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 *fully* paid *without deductible or co-insurance remaining* excluded. |
| E | Original Medicare claims paid at greater than 100% of the submitted charges without deductible or co-insurance remaining excluded. ***Also covers the exclusion of Original Medicare claims paid at greater than 100% of the submitted charges for Part B ambulatory surgical center (ASC) claims, even if deductible or co-insurance applies.* |
| F | 100% denied claims, with no additional beneficiary liability excluded. |
| G | 100% denied claims, with additional beneficiary liability excluded. |
| H | Adjustment claims, monetary, excluded *(represents non-mass adjustment claims)* |
| I | Adjustment claims, non-monetary/statistical, excluded *(represents non-mass adjustment claims)* |
| J | MSP claims excluded |
| K | This Claim contains a provider identification number (ID) or provider state that is excluded by the COBA trading partner. |
| L | Claims from this Contractor ID excluded |
| M | The beneficiary has other insurance (such as Medigap, supplemental, TRICARE, or other) that pays before Medicaid. Claim excluded by Medicaid. |
| N | NCPDP claims excluded. |
| O | All Part A claims excluded. |
| P | All Part B claims excluded. |
| Q | All DMERC claims excluded. |
| R | Adjustment claim excluded because original claim was not crossed over. |
| S | Adjustment Claims *Fully* Paid *without deductible and co-insurance remaining* excluded. |
| T | Adjustments Claims, 100% Denied, with no additional beneficiary liability excluded. |
| U | Adjustment Claims, 100% Denied, with additional beneficiary liability excluded. |

| | |
|---|---|
| V | MSP cost-avoided claims excluded. |
| *W* | *Mass Adjustment Claims-Medicare Physician Fee Schedule (MPFS) update excluded.* |
| *X* | *Mass Adjustment Claims-Other excluded.* |
| *Y* | *Archived adjustment claim excluded* |

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.

`

**ATTACHMENT C**

# COBC Detailed Error Report
# Institutional Error File Layout
## (Detail Record)

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

## Institutional Error File Layout – (Summary Record)

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

# COBC Detailed Error Report
# Professional Error File Layout
## (Detail Record)

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

## Professional Error File Layout – (Summary Record)

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

# COBC Detailed Error Report
# NCPDP Error File Layout
## (Detail Record)

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

## NCPDP Error File Layout – (Summary Record)

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

# Medicare Claims Processing Manual

## Chapter 27 - Contractor Instructions for CWF

**Table of Contents**
***(Rev. 1189, 02-28-07)***

## 80.15 - Claims Crossover Disposition Indicators

***(Rev.1189, Issued: 02-28-07, Effective: 07-01-07, Implementation: 07-02-07)***

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

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

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

Effective with October 2006, the CWF maintainer shall update its data elements/documentation to capture the revised descriptor for crossover disposition indicators 'E,' as reflected below. In addition, the CWF maintainer shall update its data elements/documentation to capture the newly added 'R,' 'S,' 'T,' 'U,' and 'V' crossover disposition indicators, as reflected in the Claims Crossover Disposition Indicators *table* below.

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

| **Claims Crossover Disposition Indicator** | **Definition/Description** |
|---|---|
| A | This claim was selected to be crossed over. |
| B | This Type of Bill (TOB) excluded. |
| C | Non-assigned claim excluded. |
| D | Original *Fully Paid* Medicare claims *without deductible and co-insurance remaining* excluded. |

| | |
|---|---|
| E | Original Medicare claims paid at greater than 100% of the submitted charges without deductible or co-insurance remaining excluded *(Part A).*<br>***Also covers the exclusion of Original Medicare claims paid at greater than 100% of the submitted charges excluded for Part B ambulatory surgical center (ASC) claims, even if deductible or co-insurance applies.* |
| F | 100% denied claims, with no additional beneficiary liability excluded. |
| G | 100% denied claims, with additional beneficiary liability excluded. |
| H | Adjustment claims, monetary, excluded *(not representative of mass adjustments).* |
| I | Adjustment claims, non-monetary/statistical, excluded *(not representative of mass adjustments).* |
| J | MSP claims excluded. |
| K | This claim contains a provider identification number (ID) or provider state that is excluded by the COBA trading partner. |
| L | Claims from this Contractor ID excluded. |
| M | The beneficiary has other insurance (such as Medigap, supplemental, TRICARE, or other) that pays before Medicaid. Claim excluded by Medicaid. |
| N | NCPDP claims excluded. |
| O | All Part A claims excluded. |
| P | All Part B claims excluded. |
| Q | All DMERC claims excluded. |
| R | Adjustment claim excluded because original claim was not crossed over. |
| S | Adjustment *fully paid claims with no deductible or* |

| | |
|---|---|
| | *co-Insurance remaining* excluded. |
| T | Adjustment Claims, 100% Denied, with no additional beneficiary liability excluded. |
| U | Adjustment Claims, 100% Denied, with additional beneficiary liability excluded. |
| V | MSP cost-avoided claims excluded. |
| *W* | *Mass Adjustment Claims—Medicare Physician Fee Schedule (MPFS) excluded.* |
| *X* | *Mass Adjustment Claims—Other excluded.* |
| *Y* | *Archived adjustment claim excluded.* |

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

***80.16- Special Mass Adjustment and Other Adjustment Crossover Requirements***

***(Rev.1189, Issued: 02-28-07, Effective: 07-01-07, Implementation: 07-02-07)***

***1. Developing a Capability to Exclude Mass Adjustment Claims Tied to the Medicare Physician Fee Schedule Updates and Mass Adjustment Claims-Other***

*Effective with July 2, 2007, the Common Working File (CWF) maintainer shall create a new header field for a one (1)-byte mass adjustment indicator within its HUBC, HUDC, HUOP, HUHH, and HUHC claims transactions. The valid values for the newly created field shall be 'M'—mass adjustment claim-Medicare Physician Fee Schedule (MPFS) and 'O'—mass adjustment claim-other. Further, effective with that date, the Coordination of Benefits Contractor shall send the CWF host sites a modified Coordination of Benefits Agreement Insurance File (COIF) that contains two new claims exclusion categories: mass adjustments-MPFS and mass adjustments-other.*

*Upon receipt of a claim that contains an 'M' indicator (new field) in the header of an HUBC, HUDC, HUIP, HUOP, HUHH, or HUHC claim, CWF shall read the COIF to determine whether the COBA trading partner wishes to exclude the claim. If CWF determines that the trading partner wishes to exclude the mass adjustment-MPFS claim, it shall exclude the claim from the COBA crossover process.*

*Upon receipt of a claim that contains an 'O' indicator in the header of an HUBC, HUDC, HUIP, HUOP, HUHH, or HUHC claim, which designates 'mass adjustment claim-other,' the CWF shall read the COIF to determine whether the COBA trading partner wishes to exclude the claim. If CWF determines that the trading partner wishes to exclude mass adjustment claims-other, it shall exclude the claim from the COBA crossover process.*

**Creation of New Crossover Disposition Indicators**

*In relation to its receipt of a claim that has either an 'M' or an 'O' header value, the CWF shall create two new crossover disposition indicators 'W' ("mass adjustment claim-MPFS) and 'X' ("mass adjustments claim-other excluded") on the Health Insurance Master Record (HIMR) detailed history screens in association with excluded processed claims for 'production' COBA trading partner. The CWF shall display each of the new crossover disposition indicators appropriately in association with the processed mass adjustment claim-MPFS on the HIMR detailed history screen. (See §80.15 of this chapter for further information.) In addition, the CWF maintainer shall develop and display two (2) new exclusion fields within the COBA Inquiry Screen (COBS) for 'mass adj.-M' (mass adjustments-MPFS) and 'mass adj.-O' (mass adjustments-other).*

***2. Developing a Capability to Treat Entry Code '5' and Action Code '3' Claims As t Recycled 'Original' Claims For Crossover Purposes***

*Effective with July 2007, the CWF maintainer shall create a new header field within its HUBC, HUDC, HUIP, HUOP, HUHH, and HUHC claims transactions for a 1-byte -*

*adjustment indicator (valid values='N'--non adjustment claim for crossover purposes; 'A'--adjustment claim for crossover purposes; or space).*

*In instances when CWF returns an error code 5600 to a contractor, thereby causing it to reset the claim's entry code to '5' to action code to '3,' the contractor shall set a newly developed 'N' non-adjustment claim indicator ('treat as an original claim for crossover purposes') in the header of the HUBC, HUDC, HUIP, HUOP, HUHH, HUIP, HUOP, HUHH, and HUHC claim in the newly defined field before retransmitting the claim to CWF. The contractor's system shall then resend the claim to CWF.*

*Upon receipt of a claim that contains entry code '5' or action code '3' with a non-adjustment claim header value of 'N,' the CWF shall treat the claim as if it were an 'original' claim (i.e., as entry code '1' or action code '1') for crossover inclusion or exclusion determinations. If CWF subsequently determines that the claim meets all other inclusion criteria, it shall mark the claim with an 'A' ("claim was selected to be crossed over") crossover disposition indicator.*

**Additional Contractor Requirements Following Receipt of a CWF Beneficiary Other Insurance (BOI) Reply Trailer 29 for Such Claims**

*Upon receipt of a Beneficiary Other Insurance (BOI) reply trailer (29) for the recycled claim, the contractors' systems shall ensure that, as part of their 837 flat file creation processes, they populate the 2300 loop CLM05-3 (Claim Frequency Type Code) segment with a value of '1' (original). In addition, the contractors' systems shall ensure that, as part of their 837 flat file creation process, they do not create a corresponding 2330 loop REF*T4*Y segment, which typically signifies 'adjustment.'*

***3. Developing a Capability to Treat Claims with Non-Adjustment Entry or Action Codes as Adjustment Claims For Crossover Purposes***

*In instances where contractors must send adjustment claims to CWF as entry code '1' or action code '1' (situations where the accrete claim cannot be processed at CWF), they shall set an 'A' indicator in a newly defined field within the header of the HUBC, HUDC, HUIP, HUOP, HUHH, or HUHC claim.*

*Upon receipt of a claim that contains entry code '1' or action code '1' with a claim adjustment indicator value of 'A,' the CWF shall take the following actions:*

- *Verify that, as per the COIF, the COBA trading partner wishes to exclude **either** adjustments, monetary or adjustments, non-monetary, **or both**; and*
- *Suppress the claim from crossover if the COBA trading partner wishes to exclude either adjustments, monetary or adjustments, non-monetary, or both.*

*(**NOTE:** The expectation is that such claims do **not** represent mass adjustments tied to the MPFS or mass adjustments-other.)*

***ByPassing of Logic to Exclude Adjustment Claim if Original Claim was Not Crossed Over***

*For purposes of excluding entry code '1' or action code '1' claims that contain an 'A' adjustment indicator value, CWF shall 1) assume that the 'original' claim that was purged from its online history was crossed over, and 2) bypass its logic for crossover disposition indicator 'R' (cross the adjustment claim over only if the original claim was previously crossed over). Refer to §80.14 of this chapter for further details regarding this logic.*

**Actions to Take When Contractors Send Invalid Values**

*If contractors claim adjustment indicator values other than 'N,' 'A,' or space within the newly designated header field within their HUBC, HUDC, HUIP, HUOP, HUHH, and HUHC claims, CWF shall apply an edit to reject the claim back to the contractor. Upon receipt of the CWF rejection edit, the contractors' systems shall correct the invalid value and retransmit the claim to CWF for verification and validation.*

**Creation of a New Crossover Disposition Indicator For This Scenario**

*In relation to its receipt of a claim that has an 'A' header value, the CWF shall create a new crossover disposition indicator 'Y' ("archived adjustment claim-excluded") on the HIMR detailed history screens in association with excluded processed claims for 'production' COBA trading partners. The CWF shall display the new 'Y' crossover disposition indicator in association with the processed mass adjustment claim-MPFS on the HIMR detailed history screen. (See §80.15 of this chapter for further information.)*

**Additional Contractor Requirements Following Receipt of a CWF Beneficiary Other Insurance (BOI) Reply Trailer 29**

*If contractors receive a BOI reply trailer (29) on a claim that had an 'A' indicator set in its header, the contractors' systems shall ensure that, as part of their 837 flat file creation processes, they populate the 2300 loop CLM05-3 ('Claim Frequency Type Code') segment with a value that designates 'adjustment' rather than 'original' to match the 2330B loop REF*T4*Y that they create to designate 'adjustment claim.'*

*If a contractor's system does not presently create a loop 2330B REF*T4*Y to designate adjustments, it shall not make a change to do so as part of this instruction.*

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

## 70.6 - Consolidation of the Claims Crossover Process

***(Rev.1189, Issued: 02-28-07, Effective: 07-01-07, Implementation: 07-02-07)***

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.

### *I. Contractor Actions Relating to CWF Claims Crossover Exclusion Logic*

#### *A. Determination of Beneficiary Liability for Claims with Denied Services*

Effective with the January 2005 release, the Part B and *Durable Medical Equipment Regional Carrier (*DMERC*)/DME Medicare Administrative Contractor (DME MAC)* contractor shared systems will be required to include an indicator "L" (beneficiary is liable for the denied service[s]) or "N" (beneficiary is not liable for the denied service[s]) in an available field on the HUBC and HUDC queries to CWF for claims on which all line items are denied. The liability indicators (L or N) will be at the header or claim level rather than at the line level.

For purposes of applying the liability indicator L or N at the header/claim level and, in turn, including such indicators in the HUBC or HUDC query to CWF, the Part B and DMERC*/DME MAC* contractor shared systems shall follow these business rules:

- The L or N indicators are not applied at the header/claim level if any service on the claim is payable by Medicare;
- The "L" indicator is applied at the header/claim level if the beneficiary is liable for any of the denied services on a fully denied claim; and
- The "N" indicator is applied at the header/claim level if the beneficiary is not liable for all of the denied services on a fully denied claim.

***B. Developing a Capability to Treat Entry Code '5' and Action Code '3' Claims As Recycled 'Original' Claims For Crossover Purposes***

*Effective with July 2007, in instances when CWF returns an error code 5600 to a contractor, thereby causing it to reset the claim's entry code to '5' to action code to '3,' the contractor shall set a newly developed 'N' ( non-adjustment) claim indicator ('treat as an original claim for crossover purposes') in the header of the HUBC, HUDC, HUIP, HUOP, HUHH, HUIP, HUOP, HUHH, and HUHC claim in the newly defined field before retransmitting the claim to CWF. The contractor's system shall then resend the claim to CWF.*

*Upon receipt of a claim that contains entry code '5' or action code '3' with a non-adjustment claim header value of 'N,' the CWF shall treat the claim as if it were an 'original' claim (i.e., as entry code '1' or action code '1') for crossover inclusion or exclusion determinations. If CWF subsequently determines that the claim meets all other inclusion criteria, it shall mark the claim with an 'A' ("claim was selected to be crossed over") crossover disposition indicator.*

*Following receipt of a Beneficiary Other Insurance (BOI) reply trailer (29) for the recycled claim, the contractors' systems shall ensure that, as part of their 837 flat file creation processes, they populate the 2300 loop CLM05-3 (Claim Frequency Type Code) segment with a value of '1' (original). In addition, the contractors' systems shall ensure that, as part of their 837 flat file creation process, they do not create a corresponding 2330 loop REF*T4*Y segment, which typically signifies 'adjustment.'*

***C. Developing a Capability to Treat Claims with Non-Adjustment Entry or Action Codes as Adjustment Claims For Crossover Purposes***

*Effective with July 2007, in instances where contractors must send adjustment claims to CWF as entry code '1' or as action code '1' (situations where an accrete claim cannot be processed at CWF), they shall set an 'A' indicator in a newly defined field within the header of the HUBC, HUDC, HUIP, HUOP, HUHH, or HUHC claim.*

*If contractors send a value other than 'A' or spaces within the newly designated header field within their HUBC, HUDC, HUIP, HUOP, HUHH, and HUHC claims, CWF shall apply an edit to reject the claim back to the contractor. Upon receipt of the CWF*

*rejection edit, the contractors' systems shall correct the invalid value and retransmit the claim to CWF for verification and validation.*

*Upon receipt of a claim that contains entry code '1' or action code '1' with a header value of 'A,' the CWF shall take the following actions:*

- *Verify that, as per the COIF, the COBA trading partner wishes to exclude **either** adjustments, monetary **or** adjustments, non-monetary, **or both**; and*
- *Suppress the claim if the COBA trading partner wishes to exclude **either** adjustments, monetary **or** adjustments, non-monetary, **or both**.*

*(**NOTE:** The expectation is that such claims do **not** represent mass adjustments tied to the MPFS or mass adjustments-other.)*

*If contractors receive a BOI reply trailer (29) on a claim that had an 'A' indicator set in its header, the contractors' systems shall ensure that, as part of their 837 flat file creation processes, they populate the 2300 loop CLM05-3 ('Claim Frequency Type Code') segment with a value that designates 'adjustment' rather than 'original' to match the 2330B loop REF*T4*Y that they create to designate 'adjustment claim.'*

*If a contractor's system does not presently create a loop 2330B REF*T4*Y to designate adjustments, it shall not make a change to do so as part of this instruction.*

***Correcting Invalid Claim Header Values Sent to CWF***

*If contractors send a value other than 'A,' 'N,' or spaces within the newly designated header field within their HUBC, HUDC, HUIP, HUOP, HUHH, and HUHC claims, CWF shall apply an edit to reject the claim back to the contractor. Upon receipt of the CWF rejection edit, the contractors' systems shall correct the invalid value and retransmit the claim to CWF for verification and validation.*

### *D. CWF Identification of National Council for Prescription Drug Claims*

Currently, the DMERC*/DME MAC* contractor shared system is able to identify, through the use of an internal indicator, whether a submitted claim is in the National Council for Prescription Drug Programs (NCPDP) format. Effective with January 2005, the DMERC*/DME MAC* contractor shared system shall pass an indicator "P" to CWF in an available field on the HUDC query when the claim is in the NCPDP format. The indicator "P" should be included in a field on the HUDC that is separate from the fields used to indicate whether a beneficiary is liable for all services that are completely denied on his/her claim.

The CWF shall read the new indicators passed via the HUBC or HUDC queries for purposes of excluding 100% denied claims with or without beneficiary liability and NCPDP claims. After applying the claims selection options, CWF will return a BOI reply trailer (29) to the Medicare contractor only in those instances when the COBA trading partner expects to receive a Medicare processed claim from the COBC.

*Effective with July 2007, CWF shall reject claims back to DMERCs/DME MACs if their HUDC claim contains a value other than 'P' in the established field used to identify NCPDP claims.*

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).

## *II. CWF Crossover Processes In Association with the Coordination of Benefits Contractor*

### A. CWF Processing of the COBA Insurance File (COIF) and Returning of BOI Reply Trailers

Effective July 6, 2004, the COBC will begin to send initial copies of the COBA Insurance File (COIF) to the nine CWF host sites. The COIF will contain specific information that will identify the COBA trading partner, including name, COBA ID, address, and tax identification number (TIN). It will also contain each trading partner's claims selection criteria along with an indicator (Y=Yes or N=No) of whether the trading partner wishes its name to be printed on the Medicare Summary Notice (MSN). Effective with the October 2004 systems release, the COIF will also contain a 1-digit Test/Production Indicator that will identify whether a COBA trading partner is in test (T) or production (P) mode. The CWF will be required to return that information as part of the BOI reply trailer (29) to Medicare contractors.

Upon receipt of a claim, CWF shall take the following actions:

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/ *DME MAC* contractors.)

In addition, the contractor shall send claims for which it receives BOI reply trailer to the COBC on the 837 v4010A1 flat file or National Council for Prescription Drug Programs (NCPDP) file.

When a COBA trading partner is in test mode, the contractor shall not change its current procedures regarding suppression of Medicaid claims when a beneficiary has non-Medigap and/or Medigap insurance. The contractor's Medicaid suppression logic should remain the same as with current existing trading partners, even when you receive a BOI reply trailer (29) that includes a Medicaid COBA ID.

Beginning with the October 2004 release, contractors shall follow these rules when they receive a BOI reply trailer (29) that contains Test/Production Indicator "P" and there is some other indication of crossover eligibility:

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.)

Effective with October 2, 2006, the contractors or their Data Centers shall transmit a combined COBA "test" and "production" 837 flat file and a combined "test" and "production" NCPDP file to the COBC. (NOTE: This requirement changes the direction previously provided in October 2005 through the issuance of Transmittal 586.)

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*/DME MAC* 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*/ DME MAC* contractors shall not cease their existing claim-based Medigap and/or Medicaid crossover processes. Part B

and DMERC*/DME MAC* 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.

## *III. Identification of Mass Adjustments for COBA Crossover Purposes*

*All contractors and their systems shall develop a method for differentiating 'mass adjustments tied to the Medicare Physician Fee Schedule (MPFS) updates' and 'all other mass adjustments' from all other kinds of adjustments and non-adjustment claims.*

*(**NOTE:** For appropriate classification, all adjustments that do not represent 'mass adjustments-MPFS' or 'mass adjustments-other' shall be regarded as 'other adjustments.') DMERCs/DME MACs and their shared system shall only be required to identify mass adjustments-other, which represents a current functionality available within VMS. This is because DMERCs/DME MACs do not use pricing from the MPFS when processing their claims.)*

### Working Definition of 'Mass Adjustment'

*For COBA crossover purposes, a 'mass adjustment' refers to an action that a contractor undertakes using special software (e.g., Super-Op Events or Express Adjustments) to pull claims with the anticipated purpose of making monetary changes to a high number of those claims. If, however, contractors do **not** have special software to perform high volume adjustments (i.e., typically adjustments to 100 or more claims), but instead must perform their high volume adjustments manually, this action also fulfills the definition of a 'mass adjustment.'*

### *Inputting a One-Byte Header Value on Claim Transactions to Designate Mass Adjustment and Associated Processes*

*Before contractors cable their claims to CWF for verification and validation, they shall populate a 1-byte 'mass adjustment' indicator in the header of their HUBC, HUDC, HUIP, HUOP, HUHH, or HUHC entry code '5' or action code '3'claim transactions. The CWF maintainer shall create a new 1-byte field within the header of its HUBC, HUDC, HUIP, HUOP, HUHH, or HUHC claims transactions for this purpose.*

*Contractors shall determine whether the 'M' or 'O' indicator applies in relation to a given claim at the point that they initiate a mass adjustment action on that claim using a manual process or an automated adjustment process; e.g., Super Op Events or Express Adjustments. Upon making this determination, the contractors and their shared systems shall populate one (1) of the following mass adjustment claim indicators, specific to the particular claim situation, within the header of the contractors' processed claims that they will cable to CWF for verification and validation:*

*'M'—if mass adjustment claim tied to an MPFS update; **or***

*‘O’—if mass adjustment claim-other.*

*If contractors send values other than ‘M’ or ‘O’ within the newly designated field within the header of their HUBC, HUDC, HUIP, HUOP, HUHH, or HUHC entry code ‘5’ or action code ‘3’ claims, CWF shall apply an edit to reject the claims back to the contractor. Upon receipt of the CWF rejection edit, the contractors’ systems shall correct the invalid value and retransmit the claims to CWF for verification and validation.*

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

***(Rev.1189, Issued: 02-28-07, Effective: 07-01-07, Implementation: 07-02-07)***

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

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

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

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

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

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

b. Julian date as YYDDD (5 bytes);

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

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

e. COBA Test/Production Indicator (1-byte alpha indicator; acceptable values=”T” [test] and “P” [production]);

The 22-digit CRI shall be left-justified in the BHT 03 segment of the 837 flat file, with spaces used for the remaining 8 positions. (**NOTE:** The CRI is unique inasmuch as no two files should ever contain the same combination of numbers.)

| **Data Center Name** | **Data Center Identification Number for BHT 03 Field** |
|---|---|
| AdminaStar Federal | 01 |
| Alabama (Cahaba) | 02 |
| Arkansas BCBS | 03 |
| CIGNA | 04 |
| EDS/MCDC2 (Plano) | 05 |
| EDS/MCDC2 (Sacramento) | 06 |
| Empire Medicare Services | 07 |
| Florida BCBS | 08 |
| Highmark | 09 |
| IBM/MCDC1 (Southbury, CT) | 10 |
| Info Crossing | 11 |
| Medicare Northwest/Regence of Oregon | 12 |
| Mutual of Omaha | 13 |
| South Carolina BCBS (Palmetto GBA) | 14 |
| TrailBlazer Health Enterprises | 15 |
| Veritus Medicare Services | 16 |

**2. NCPDP 22-Digit Unique Identifier**

The DMERC*/DME Medicare Administrative Contractor (DME MAC)* contractor system shall also adopt the unique 2*3*-digit format, referenced directly above under "Populating the BHT 03 Portion of the 837 Flat File." However, the system shall populate the unique 22-digit identifier in field 504-F4 (Message) within the NCPDP file (field length=35 bytes). The DMERC*/DME MAC* contractor system shall populate the new identifier, left justified, in the field. Spaces shall be used for the remaining bytes in the field.

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

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

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

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

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

## COBC Detailed Error Report

## Institutional Error File Layout

**(Detail Record)**

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

## Institutional Error File Layout – (Summary Record)

| | | | |
|---|---|---|---|
| **1.** | **Date** | **8** | **1-8** |
| **2.** | **Total Number of Claims** | | |
| | **For Processing Date** | **10** | **9-18** |
| **3.** | **Number of '111' Errors** | **10** | **19-28** |
| *4.* | **Number of '222' Errors** | **10** | *29-38* |
| *5.* | **Percentage of '222' Errors** | **3** | *39-41* |
| 6. | **Number of '333' Errors** | **10** | *42-51* |
| *7.* | **Percentage of '333' Errors** | **3** | *52-54* |
| *8.* | **Filler** | *19* | *55-73* |

| | | | |
|---|---|---|---|
| **9.** | **Summary Record Id (Error Source Code)** | **3** | *74-76 (‘999’)* |
| *10.* | **Filler** | *227* | *77-303* |

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

## COBC Detailed Error Report

## Professional Error File Layout

**(Detail Record)**

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

## Professional Error File Layout – (Summary Record)

| | | | |
|---|---|---|---|
| **1.** | **Date** | **8** | **1-8** |
| **2.** | **Total Number of Claims** | | |
| | **For Processing Date** | **10** | **9-18** |
| **3.** | **Number of ‘111’ Errors** | **10** | **19-28** |
| **4.** | **Number of ‘222’ Errors** | **10** | *29-38* |
| **5.** | **Percentage of ‘222’ Errors** | **3** | *39-41* |
| **6.** | **Number of ‘333’ Errors** | **10** | *42-51* |
| *7.* | **Percentage of ‘333’ Errors** | **3** | *52-54* |
| *8.* | **Filler** | *19* | *55-73* |
| **9.** | **Summary Record Id** | | |

| | | | |
|---|---|---|---|
| | **(Error Source Code)** | **3** | *74-76 (‘999’)* |
| *10.* | **Filler** | *227* | *77-303* |

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

## COBC Detailed Error Report

## NCPDP Error File Layout

**(Detail Record)**

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

## NCPDP Error File Layout – (Summary Record)

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

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

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

**1. Error Source Code**

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

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

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

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

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

**Special Automated Provider Correspondence**

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

1. Notify the physician, supplier, or provider via automated letter from your internal correspondence system that the claim did not cross over. The letter shall include specific claim information, not limited to, Internal Control Number (ICN)/Document Control Number (DCN), Health Insurance Claim (HIC) number, Medical Record Number (for Part A only), Patient Control Number (only if it is contained in the claim), beneficiary name, date of service, and the date claim was processed.

   *Effective with July 2007, contractors and their systems shall ensure that their contractors' special provider letters/reports, which are generated for '222' and '333' error rejections in accordance with CR 4277, now include the following additional elements, as derived from the COBC Detailed Error Report: 1) Claredi HIPAA rejection code or other rejection code, and 2) the rejection code's accompanying description.*

   *Contractors and their systems shall also ensure that their contractors' special provider letters/reports generated for '111' errors contain the following generic message: "Claim was not crossed over because the file in which the claim was contained could not be successfully transmitted from the Medicare contractor to CMS' crossover contractor."*

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

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

## 70.6.2 – Coordination of Benefits Agreement (COBA) Full Claim File Repair Process

***(Rev.1189, Issued: 02-28-07, Effective: 07-01-07, Implementation: 07-02-07)***

Effective with the July 2006 release, CMS will implement a full claim file repair process at its Medicare contractors to address situations where one or more of the contractor shared systems inadvertently introduced a severe error condition into the claims processing cycle, with the effect being that the Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X12-N 837 Coordination of Benefits (COB) Institutional and Professional crossover claims files or National Council for Prescription Drug Programs (NCPDP) claim files become unusable for COB purposes**.**

When a Medicare contractor, the COBC, or a COBA trading partner identifies a shared system problem that will prevent, or has prevented, the COBA trading partner from accepting a HIPAA ANSI X12-N 837 COB Institutional and Professional claims file from the COBC, the Medicare contractor shall work with its shared system maintainer to assess the feasibility of executing a full claim file repair. Contractors shall utilize the COBC Detailed Error Reports to determine the percentage of errors present for each error source code—"111" (flat file) errors, "222" (HIPAA ANSI X12-N 837 COB) errors, and "333" (trading partner dispute) errors. When the contractors or their shared system maintainers determine that the error percentages are at or above the parameters discussed later within this section, the contractors shall begin the process of analyzing the claim files for a possible full claim repair process. If the Medicare contractors and their shared systems subsequently initiate a full claim file repair process, that process shall be accomplished within a maximum of 14 work days, unless determined otherwise by CMS.

Effective with July 2, 2007, contractors and their systems shall now base their decision making calculus for initiation of a claims repair of '111' (flat file) errors upon the number of errors received rather than upon an established percent parameter, as specified in §70.6.1 of this chapter. If a contractor receives even one (1) '111' error via the COBC Detailed Error Report, the contractor, working with its Data Center or shared system as necessary, shall immediately attempt a repair of the claims file, in accordance with all other requirements communicated within this section.

### 1. Medicare Contractor or Shared System Identification of a Full Claim File Problem and Subsequent Actions

When a contractor, working with its shared system maintainer, identifies a severe error condition that will negatively impact the claims that it has transmitted to the COBC, the contractor shall, upon detection, immediately notify CMS and the COBC by calling current COBC or CMS COBA crossover contacts and sending e-mail communications to: COBAProcess@cms.hhs.gov and cobva@ghimedicare.com.

The contractor shall work closely with its system maintainer to determine the timeframes for developing, testing, and applying a fix to correct the severe error(s) that was/were identified within the 837 or NCPDP files that were previously transmitted to the COBC. The Part A, Part B, or DMERC shared system maintainers shall then report the

timeframes for developing, testing, and applying a fix to the full claim file problem in accordance with their procedures as outlined in their systems maintenance contract. If CMS determines that the timeframes for affecting a full claim file repair of the previously transmitted claims exceed what is considered reasonable (a maximum of 14 work days, unless determined otherwise by CMS), a designated COBA team representative will notify the Medicare contractors and their shared system maintainers via e-mail to abort the full claim file repair process.

Upon receipt of a notification from the CMS COBA team representative that indicates that the timeframes for fixing a full claim file problem exceed those that are acceptable to CMS, the contractors' shared systems shall abort the full claim file repair process. Contractors shall then follow the requirements provided in §70.6.1 of this chapter with respect to the special provider notification and other COBA crossover operational processes. In such cases, however, contractors shall not be required to wait the customary five (5) business days before generating the special provider notification letters to their affected physicians, suppliers, or other providers of service.

**2. Alerting Contractors to the Possible Need for a Full Claim File Repair via the COBC Detailed Error Reports and Subsequent Contractor Actions**

**a. Severe Error Percentage Parameters and Suppression of the Special Provider Notification Letters**

Effective with July 2006, the CMS, working in conjunction with the COBC, shall modify the COBC Detailed Error Report layouts, as found in §70.6.1 of this chapter, to include the following new elements: Total Number of Claims for Date of Receipt; Total Number of "111" (flat file) Errors and corresponding percentage; Total Number of "222" (HIPAA ANSI X12-N 837 COB) Errors and corresponding percentage; and Total Number of "333" (trading partner dispute) Errors and corresponding percentage.

*Effective with July 2007, CMS is directing its Medicare contractors to now base their severe error decision calculus upon the number of '111' errors received rather than percentage of such errors. Therefore, w*hen a contractor or its shared system maintainer receives a COBC Detailed Error Report that indicates that the trading partner is in production and the *number* of "111" (flat file) errors is equal to or greater than one, the contractor's shared system shall suppress the generation of special provider notifications, as provided in § 70.6.1 of this chapter, until after the severe error condition(s) has/have been analyzed. (**NOTE:** If the "222" and/or "333" errors indicated on the COBC Detailed Error Report do **not** exceed the four (4) percent parameter, then the contractor shall continue with the generation of the provider notification letters for those errors while it is analyzing the "111" severe error(s).

When a contractor or its shared system maintainer receives a COBC Detailed Error Report that indicates that the trading partner is in production and the percentage of "222" (HIPAA ANSI X12-N 837) errors and "333" (trading partner dispute) errors is equal to or greater than four (4) percent, the contractor's shared system shall suppress the generation of special provider notifications, as provided in §70.6.1 of this chapter, until after the severe error

condition(s) has/have been analyzed. **NOTE:** If the *number of* "111" errors indicated on the COBC Detailed Error Report *is* **not** *equal to or greater than* one (1), then the contractor shall continue with the generation of the provider notification letters for those errors while it is analyzing the "222" and "333" severe errors.

For each of the severe error situations discussed above, contractors, or their shared systems, shall suppress the special provider notification for a minimum of five (5) business days. However, the contractors' shared systems shall also have the capability to adjust the parameters for generation of the provider notification letters, as referenced in §70.6.1 of this chapter, of up to 14 work days while analysis of the claims that are being "held" for possible full claim file repair is proceeding.

Also, for each of the situations discussed above, the contractors' shared systems shall establish percentage parameters for each error source code (222 and 333) that allow for flexibility within a range (e.g., 1 to 10 percent).

**b. Additional Information Highlighting Possible Severe Error Conditions on the COBC Detailed Error Reports.**

Effective with July 2006, the COBC will report one of the following error sources and error codes/trading partner dispute codes that may be indicative of a severe error condition on the returned COBC Institutional and Professional Detailed Error Reports:

1.) Error source code "111" will be reported in field 10, along with a 6-digit error code in field 11 (note: unlike routine reporting of flat file errors, a full claim file error condition would be indicated if there were numerous instances of the same error code repeated throughout a Report); the description of the problem(s) that has/have caused the full claim file to be unusable will be reported in field 12 (error description);

2.) Error source code "222" will be reported in field 10, along with a 6-digit error code in field 11 that begins with an "N"; the description of the problem(s) that has/have caused the full claim file to be unusable will be reported in field 12 (error description);

3.) Error source code "333" will be reported in field 10; an error/trading partner dispute code "999" (trading partner dispute—"other") will be reported in field 11, left-justified and followed by spaces; and a description of the problem(s) that has/have caused the full claim file to be unusable will be reported in field 12 (error description).

DMERC contractors and their shared systems shall process NCPDP Detailed Error Reports returned from the COBC that contain the following combination of error source codes, error/trading partner dispute codes, and error descriptions within the Reports:

1.) Error source code "111" will be reported in field 9, along with a 6-digit error code in field 10 (note: unlike routine reporting of flat file errors, a full claim file error condition would be indicated if there were numerous instances of the same error code repeated throughout a Report);

and a description of the problem(s) that has/have caused the full claim file to be unusable will be reported in field 11; **or**

2.) Error source code "333" will be reported in field 9; an error/trading partner dispute code "999" will be reported in field 10, left-justified and followed by spaces; and a description of the problem(s) that has/have caused the full claim file to be unusable will be reported in field 11 (error description).

**c. Contractor Actions Following Suppression of the Special Provider Notification Letters to Analyze Possible Severe Error Conditions**

When contractors receive COBC Detailed Error Reports that contain "222" or "333" errors with percentages that are at or above the established parameters—*or if the contractors receive '111' errors that are at or above zero ('0')*—they shall work closely with their system maintainers to determine the timeframes for developing, testing, and applying a fix to correct the severe error(s) that was/were identified within the 837 or NCPDP files that were previously transmitted to the COBC. The Part A, Part B, or DMERC shared system maintainers shall then report the timeframes for developing, testing, and applying a fix to the full claim file problem in accordance with their procedures as outlined in their systems maintenance contract. If CMS determines that the timeframes for affecting a full claim file repair of the previously transmitted claims exceed what is considered reasonable (a maximum of 14 work days, unless determined otherwise by CMS), a designated COBA team representative will notify the Medicare contractors and their shared system maintainers via e-mail to abort the full claim file repair process.

Upon receipt of a notification from the CMS COBA team representative that indicates that the timeframes for fixing a full claim file problem exceed those that are acceptable to CMS, the contractors' shared systems shall abort the full claim file repair process. Contractors shall then follow the requirements provided in §70.6.1 of this chapter with respect to the special provider notification and other COBA crossover operational processes. In such cases, however, contractors shall not be required to wait the customary five (5) business days before generating the special provider notification letters to their affected physicians, suppliers, or other providers of service.

In the event that CMS indicates that a full claim file repair process is feasible, the contractors' shared systems shall have the ability to cancel the generation of the provider notification letters, as stipulated in §70.6.1 of this chapter, for the "repaired" claims **and** only generate the provider notification letters for the claims containing legitimate 111, 222, or 333 errors not connected with the severe error condition(s).

**3. Steps for Ensuring that Only "Repaired" Claims are Re-transmitted to the COBC**

Once the contractors' shared systems have determined that they are able to affect a "timely" repair to the full claim files that were previously transmitted to the COBC, they shall take the following actions:

a.) Apply the fix to the unusable claims;

b.) Compare the claims files previously sent to the COBC with the repaired claims file to isolate the claims that previously did **not** contain the error condition(s);

c.) Strip off the claims that did not contain the error condition(s), including claims that contained 111, 222, and 333 errors that were not connected with the severe error condition(s). For the latter set of claims (those with 111, 222, and 333 errors that were **not** connected to the severe error condition), contractors shall then generate the provider notification letters, as stipulated in §70.6.1 of this chapter and specified in the concluding paragraph of the above sub-section entitled, "Contractor Actions Following Suppression of the Special Provider Notification Letters to Analyze Possible Severe Error Conditions";

d.) Recreate the job; and

e.) Send only the "repaired" claims to the COBC.

Contractors' shared systems shall add an indicator"18" to the BHT02 (Beginning of the Hierarchical Transaction/Transaction Set Purpose Code) segment of the HIPAA 837 flat file to designate that the file contains only repaired claims. In addition, the contractor systems shall include the repaired claims in different ST-SE envelopes to differentiate the repaired claims from normal 837 flat file transmissions.

The DMERC contractor system shall add an indicator "R" after the COBA ID reported in the Batch Header Record in the Receiver ID field (field number 880-K7) of the NCPDP claim when transmitting the repaired claims to the COBC.