CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 13314	**Date: July 24, 2025**
	Change Request 14139

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

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to clarify the actions that our Medicare Administrative Contractors (MACs) should be taking in association with certain kinds of mass adjustment claims activities. The current practices that MACs are following are resulting in claims being marked incorrectly as certain kinds of mass adjustments under the COBA claims crossover process.

EFFECTIVE DATE: January 1, 2026
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 5, 2026

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	27/ 80.6- Special Mass Adjustment and Other Adjustment Crossover Requirements
R	28/ 70.6- Consolidation of the Claims Crossover Process
R	28/ 70.6.1 - Coordination of Benefits Agreement (COBA) Detailed Error Report Notification Process

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

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 13314	Date: July 24, 2025	Change Request: 14139

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I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to clarify the actions that our Medicare Administrative Contractors (MACs) should be taking in association with certain kinds of mass adjustment claims activities. The current practices that MACs are following are resulting in claims being marked incorrectly as certain kinds of mass adjustments under the COBA claims crossover process.

II. GENERAL INFORMATION

A. Background: Following the original enactment of the Affordable Care Act, the Centers for Medicare & Medicaid Services (CMS) required its Medicare Administrative Contractors (MACs) to mass adjust huge volumes of Part A and B claims to modify the claims' approved and payment amounts. As the result of this event and a mid-year change to the Medicare Physician Fee Schedule (MPFS) approved amounts on various claims, CMS created change request (CR) 5472. Through this instruction, it would be possible to differentiate between types of mass adjustment and routine adjustment claims actions for the national COBA claims crossover purposes. CMS further refined this process through CR 7136.

Because the volume of ACA and MPFS mass adjustment claims was originally extremely high, CMS decided it would forgo charging commercial COBA trading partners for these claims. Thus, CMS developed another CR to alert all MACs to situations where claims that were marked with the value "P" (Affordable Care Act mass adjustment claims) or "M" (Medicare Physician Fee Schedule mass adjustment claims) in position 23 of the Beginning of the Hierarchical Transaction Reference Identification (BHT03) file identifier would not result in their receiving complementary credits or crossover fees. Recently, CMS noticed that certain MACs were submitting large volumes of claims that had the values "P" or "M" reflected. Since the ACA and mid-year MPFS mass adjustment events occurred many years ago, neither CMS nor the Benefits Coordination and Recovery Center (BCRC) was expecting to see instances of "P" and "M" values included in current COBA crossover claims. Therefore, CMS believes a clarification around the actions that MACs should be taking in various mass adjustment claims situations is needed.

Through its own analysis, the Fiscal Intermediary Shared System (FISS) maintainer determined that when it creates a certain type of mass adjustment on behalf of its associated MACs, this action is also creating the value "P" incorrectly as part of the 23rd position of the BHT03 file identifier. FISS has proposed a remedy to this issue, which entails having CMS create a new 1-byte Mass Adjustment Indicator value and having that value uniquely associated with the 23rd position value of "P" in the BHT03 file identifier. This remedy is incorporated as part of this instruction.

B. Policy: Operational policies relating to MAC handling of mass adjustments will be clarified through this instruction. All other operational policies relating to the creation of values for position 23 of the BHT03 file identifier remain unchanged, except for the new change being implemented for FISS involving the new Mass Adjustment Indicator value.

III. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
14139.1	Effective January 5, 2026, MACs shall discontinue their actions that result in the value "P" being populated in the 23rd position of the BHT03 file identifier of outbound 837 COBA crossover claims. (Note: This action is requested because the use of "P" is only appropriate when CMS directs its MACs to reprocess large volumes of claims due to specific changes to Affordable Care Act (ACA) provisions. The value "P" shall remain active; however, the value shall only be used when CMS specifically directs.)	X	X	X	X	X				RRB-SMAC
14139.1.1	For MACs (Part A, HHH) to comply with requirement 14139.1, FISS shall develop a new 1-byte alpha value for the Mass Adjustment Indicator field that is part of the HUIP, HUOP, HUHH, and HUHC claims transactions that the shared system sends to the Common Working File (CWF).					X				
14139.1.2	Effective January 5, 2026, CWF shall now accept a new 1-byte alpha value of "N" (which designates an ACA mass adjustment) in the Mass Adjustment Indicator field in the header of the HUIP, HUOP, HUHH, and HUHC claims that FISS sends to CWF for normal processing.								X	
14139.1.2.1	Effective January 5, 2026, National Claims History									NCH

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	(NCH) shall accept the new 1-byte alpha value of "N" in the Mass Adjustment Indicator field as passed on by CWF.									
14139.1.3	CWF shall modify Part A consistency edit 0045 to accept the new Mass Adjustment indicator value of "N."								X	
14139.1.4	Upon receipt of the Mass Adjustment Indicator "N," CWF shall read the Coordination of Benefits Agreement Insurance File (COIF) to determine if the COBA trading partner associated with the claim wishes to exclude "mass adjustment claims/other."								X	
14139.1.5	CWF shall use its previously created logic for annotating the affected claim with crossover disposition indicator "X" ("mass adjustment claims--other excluded") if CWF detects such an exclusion.								X	
14139.1.6	When the FISS maintainer or the MACs (Part A, HHH) input the value "N" into the Mass Adjustment Indicator header field of the HUIP, HUOP, HUHH, and HUHC claims transactions for its associated MACs, FISS shall ensure that it maps the value "P" to the 23rd position of the BHT03 file identifier when creating outbound 837 institutional Coordination of Benefits (COB) claims. **(Note:** As mentioned in 14139.1, the FISS maintainer and associated MACs shall only map the value "P" to the 23rd position of the BHT03 file					X				

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	identifier when CMS specifically directs this action. This should be a rare, qualified occurrence.)									
14139.1.7	For MACs (Part B) to comply with requirement 14139.1, they shall take the following action: • Review the HxxTCACT spi-tab to temporarily remove any records with a "P" indicator unless they are needed for CMS specifically directed mass adjustment transactions tied to a future ACA update.		X							RRB-SMAC
14139.2	MACs (Part B) shall only trigger the value "M" for the 23rd position of the BHT03 file identifier in the following circumstance: • When CMS has specifically directed them to mass adjust large volumes of claims (i.e., typically 1 million or greater) due to a needed change that has been implemented to the Medicare Physician Fee Schedule (MPFS), such that the approved amounts have been adjusted downward or upward due to a legislative or regulatory change. (**Note:** This scenario is unique to MPFS changes		X							RRB-SMAC

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	only and would apply to an entire timeframe within a given year or a previous year, e.g., from January 1 to June 30 or, for the previous year, from January 1 through December 31.)									
14139.2.1	When CMS directs the MACs (Part B) to perform mass adjustments following an update to the MPFS, the MACs (Part B) shall continue to map the value "M" to the Mass Adjustment Indicator claim header field. (**Note:** This action will ensure that the Common Working File has the information it needs to exclude mass adjustments/MPFS as applicable.)		X							RRB-SMAC
14139.2.2	MACs (Part B) shall <u>not</u> trigger the value "M" when they are merely correcting claims that were processed incorrectly due to a non-MPFS systematic issue (e.g., reprocessing a whole series of demonstration project claims because the claims originally were not processed with the appropriate demonstration project reduction amounts reflected).		X							
14139.2.3	For the specific scenario discussed in 14139.2.2., the MACs (Part B) shall instead trigger the value "S" (mass adjustment claims --other) for the 23rd byte of the BHT03 file identifier.		X							
14139.2.4	For MACs (Part B) to comply with requirement 14139.2, they shall take the following action:		X							RRB-SMAC

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	• Review the HxxTCACT spi-tab to temporarily remove any records with an "M" indicator unless they are needed for CMS specifically-directed mass adjustment transactions tied to MPFS updates.									
14139.3	Unless CMS has directed the MACs to include the value "C" in the 23rd position of the BHT03, in accordance with change request (CR) 8454, MACs shall otherwise take action to trigger the value "S" (mass adjustment--other) in the 23rd position of the BHT03 file identifier when adjudicating mass adjustment claims. (**Note:** This direction applies unless the mass adjustments are specific to the Medicare Physician Fee Schedule (MPFS) required updates, as applicable (see also 14139.2), and adjustments resulting from Recovery Audit Contractor (RAC) post-payment review activities.)	X	X	X	X					
14139.4	All MACs shall continue to trigger the value "R" in the 23rd position of the BHT03 file identifier when they are completing routine adjustments or mass adjustments tied to RAC post-payment reviews.	X	X	X	X					
14139.5	All MACs shall continue to trigger the value "A" for routine adjustment claims (i.e., non-mass adjustment	X	X	X	X					

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	claims) in position 23 of the BHT03 file identifier, unless they are processing RAC adjustments, which may be handled as routine adjustments. (See 14139.4 for direction on RAC adjustments.)									

IV. PROVIDER EDUCATION

None

Impacted Contractors: None

V. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

VI. CONTACTS

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VII. FUNDING

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

ATTACHMENTS: 0

Medicare Claims Processing Manual
Chapter 27 - Contractor Instructions for CWF

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(Rev. 13314; Issued: 07-24-25)

80.6 - Special Mass Adjustment and Other Adjustment Crossover Requirements

(Rev. 13314; Issued: 07-24-25; Effective: 01-01-26; Implementation: 01-05-26)

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 CWF maintainer created 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 BCRC shall send the CWF host sites a modified COIF that contains two new claims exclusion categories: mass adjustments-MPFS and mass adjustments-other.

Effective January 5, 2026, the CWF maintainer shall accept the new one (1)-byte Mass Adjustment Indicator value of "N" (defined as Affordable Care Act (ACA) mass adjustment) within the header of its HUIP, HUOP, HUHH, and HUHC claims transactions. Additionally, the CWF maintainer shall modify Part A consistency edit 0045 to accept the new Mass Adjustment indicator value of "N." Thus, effective January 5, 2026, the valid values for the Mass Adjustment Indicator field will include N, as well as M and O.

Upon receipt of a claim that contains an "N" or "O" indicator in the header of an HUIP, HUOP, HUHH, and HUHC claim, CWF shall read the COIF to determine if the COBA trading partner wishes to exclude "mass adjustment claim--other." 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.

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 HIMR detailed history screens in association with excluded processed claims for 'production' COBA trading partner. *Effective January 5, 2026, CWF shall associate Mass Adjustment Indicator value "N" with COBA crossover disposition indicator 'X."*
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 §80.5 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 Recycled 'Original' Claims For Crossover Purposes

Effective 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 spaces).

In instances when CWF returns an error code 5600 to an A/B MAC or DME MAC, thereby causing it to reset the claim's entry code to '5' to action code to '3,' the A/B MAC or DME MAC 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 A/B MAC or DME MAC'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 A/B MAC or DME MAC 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 A/B MAC or DME MACs' 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 shared 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 A/B MACs and DME MACs 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.)

By Passing 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 §80.4 of this chapter for further details regarding this logic.

Actions to Take When A/B MAC or DME MACs Send Invalid Values

If A/B MAC or DME MAC sends 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 to CWF, CWF shall apply an edit to reject the claim back to the A/B MAC or DME MAC. Upon receipt of the CWF rejection edit, the shared 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 §80.5 of this chapter for further information.)

Additional A/B MAC or DME MAC Requirements Following Receipt of a CWF Beneficiary Other Insurance (BOI) Reply Trailer 29

If A/B MACs or DME MACs receive a BOI reply trailer (29) on a claim that had an 'A' indicator set in its header, the A/B MAC or DME MACs' 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 given shared 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

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(Rev. 13314; Issued: 07-24-25)

70.6 - Consolidation of the Claims Crossover Process

(Rev. 13314; Issued: 07-24-25; Effective: 01-01-26; Implementation: 01-05-26)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Background – Medicare Claims Crossover Process—General

Through the Benefits Coordination & Recovery Center (BCRC), Medicare transmits outbound 837 Coordination of Benefit (COB) and Medigap claims to COB trading partners and Medigap plans, collectively termed "trading partners," on a post-adjudicative basis. This type of transaction, originating at individual A/B MACs and DME MACs following their claims adjudication activities, includes incoming claim data, as modified during adjudication if applicable, as well as payment data. All A/B MACs and DME MACs are required to accept all ASC X12 837 segments and data elements permitted by the in-force applicable guides on an initial ASC X12 837 professional or institutional claim from a provider, but they are not required to use every segment or data element for Medicare adjudication. Segments and data elements determined to be extraneous for Medicare claims adjudication shall, however, be retained by the A/B MACs (Part B) and DME MACs within its store-and-forward repository (SFR). Incoming claims data shall be subjected to standard syntax and applicable implementation guide (IG) edits prior to being deposited in the SFR to assure non-compliant data will not be forwarded on to another payer as part of the Medicare crossover process. SFR data shall be re-associated with those data elements used in Medicare claim adjudication, as well as with payment data, to create an ASC X12 837 IG-compliant outbound COB/Medigap transaction. The shared systems shall always retain the data in the SFR for a minimum of 6 months.

The ASC X12 837 institutional and professional implementation guides require that claims submitted for secondary payment contain standard claim adjustment reason codes (CARCs) to explain adjudicative decisions made by the primary payer. For a secondary claim to be valid, the amount paid by the primary payer plus the amounts adjusted by the primary payer shall equal the billed amount for the services in the claim. A tertiary payer to which Medicare may forward a claim may well need all data and adjustment codes Medicare receives on a claim. A tertiary payer could reject a claim forwarded by Medicare if the adjustment and payment data from the primary payer or from Medicare did not balance against the billed amounts for the services and the claim. As a result, shared systems shall reject inbound Medicare Secondary Payer (MSP) claims if the paid and adjusted amounts do not equal the billed amounts and if the claims lack standard CARCs to identify adjustments to the total amount billed.

As a rule, the shared system maintainers shall populate an outbound COB/Medigap file as an ASC X12 837 flat file with the Employer Identification Number (EIN)/Tax ID or SSN (for a sole practitioner) present in the provider's file, unless otherwise specified within §70.6.5 or §70.6.6 of this chapter. With the adoption of the National Provider Identifier (NPI), the shared system shall report qualifier XX in NM108 and the NPI value in NM109. The shared system shall report the provider's EIN/TAX ID within the REF segment of the billing provider loop, as appropriate. In addition, unless otherwise stated within §70.6.5 or §70.6.6 of this chapter, the shared systems shall populate the provider loops on outbound ASC X12 837 claims with the provider's first name, last name, middle initial, address, city, state and zip code as contained in the Medicare provider files, the information for which is derived from the Provider Enrollment Chain and Ownership System (PECOS).

Background—Specific COBA Crossover Process

The CMS has streamlined the claims crossover process to better serve its customers. Under the consolidated claims crossover process, trading partners execute national agreements called Coordination of Benefits Agreements (COBAs) with CMS's BCRC. 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 BCRC. The BCRC will transmit the beneficiary eligibility file(s) to the Common Working File (CWF) via the HUBO maintenance transaction. The transaction is also termed the "Beneficiary Other Insurance (BOI)" auxiliary file. (See Pub.100-04, chapter 27, §80.4 for more details about the contents of the BOI auxiliary file.)

During August 2003, the CMS modified CWF to accept both the HUBO (BOI) transaction on a regular basis and COBA Insurance File (COIF) as a weekly file replacement. Upon reading both the BOI and the COIF, CWF applies each COBA trading partner's claims selection criteria against processed claims with service dates that fall between the effective and termination date of one or more BOI records.

Upon receipt of a BOI reply trailer (29) that contains (a) COBA ID (s) and other crossover information required on the Health Insurance Portability and Accountability Act (HIPAA) ASC X12 835 Electronic Remittance Advice (ERA), all A/B MACs and DME MACs shall send processed claims via an ASC X12 837 COB flat file or National Council for Prescription Drug Programs (NCPDP) file to the BCRC. The BCRC, in turn, will cross the claims to the COBA trading partner in the HIPAA ASC X12 837 or NCPDP formats, following its validation that the incoming Medicare claims are formatted correctly and pass HIPAA or NCPDP compliance editing.

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

For more information regarding the COBA Medigap claim-based crossover process, which was enacted on October 1, 2007, consult §70.6.4 of this chapter.

I. A/B MAC (Part A, Part B, or Part HHH) or DME MAC 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 A/B MAC (Part B) and DME MAC shared systems shall 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) shall be reflected 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 A/B MACs (Part B) and DME MAC shared systems shall follow these business rules:

- The L or N indicators are not applied at the header/claim level if any service on the claim is payable by Medicare;

- The "L" indicator is applied at the header/claim level if the beneficiary is liable for any of the denied services on a fully denied claim; and

- The "N" indicator is applied at the header/claim level if the beneficiary is not liable for all of the denied services on a fully denied claim.

Effective with October 2007, the CWF maintainer shall create a 1-byte beneficiary liability indicator field within the header of its HUIP, HUOP, HUHH, and HUHC Part A claims transactions (valid values for the

field="L," "N," or space).

As A/B MACs (Part A) and A/B MACs (Part HHH) adjudicate claims and determine that the beneficiary has payment liability for any part of the fully denied services or service lines, they shall set an "L" indicator within the newly created beneficiary liability field in the header of their HUIP, HUOP, HUHH, and HUHC claims that they transmit to CWF. In addition, as A/B MACs (Part A) and A/B MACs (Part HHH) adjudicate claims and determine that the beneficiary has no payment liability for any of the fully denied services or service lines - that is, the provider must absorb all costs for the fully denied claims - they shall include an "N" beneficiary indicator within the designated field in the header of their HUIP, HUOP, HUHH, and HUHC claims that they transmit to CWF. NOTE: A/B MACs (Part A) and A/B MACs (Part HHH) shall not set the "L" or "N" indicator on partially denied/partially paid claims.

Upon receipt of an HUIP, HUOP, HUHH, or HUHC claim that contains an "L" or "N" beneficiary liability indicator, CWF shall read the COBA Insurance File (COIF) to determine whether the COBA trading partner wishes to receive "original" fully denied claims with beneficiary liability (crossover indicator "G") or without beneficiary liability (crossover indicator "F") or "adjustment" fully denied claims with beneficiary liability (crossover indicator "U") or without beneficiary liability (crossover indicator "T").

If CWF determines that the COBA trading partner wishes to exclude the claim, as per the COIF, it shall suppress the claim from the crossover process.

CWF shall post the appropriate crossover disposition indicator in association with the adjudicated claim on the HIMR detailed history screen (see §80.5 of this chapter).

In addition, the CWF maintainer shall create and display the new 1-byte beneficiary liability indicator field within the HIMR detailed history screens (INPL, OUTL, HHAL, and HOSL), to illustrate the indicator ("L" or "N") that appeared on the incoming HUIP, HUOP, HUHH, or HUHC claim transaction.

CWF Editing for Incorrect Values

If an A/B MAC (Part A) or A/B MAC (Part HHH) sends values other than "L," "N," or space in the newly defined beneficiary liability field in the header of its HUIP, HUOP, HUHH, or HUHC claim, CWF shall reject the claim back to the A/B MAC for correction. Following receipt of the CWF rejection, the A/B MAC (Part A) and A/B MAC (Part HHH) shall change the incorrect value placed within the beneficiary liability field and retransmit the claim to CWF.

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

Effective with July 2007, in instances when CWF returns an error code 5600 to an A/B MAC and DME MAC, thereby causing it to reset the claim's entry code to "5" and action code to "3," the MAC 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. The A/B MAC and DME MAC shared 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 A/B MACs' and DME MACs' shared systems shall ensure that, as part of their ASC X12 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 A/B MACs' and DME MACs' shared systems shall ensure that, as part of their ASC X12 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 A/B MACs and DME MACs must send adjustment claims to CWF as entry code "1" or as action code "1" (situations where CWF has rejected the claim with edit 6010), they shall set an "A" indicator in a newly defined field within the header of the HUBC, HUDC, HUIP, HUOP, HUHH, or HUHC claim.

If A/B MACs and DME MACs 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 MAC. Upon receipt of the CWF rejection edit, the MACs' 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 adjustments, non-monetary, **or both**; and

- Suppress the claim if the COBA trading partner wishes to exclude **either** adjustments, monetary 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 A/ B MACs and DME MACs receive a BOI reply trailer (29) on a claim that had an "A" indicator set in its header, the A/B MACs' or DME MACs' systems shall ensure that, as part of their ASC X12 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 an A/B MAC's or DME MAC's shared 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.

<u>Correcting Invalid Claim Header Values Sent to CWF</u>

If A/B MACs and DME MACs 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 A/B MAC or DME MAC. Upon receipt of the CWF rejection edit, the A/B MACs' or DME MACs' 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 DME MAC 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 DME MAC shared system shall pass an indicator "P" to CWF in an available field on the HUDC query when the claim is in the NCPDP format. The indicator "P" should be included in a field on the HUDC that is separate from the fields used to indicate whether a beneficiary is liable for all services that are completely denied on his/her claim.

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

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

E. CWF Identification and Auto-Exclusion of ASC X12 837 Professional Claims That Contain Only Physician Quality Reporting Initiative (PQRI) Codes

Effective October 6, 2008, the CWF maintainer shall create space within the header of its HUBC claim transmission for a 1-byte PQRI indicator (valid values=Q or space).

In addition, CWF shall create a 2-byte field on page 2 of the HIMR claim detail in association with the new category "COBA Bypass" for the value "BQ," which shall designate that CWF auto-excluded the claim because it contained only PQRI codes (see §80.*5* of this chapter for more details regarding the bypass indicator).

Prior to transmitting the claim to CWF for normal processing, the A/B MAC (Part B) shared system shall input the value "Q" in the newly defined PQRI field in the header of the HUBC when **all** service lines on a claim contain PQRI (status M) codes.

Upon receipt of a claim that contains a "Q" in the newly defined PQRI field (which signifies that the claim contains only PQRI codes on all service detail lines, CWF shall auto-exclude the claim from the national COBA eligibility file-based and Medigap claim-based crossover processes. Following exclusion of the claim, CWF shall populate the value "BQ" in association with the newly developed "COBA Bypass" field on page 2 of the HIMR A/B MAC (Part B) and DME MAC claim detail screens.

Prior to October 6, 2008, all A/B MACs and DME MACs shall update any of their provider customer service materials geared towards crossover claims related inquiries to reflect the newly developed "BQ" by-pass value, which designates that CWF auto-excluded the claim because it only contained PQRI codes.

The Next Generation Desktop (NGD) contractor shall also modify its user screens and documentation to reflect the new "BQ" code.

F. CWF Identification and Exclusion of Claims Containing Placeholder National Provider Identifiers (NPIs)

Effective October 6, 2008, the CWF maintainer shall create space within the header of its HUIP, HUOP, HUHH, HUHC, HUBC, and HUDC claims transactions for a new 1-byte "NPI-Placeholder" field (acceptable values=Y or space).

In addition, the CWF maintainer shall create space within page two (2) of the HIMR detail of the claim screen for 1) a new category "COBA Bypass"; and 2) a 2-byte field for the indicator "BN." (See Pub. 100-04, chapter 27, §80.*5* for more details regarding the "BN" bypass indicator.)

NOTE: With the implementation of the October 2008 release, the CWF maintainer shall remove all current logic for placeholder provider values with the implementation of this new solution for identifying claims that contain placeholder provider values.

As A/B MACs and DME MACs adjudicate **non VA MRA** claims that fall within any of the NPI placeholder requirements, their shared system shall take the following combined actions:

1) Input a "Y" value in the newly created "NPI Placeholder" field on the HUIP, HUOP, HUHH, HUHC, HUBC, or HUDC claim transaction if a placeholder value exists on or is created anywhere within the SSM claim record. **NOTE**: The A/B MAC and DME MAC shared systems shall include spaces within the "NPI Placeholder" field when the claim does not contain a placeholder NPI value; **and**

2) Transmit the claim to CWF, as per normal requirements.

Upon receipt of claims where the NPI Placeholder field contains the value "Y," CWF shall auto-exclude the claim from the national COBA crossover process. In addition, CWF shall populate the value "BN" in association with the newly developed "COBA Bypass" field on page 2 of the HIMR Part B and DME MAC claim detail screen and on page 3 of the HIMR intermediary claim detail screen. (See Pub.100-04, chapter 27, §80.4 for more details.)

Prior to October 6, 2008, all A/B MACs and DME MACs shall update any of their provider customer service materials geared towards crossover claims related inquiries to reflect the newly developed "BN" by-pass value, which designates that CWF auto-excluded the claim because it contained a placeholder provider value.

The Next Generation Desktop (NGD) contractor shall also modify its user screens and documentation to reflect the new "BN" code.

G. New CWF Requirements for Other Federal Payers

Effective with October 3, 2011, the CWF maintainer shall expand its logic for "Other Insurance," which is COIF element 176, to include TRICARE for Life (COBA ID 60000-69999) and CHAMPVA (COBA ID 80214), along with State Medicaid Agencies (70000-79999), as entities eligible for this exclusion.

Through these changes, if either TRICARE for Life or CHAMPVA wishes to invoke the "Other Insurance" exclusion, and if element 176 is marked on the COIF for these entities, CWF shall suppress claims from the national COBA crossover process if it determines that the beneficiary has active additional supplemental coverage.

As part of this revised "Other Insurance" logic for TRICARE and CHAMPVA, CWF shall interpret "additional supplemental coverage" as including entities whose COBA identifiers fall in any of the following ranges:

00001-29999 (Supplemental);
30000-54999 (Medigap eligibility-based);
80000-80213 (Other Insurer); and
80215-88999 (Other Insurer).

The "Other Insurance" logic for State Medicaid Agencies includes all of the following COBA ID ranges:

00001-29999 (Supplemental);
30000-54999 (Medigap eligibility-based);
60000-69999 (TRICARE);
80000-80213 (Other Insurance)
80214 (CHAMPVA)
80215-88999 (Other Insurer).

NOTE: As of October 3, 2011, CWF shall now omit COBA ID range 89000-89999 as part of its Other Insurance logic for State Medicaid Agencies.

CWF shall mark claims that it excludes due to "Other Insurance" with crossover disposition indicator "M" when storing them within the CWF claims history screens. (See §80.5 of chapter 27 for additional

information concerning this indicator.)

II. A/B MAC and DME MAC Actions Relating to CWF Claims Crossover Inclusion or Inclusion/Exclusion Logic

A. Inclusion of Two Categories of Mass Adjustment Claims for Crossover Purposes

All A/ B MACs and DME MACs shall continue to identify mass adjustment claims-MPFS and mass adjustment claims—other by including an "M" (mass adjustment claims—MPFS) or "O" (mass adjustment claims—other) within the header of the HUIP, HUOP, HUHH, HUHC, HUBC, and HUDC claim transactions, as specified in Pub.100-04, chapter 27, §80.*6*. (Refer to Pub.100-04, chapter 27, §80.*8* for CWF specific requirements relating to the unique inclusion of mass adjustment claims for crossover purposes.)

Effective January 5, 2009, the BCRC, at CMS's direction, modified the COIF to allow for the unique inclusion of mass adjustment claims—MPFS updates and mass adjustment claims—other. The CWF maintainer shall 1) create these new fields, along with accompanying 1-byte file displacement, within its version of the COIF; and 2) accept and process these new fields when the BCRC transmits them as part of its regular COIF updates.

Upon receipt of a HUIP, HUOP, HUHH, HUHC, HUBC, or HUDC claim transaction that contains an "M" or "O" mass adjustment indicator, CWF shall undertake all additional actions with respect to determination as to whether the claim should be included or excluded for crossover purposes as specified in chapter 27, §80.8.

A/B MAC and DME MAC Flat File Requirements

Before the A/B MAC and DME MAC shared systems send "mass adjustment claims—MPFS" to the BCRC via an ASC X12 837 flat file transmission, they shall take the following actions with respect to the fields that correspond to the loop 2300 NTE01 and NTE02 segments on the ASC X12 837 COB flat file only if there was not a pre-existing 2300 NTE segment on the incoming Medicare claim:

1) Populate "ADD" in the field that corresponds to NTE01; and

2) Populate "MP," utilizing bytes 01 through 02, in the field that corresponds to NTE02.

Before the A/B MAC and DME MAC shared systems send "mass adjustment claims—other" to the BCRC via an ASC X12 837 flat file transmission, they shall take the following actions with respect to the fields that correspond to the loop 2300 NTE01 and NTE02 segments on the 837 COB flat file only if there was not a pre-existing 2300 NTE segment on the incoming Medicare claim:

1) Populate "ADD" in the field that corresponds to NTE01; and

2) Populate "MO," utilizing bytes 01 through 02, in the field that corresponds to NTE02.

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

Effective January 5, 2009, at CMS's direction, the BCRC modified the COIF to allow for the unique inclusion and exclusion of RAC-initiated adjustment claims. The CWF maintainer shall 1) create these new fields, along with accompanying 1-byte file dis-placement, within its version of the COIF; and 2) accept and process these new fields when the BCRC transmits them as part of its regular COIF updates. In addition, the CWF maintainer shall create a 1-byte RAC adjustment value in the header of its HUIP, HUOP, HUHH, HUHC, HUBC, and HUDC claims transactions (valid values="R" or spaces).

Through this instruction, all A/B MAC and DME MAC shared systems shall develop a method for uniquely identifying all varieties of RAC-requested adjustments, which occur as the result of post-payment review

activities.

NOTE: Currently, fewer than five (5) MACs process RAC adjustments.

Prior to sending its processed 11X and 12X type of bill RAC-initiated adjustment transactions to CWF for normal verification and validation, the A/B MAC (Part A) and A/B MAC (Part HHH) shared system shall input the "R" indicator in the newly defined header field of the HUIP claim transaction if the RAC adjustment claim meets either of the following conditions:

1) The claim resulted in Medicare changing its payment decision from paid to denied (i.e., Medicare paid $0.00 as a result of the adjustment performed)**; or**

2) The claim resulted in a Medicare adjusted payment that falls below the amount of the inpatient hospital deductible.

Prior to sending RAC-initiated adjustment claims **with all other type of bill designations to CWF** for normal processing, the A/ B MAC (Part A) and A/B MAC (Part HHH) shared system shall input an "R" indicator in the newly defined header field of the HUOP, HUHH, and HUHC claim.

Prior to sending their processed RAC adjustment transactions to CWF for normal verification and validation, the A/B MAC (Part B) and DME MAC shared systems shall input the "R" indicator in the newly defined header field of the HUBC and HUDC claim transactions.

Unique COBA ID Assignment to Trading Partners That Accept RAC-Initiated Adjustment Claims Only and Attendant A/B MAC and DME MAC Responsibilities

The BCRC will assign a unique COBA ID range (88000-88999) to COBA trading partners that elect to "include" RAC-initiated adjustment claims for crossover purposes and will not, at CMS's direction, charge the trading partner the standard crossover fee for that category of adjustment claims. Therefore, when A/B MACs and DME MACs receive a BOI reply trailer (29) on a claim that contains only a COBA ID in the range 88000 through 88999 (which designates RAC adjustment), the A/B MAC and DME MAC shall not expect payment for the claim.

Before the A/B MAC and DME MAC shared systems send "tagged" RAC-initiated adjustment claims to the BCRC via an ASC X12 837 flat file transmission, they shall take the following actions with respect to the fields that correspond to the loop 2300 NTE01 and NTE02 segments on the ASC X12 837 COB flat file only if there was **not** a pre-existing 2300 NTE segment on the incoming Medicare claim:

1) Populate "ADD" in the field that corresponds to NTE01; and

2) Populate "RA," utilizing bytes 01 through 02, in the field that corresponds to NTE02.

III. 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 BCRC began to send initial copies of the COBA Insurance File (COIF) to the nine CWF host sites. The COIF contains specific information that will identify the COBA trading partner, including name, COBA ID, address, and tax identification number (TIN). It also contains 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 also contains a 1-digit Test/Production Indicator that will identify whether a COBA trading partner is in test (T) or production (P) mode. The CWF shall return that information as part of the BOI reply trailer (29) to A/B MACs and DME MACs.

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

- Search for a COBA eligibility record on the BOI auxiliary record for each beneficiary and obtain the associated COBA ID(s) [NOTE: There may be multiple COBA IDs associated with each beneficiary.];

- Refer to the COIF associated with each COBA ID **NOTE**: The CWF shall pull the COBA ID from the BOI auxiliary record to obtain the COBA trading partner's name and claims selection criteria;

- Apply the COBA trading partner's selection criteria; and

- Transmit a BOI reply trailer to the A/B MAC and DME MAC only if the claim is to be sent, via 837 COB flat file or NCPDP file, to the BCRC to be crossed over.

B. BOI Reply Trailer and Claim-based Reply Trailer Processes

1. BOI Reply Trailer Process

For eligibility file-based crossover, all A/B MACs and DME MACs shall send processed claims information to the BCRC for crossover to a COBA trading partner in response to the receipt of a CWF BOI reply trailer (29). A/B MACs and DME MACs 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, A/B MACs and DME MACs 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 A/B MACs and DME MACs.

MSN Crossover Messages

Effective with the October 2004 systems release, the A/ B MACs and DME MACs began 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).

When a COBA trading partner is in full production (Test/Production Indicator=P), the A/ B MAC and DME MAC shall read the MSN indicator returned on the BOI reply trailer (29). If the A/B MAC or DME MAC 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, A/B MACs and DME MACs shall follow these procedures when determining whether to update its claims history to show that a beneficiary’s claim was selected by CWF to be crossed over.

- If the A/B MAC or DME MAC receives a BOI reply trailer (29) that contains a Test/Production Indicator “T,” it shall not update its claims history to show that a beneficiary’s claim was selected by CWF to be crossed over.

- If the A/B MAC or DME MAC receives a BOI reply trailer (29) that contains a Test/Production Indicator “P,” it shall update its claims history to show that a beneficiary’s claim was selected by CWF to be crossed over.

Effective January 5, 2009, when CWF returns a BOI reply trailer (29) to an A/B MAC and DME MAC that contains only a COBA ID in the range 89000 through 89999, the A/B MAC and DME MAC shared system shall suppress all crossover information, including name of insurer and generic message#35.1, from all beneficiary MSNs.

A/B MACs and DME MACs shall not update their claims histories to reflect transference of “tagged” claims with COBA ID range 89000 through 89999 to the BCRC.

ASC X12 835 (Electronic Remittance Advice)/Provider Remittance Advice Crossover Messages

Beginning with the October 2004 release, when CWF returns a BOI reply trailer (29) that contains a “T” Test/Production Indicator to the A/B MACs and DME MACs, they shall not print information received from the BOI reply trailer (29) in the required crossover fields on the ASC X12 835 Electronic Remittance Advice or other provider remittance advices that are in production.

Beginning with the October 2004 release, when CWF returns a BOI reply trailer (29) that contains a “P” Test/Production Indicator to the A/B MACs and DME MACs, they shall use the returned BOI trailer information to take the following actions on the provider’s 835 Electronic Remittance Advice:

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

b. Update the 2100 Loop (Crossover Contractor 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

Effective with January 5, 2009, if CWF returns only COBA ID range 89000 through 89999 on a BOI reply trailer (29) to an A/B MAC and DME MAC, the associated shared system shall suppress all crossover information (the entire 2100 loop) on the 835 ERA.

CWF Sort Routine for Multiple COBA IDs

Effective with October 3, 2011, 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 (30000-54999); 2) Medigap claim-based (55000-59999); 3) Supplemental (00001-29999); 4) Other Insurer (80000-80213); 5) Other Insurance (80215-88999); 6) TRICARE (60000-69999); 7) CHAMPVA (80124); 8) Medicaid (70000-79999); and 9) Other-Health Care Pre-payment Plan [HCPP] (89000-89999). When two or more COBA IDs fall in the same range (see element 24 of the "Data Elements Required for the BOI Aux File Record" Table in chapter 27, §80.4 for more details), CWF shall sort numerically within the same range.

IV. A/B MAC and DME MAC Actions Relating to the Transition to the ASC X12 837 Version 5010 and NCPDP Version D.O

A. CWF COIF and BOI Reply Trailer (29) Processes

Effective January 5, 2009, the BCRC , at CMS's direction, created a new 1-byte "5010 Test/Production Indicator" and a new 1-byte "NCPDP D.0 Test/Production Indicator" on the COBA Insurance File [COIF] (valid values= "N"—not applicable or not ready as yet; "T"—test; "P"—production). In addition, the CWF maintainer shall add a new "5010 Test/Production Indicator" and an "NCPDP D.0 Test/Production Indicator" to the BOI reply trailer (29) format. (See Pub.100-04 chapter 27, §80.*7* for additional details regarding CWF requirements relating to the new crossover claim formats.)

B. Transmission of the COB Flat File or NCPDP File to the BCRC

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), A/B MACs and DME MACs shall transmit all non-NCPDP claims received with a COBA ID via a BOI reply trailer to the BCRC in an ASC X12 837 flat file, as described in Transmittal AB-03-060. In a separate transmission, DME MACs shall send the claims received in the NCPDP file format to the BCRC. A/B MACs and DME MACs 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, A/B MACs and DME MACs shall send a separate ASC X12 837 or NCPDP transaction to the BCRC for each COBA ID. A/B MACs and DME MACs shall perform the transmission at the end of their regular batch cycle, when claims are removed from their payment floor, to ensure crossover claims are not processed by the COBA trading partner prior to Medicare's final payment. Transmission to the BCRC shall occur via Connect: Direct or other CMS dictated connectivity.

Effective with October 4, 2005, when the A/B MAC and DME MAC shared systems transfer processed claims to the BCRC 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 ASC X12 837 flat file or NCPDP submissions. The

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 October 2, 2006, the Virtual Data Center (VDC), formerly the Enterprise Data Centers (EDCs), shall transmit a combined COBA "test" and "production" ASC X12 837 flat file and a combined "test" and "production" NCPDP file, as applicable, to the BCRC.

NOTE: This requirement changes the direction previously provided in October 2005 through the issuance of Transmittal 586.

Flat File Conventions for Transmission to the BCRC For Production COBA Crossover Claims Prior to July 2012

With respect to ASC X12 837 COB flat file submissions to the BCRC, A/B MACs (Part B) and DME MACs shall observe these process rules:

The following segments shall not be passed to the BCRC:

1. ISA (Interchange Control Header Segment);
2. IEA (Interchange Control Trailer Segment);
3. GS (Functional Group Header Segment); and
4. GE (Functional Group Trailer Segment).

The 1000B loop of the NM1 segment denotes the crossover partner. If multiple COBA IDs are received via the BOI reply trailer, the shared system shall ensure that a separate ASC X12 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 BCRC completing any missing information:

NM1 segment—For NM103, NM104, NM105, and NM107, use spaces;
NM1 segment—For NM109, include beneficiary's Medicare beneficiary identifier;
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 BCRC 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 BCRC 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 BCRC 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 ASC X12 837 COB flat file submissions to the BCRC, A/B MACs (Part A) and A/B MACs (Part HHH) 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 BCRC. 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 A/B MAC or DME MAC 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 BCRC completing any missing information:

NM1 segment – For NM103, NM104, NM105, and NM107, use spaces;
NM1 segment—For NM109, include beneficiary's Medicare beneficiary identifier;
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 BCRC completing any missing information:

NM1 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 BCRC 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. The BCRC 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.

C. BCRC Processing of COB Flat Files or NCPDP Files

Effective April 5, 2021, the COB&R system supporting the BCRC will transmit modified dataset names to the VDCs for the COBA Claims Response File (the File whereby the BCRC, through the COB&R system, conveys an acceptance of the flat file with the value "A" or rejection of the file with the value"R"). The VDCs shall be prepared to accept the following modified dataset names effective April 5, 2021:

- xxxx.FISP.HBADR.GHI.COB5RESP(+1) [For 837 institutional claims]
- xxxx.MCSP.HBXDR.ADyyCOBC(+1) [For 837 non-DMEPOS professional claims]
- xxxx.VMSP.COBC.A5010.ERROR.RESPONSE(+1) [For 837 DMEPOS professional claims]
- Value is TBD [For NCPDP Part B Drug Claims] (**Note:** Since the implementation of NCPDP D.0 COB claims as part of COBA, the VDCs have <u>not</u> been set up to receive NCPDP Claim Response Files.)

Note the following definitions that apply to the above Claim Response File dataset names:

- *VDCx= directs the file to the appropriate VDC; VDC1 = CD1.EDC1; VDC3 = CD3.EDC1*
- *xxxx = High-level qualifier (HLQ) identifier currently used by the MAC*
- *yy = identifier currently used by and defined for Part B files for Plan Code*

When an A/B MAC and DME MAC receives the reject indicator "R" via the Claims Response File, it is to retransmit the entire file to the BCRC. If the A/B MAC or DME MAC 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), BCRC will cross

the claims to the COBA trading partner. The format of the Claims Response File that will be returned to each A/B MAC and DME MAC by the BCRC, following its COB ASC X12 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 BCRC Detailed Error Reports.)

Claims Response File Layout (80 bytes)

Field	Name	Size	Displacement	Description
1	A/B MAC or DME MAC Number	5	1-5	A/B MAC or DME MAC Identification Number
2	Transaction Set Control Number/ Batch Number	9	6-14	Found within the ST02 data element from the ST segment of the ASC X12 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 ASC X12 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 ASC X12 837 flat file or NCPDP file in CCYYMMDD format
5	Accept/Reject indicator	1	32	Indicator of either the acceptance or rejection of the ASC X12 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 A/B MACs and DME MACs after receipt and initial processing of a claim file. Thus, for example, if an A/B MAC or DME MAC sends a COB flat file daily via the VDC, the BCRC will return a claim response file to that entity on a daily basis.

Effective April 5, 2021, VDC-transmitted ASC X12 COB 837 flat files and NCPDP *files submitted* by the VDC on behalf of each A/B MAC and DME MAC, as applicable, to *the CMS Baltimore Data Center (BDC) to, in turn, be transmitted to the Coordination of Benefits & Recovery (COB&R) system supporting BCRC* will be assigned the following file *dataset* names, regardless of whether a COBA trading partner is in test or production mode:

- *P/T#EFT.ON.COBA.Cxxxxx.PARTA.Dyymmdd.Thhmmsst* [For Institutional Claims}
- *P/T#EFT.ON.COBA.Cxxxxx.PARTB.Dyymmdd.Thhmmsst* [For Professional Claims]
- *P/T#EFT.ON.COBA.Cxxxxx.NCPDP.Dyymmdd.Thhmmsst* [For *NCPDP Part B* Drug Claims]

Note *the following definitions that apply to the dataset names above:*

- *P/T= "P"—Production; "T"= Test*
- *Cxxxxx= C + the 5-digit MAC ID; e.g., 12302*
- *Dyymmdd.Thhmmsst = Current date and Time concatenated to literals D and T. (NOTE: This is optional for the VDCs to include, and if not present, CMS EFT will concatenate it.)*

A/B MACs and DME MACs shall perform the ASC X12 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 trading partner prior to Medicare's final payment.

Files transmitted by the VDC to the BCRC shall be stored for 51 business days from the date of transmission.

The file names for the Claims Response File returned to the A/B MAC and DME MAC via the VDC will be created as part of the NDM set-up process.

Outbound COB files transmitted by BCRC to the COBA trading partners will be maintained for 50 business days following the date of transmission.

E. The COBA Medigap Claim-Based Process Involving CWF

Refer to §70.6.4 of this chapter for more information regarding this process.

F. COBA Customer Service Issues

1. Customer Service

    a. A/ B MACs and DME MACs shall use the BCRC and CMS COBA Problem Inquiry Request Form to identify and send COBA related problems and issues to the COB contractor for research.

    In order to track trading partner requests for research of 837 ASC X12 issues, CMS requires A/B MACs and DME MACs to submit a COBA Problem Inquiry Request Form to the BCRC or CMS. This process is being implemented to reduce the number of duplicate issues being researched and to ensure your requests are processed timely. The standard form enables CMS and BCRC to track issues through completion and manage the process of addressing post-COBA production issues. Upon receipt the submitter shall receive a response from the BCRC with the assigned contact information.

    CMS is also requiring A/B MACs and DME MACs to use the COBA Problem Inquiry Request Form when requesting a BCRC representative to research a COBA issue. The combined BCRC-CMS COBA Problem Inquiry Request Form appears below.

A/B MAC and DME MAC: COBA PROBLEM INQUIRY REQUEST FORM

	Completed by Submitter – control number if applicable	**Write in this column only**
MAC ID# (Enter the A/B MAC or DME MAC ID # assigned by CMS)		
MAC Reference ID (If applicable - BHT03)		
Reported By (Enter submitter's last name, first name)		
Date Submitted (Enter current date – MM/DD/YR)		
Contact # (Enter submitter's phone #)		
E-mail Address (Enter submitter's e-mail address)		
COBA ID #		

Description of Problem (Check applicable category)

☐ **HIPAA Error Code**

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

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

File Name	
Transmission Date	

Summary of Issue- Provide detail of problem and note if back-up information will be faxed, e.g., Sample Claims to be Faxed on MM/DD/YR. Indicate whether you would like your issue on the next HIPAA issues log **– do not include any PHI information on this form if sent via email.** All PHI information must be submitted via fax to the BCRC to the attention of your BCRC representative at 646-458-6761. **Do not include PHI information on the fax cover sheet.** Claim examples of issues to be addressed must include the beneficiary Medicare beneficiary identifier and the claim ICN/DCN.

BCRC USE ONLY. Date: Ticket #:

V. Identification of Mass Adjustments for COBA Crossover Purposes

All A/B MACs and DME MACs and their shared 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.") 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 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 an A/B MAC or DME MAC undertakes using special software (e.g., Super-Op Events or Express Adjustments) to pull together claims with the anticipated purpose of making monetary changes to a high number of those claims. If, however, A/B MACs and DME MACs 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 A/B MACs and DME MACs 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.

A/ B MACs and DME MACs 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 A/B MACs and DME MACs 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 A/B MACs or DME MACs' 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 A/B MACs and DME MACs 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 MAC. Upon receipt of the CWF rejection edit, the shared systems shall correct the invalid value and retransmit the claims to CWF for verification and validation.

Important: *Effective January 5, 2026, CWF shall begin accepting the value "N" (defined as Affordable Care Act (ACA) mass adjustment) in the header of HUIP, HUOP, HUHH, or HUHC claims for situations where CMS specifically directs that ACA mass adjustments be initiated and processed. Additionally, CWF shall modify its Part A consistency edit 0045 to accept the new Mass Adjustment Indicator value of "N." This value may be generated by the Part A shared system or by a MAC (A, HHH). Only in this scenario will the Part A shared system map the value "P" (Affordable Care Act mass adjustment) to the 23rd position of the BHT03 file identifier on outbound 837 crossover claims.*

VI. Special ASC X12 835 Remittance Advice and MSN Requirements for Health Care Pre-Payment Plans (HCPPs) and Health Maintenance Organization (HMO) Cost Plans that Receive Crossover Claims

Effective January 5, 2009, at CMS's direction, the BCRC assigned all COBA HCPP and HMO Cost Plan participants a unique 5-byte COBA ID that falls within the range 89000 through 89999. The CWF system shall accept the reporting of this COBA ID range.

Upon receipt of a BOI reply trailer (29) that contains only a COBA ID in the range 89000 through 89999, the A/B MAC and DME MAC shared systems shall suppress all crossover information (including name of the insurer; generic message; and specific code (for ASC X12 835, code MA-18; for MSN, code 35.1) indicating that the claim will be crossed over) from the associated ASC X12 835 remittance advice and beneficiary MSN. (See §70.6.1 of this chapter for A/B MAC or DME MAC requirements relating to the BCRC Detailed Error Report processes and receipt of claims that contain COBA ID range 89000 through 89999.)

VII. Special Suppression Requirements for Part A Credit Claim Portion of Debit-Credit Claim Pairing

Effective with the April 2009 release, the A/B MAC (Part A) and A/B MAC (Part HHH) shared system shall suppress sending the credit claim portion of the debit-credit pairing (that transaction which cancels the original claim) associated with each affiliated A/B MAC's (A, HHH) adjustment claims to the BCRC. Upon suppressing the credit claim, the A/B MAC (Part A) and A/B MAC (Part HHH) system shall mark the claims history of its affiliate MAC to reflect this action.

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

(Rev. 13314; Issued: 07-24-25; Effective: 01-01-26; Implementation: 01-05-26)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Effective with the July 2005 release, CMS implemented an automated process to notify physicians/ practitioners, 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 ASC X12 837 flat file by the A/B MAC and DME MAC shared systems to the Benefits Coordination & Recovery Center (BCRC) may be rejected at the flat file level, at a HIPAA ASC X12 pre-edit validation level, or by trading partners as part of a financial dispute arising from an invoice received.

Effective with the April 2005 release, the A/B MAC and DME MAC shared systems began to populate the BHT 03 (Beginning of Hierarchical Reference Identification) portion of their ASC X12 837 COB flat file submissions to the BCRC with a unique 22-digit identifier. This unique identifier will enable the BCRC to successfully tie a claim that is rejected by the BCRC at the flat file or HIPAA ASC X12 pre-edit validation levels as well as claims disputed by trading partners back to the original ASC X12 837 flat file submissions.

Effective October 4, 2005, A/ B MACs and DME MACs and their shared systems began to receive notification via the BCRC 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 BCRC.

Effective April 3, 2011, all A/B MACs and DME MACs shall include an extra 1-byte "Original versus Adjustment Claim Indicator" value within the BHT03 identifier on all ASC X12 837 institutional and professional claims they transmit to the *BCRC* for crossover purposes. The BCRC shall, in turn, return this value to the appropriate A/B MAC and DME MAC via the BCRC Detailed Error Report process. In addition, the DME MAC shared system shall send an additional 1-byte value (defined as "reserved for future use") as spaces in field 504-F4 (Message) of the NCPDP flat file sent to the BCRC. The BCRC shall, in turn, also return this value to the appropriate DME MAC via the BCRC Detailed Error Report process.

Effective April 1, 2013, CMS added a new 1-byte Original versus Adjustment indicator to the suite of possible 1-byte options for position 23 of the BHT03 identifier, as reflected below.

Effective with April 7, 2014, CMS has added 2 new 1-byte Original versus Adjustment indicators to the suite of possible options for position 23 of the BHT03 identifier, as reflected below.

A. Inclusion of the Unique 23-Digit Identifier on the ASC X12 837 Flat File and NCPDP File

1. Populating the BHT 03 Portion of the ASC X12 837 Flat File

The A/B MAC and DME MAC shared systems shall populate the BHT 03 (Beginning of Hierarchical Transaction Reference Identification; **field length=30 bytes**) portion of their ASC X12 837 flat files that are sent to the BCRC for crossover with a 23-digit Contractor Reference Identifier (CRI). The identifier shall be formatted as follows:

a. A/B MAC or DME MAC number (9-bytes; until the 9-digit MAC number is used, report the 5-digit MAC 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. Claim version indicator (2 bytes, numeric, to denote claim version)

**Acceptable values = 50 (for ASC X12 claims), and 20 (for NCPDP D.0 claims);

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

f. Original versus Adjustment Claim Indicator (1-byte alpha indicator); acceptable values are defined as the following:

E - for reprocessed claims that formerly included an electronic prescribing (e-RX) negative adjustment amount;

O - for original claims;

P - for Affordable Care Act or other congressional imperative mass adjustments;

M - for non-Affordable Care Act mass adjustments tied to Medicare Physician Fee Schedule (MPFS);

S - for mass adjustment claims—all others;

R - for RAC adjustment claims;

A - for routine adjustment claims, not previously classified; and
C – for CMS-directed mass adjustment action (use specified by CMS).

The following indicator is only applicable to FISS-generated claims:
V - Void/cancel only claim

The 23-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.)

Clarification Regarding Use of Original Versus Adjustment Claim Indicator Values

BHT03 Position 23 Value "P"

- *Effective January 5, 2026, MACs shall discontinue their actions that result in the value "P" being populated in the 23rd position of the BHT03 file identifier of outbound 837 COBA crossover claims.*

  *(**Note:** This action is requested because the use of "P" is only appropriate when CMS directs its MACs to reprocess large volumes of claims due to specific changes to ACA provisions. The value "P" shall remain in effect, but the value shall only be used as CMS directs.)*

FISS shall ensure that its associated Part A MACs (AA, HHH) are able to comply with this requirement by virtue of the creation of a new Mass Adjustment Indicator field value of "N." FISS and its associated MACs shall only send this value to the Common Working File (CWF) when Affordable Care Act (ACA) mass adjustments are being created and processed in accordance with CMS direction (see Pub.100-04, chapter 27, section 80.6 for more information).

For MACs (Part B) to comply with this requirement, they shall take the following action:

- *Review the HxxTCACT spi-tab to temporarily remove any records with a "P" indicator unless they are needed for CMS specifically directed mass adjustment transactions tied to a future ACA update.*

BHT03 Position 23 Value M

- *MACs (Part B) shall only trigger the value "M" for the 23rd position of the BHT03 file identifier in the following circumstance:*
  - *When CMS has specifically directed them and/or their shared system(s) to mass adjust large volumes of claims (i.e., typically 1 million or greater) due to a needed change that has been implemented to the Medicare Physician Fee Schedule (MPFS), such that the approved amounts have been adjusted downward or upward due to a legislative or regulatory change.*

    (Note: This scenario is unique to MPFS changes only and would apply to an entire timeframe within a given year or a previous year, e.g., from January 1 to June 30 or, for the previous year, from January 1 through December 31.)

- *For MACs (Part B) to comply with this request, they shall:*
  - *Review the HxxTCACT spi-tab to temporarily remove any records with an "M" indicator unless they are needed for CMS specifically directed mass adjustment transactions tied to MPFS updates.*

When CMS has directed MACs (Part B) to perform mass adjustments following an update to the MPFS, the MACs (Part B) shall continue to map the value "M" to the Mass Adjustment Indicator claim header field.

*(**Note:** This action will ensure that the Common Working File has the information it needs to exclude mass adjustments/MPFS as applicable; see Pub.100-04, chapter 7, section 80.6 for more information regarding this subject.)*

***Important:** MACs (Part B) shall not trigger the value "M" when they are merely correcting claims that were processed incorrectly due to a non- MPFS systematic issue (e.g., reprocessing a whole series of demonstration project claims because the claims originally were not processed with the appropriate demonstration project reduction amounts reflected). Instead, they shall trigger the value "S" for the 23rd position of the BHT03 file identifier for this scenario.*

Normal Mass Adjustment Claims Scenarios and Recovery Audit Contractor Claims Adjustment Activities

Unless CMS has directed the MACs to include the value "C" in the 23rd position of the BHT03, MACs shall otherwise take action to trigger the value "S" (mass adjustment--other) in the 23rd position of the BHT03 file identifier when adjudicating mass adjustment claims that do not represent bona-fide MPFS adjustments. This guidance applies unless the claims represent Recovery Audit Contractor (RAC) adjustment claims (which often are effectuated as mass adjustments), in which case the value "R" shall be triggered.

Routine Adjustments

As of January 5, 2026, all MACs shall continue to trigger value "A" for routine adjustment claims (i.e., non-mass adjustment claims) in position 23 of the BHT03 file identifier. This would not apply when the MAC is handling RAC-related adjustments. For that scenario, the MAC would trigger the value "R" for the 23rd position of the BHT03 file identifier.

2. NCPDP 23-Digit Unique Identifier

Effective April 3, 2011, the DME MAC shared system shall also adopt a unique 23-digit format, referenced directly above under "Populating the BHT 03 Portion of the ASC X12 837 Flat File." However, prior to April 7, 2014, the system shall populate the unique 23-digit identifier (defined as "future use") with spaces in field 504-F4 (Message) within the NCPDP file (field length=35 bytes). The DME MAC shared system shall populate the unique identifier, left justified, in the field. Spaces shall be used for the remaining bytes in the field.

Effective April 7, 2014, the DME MAC shared system shall ensure that its DME MACs have the ability to 1) execute actions that will result in the transmission of their HUDC claims to CWF with Mass Adjustment Indicator set to "O"; and 2) transmit mass adjusted NCPDP D.0 COB claims to the BCRC under a 504-F04 (Message) field identifier of "C" (CMS-directed mass adjustment action) or "P" (mass adjustments tied to Affordable Care Act or Congressional/legislative mandate) as appropriate to the situation.

In addition, the DME MAC shared system shall ensure that all NCPDP D.0 crossover claims will now be sent to the BCRC with the 23rd byte 504-F04 (Message) field indicator completed, when appropriate, as indicated below.

O -- for all "original" NCPDP D.0 claims transmitted;

A-- for "routine adjustment claims" transmitted; and

R-- for recovery audit claims (RAC) adjustment claims transmitted.

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

The A/B MAC and DME MAC shared systems shall accept the BCRC Institutional, Professional, and NCPDP Detailed Error Reports received from the COB&R system supporting the BCRC.

Effective with April 5, 2021, the datasets that the COB&R system supporting BCRC will use to convey the BCRC Detailed Error Reports to the VDCs representing the MACs are as follows:

xxxx.FISP.HBADR.GHI.COB5ERR(+1) [For Institutional Claims]
xxxx.MCSP.HBXDR.ADyy5ERC(+1) [For Professional non-DMEPOS Claims]
xxxx.VMSP.COBC.A5010.ERROR.FILE(+1) [For Professional DMEPOS Claims]

The formats for each of the Detailed Error Reports appear below.

Beginning with July 2007, all A/B MAC and DME MAC systems shall no longer interpret the percentage values received for ASC X12 837 institutional and professional claim "222" and "333" errors via the BCRC Detailed Error Reports as if the values contained a 1-position implied decimal (e.g., "038" =3.8 percent). DME MACs shall also no longer interpret the percentage values received for NCPDP claims for "333" errors via the BCRC Detailed Error Report for such claims as if the values should contain a 1-position implied decimal.

In addition, A/B MACs 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.

Effective with July 2009, the A/B MAC and DME MAC shared systems shall accept the modified versions of the BCRC Detailed Error Reports for institutional and professional claims as reflected below. As part of the July 2009 changes, the BCRC will, at CMS's direction, expand the length of the "error description" field. (**NOTE:** This means that the shared systems shall therefore include the expanded error description code as part of their special provider notification letters.)

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

BCRC Detailed Error Report

Institutional Error File Layout - (Detail Record)

Field	Description	Field Size	Record Location
1	Date	8	1-8
2	Control Number	9	9-17
3	COBA ID	10	18-27
4	Subscriber ID/Medicare ID	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	Filler	100	83-182
13	Field Contents	50	183-232
14	BHT 03 Identifier	30	233-262 (23 bytes used)
15	Claim DCN/ICN	23	263-285
16	Error Description	300	286-585
17	Filler	15	586-600

Institutional Error File Layout - (Summary Record)

Field	Description	Field Size	Record Location
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	524	77-600

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

BCRC Detailed Error Report

Professional Error File Layout - (Detail Record)

Field	Description	Field Size	Record Location
1	Date	8	1-8
2	Control Number	9	9-17
3	COBA ID	10	18-27
4	Subscriber ID/Medicare ID	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', '333')
11	Error/Trading Partner Dispute Code	6	77-82
12	Filler	100	83-182
13	Field Contents	50	183-232
14	BHT 03 Identifier	30	233-262 (23 bytes used)
15	Claims DCN/ICN	23	263-285
16	Error Description	300	286-858
17	Filler	15	586-600

Professional Error File Layout – (Summary Record)

Field	Description	Field Size	Record Location
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	524	77-600

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

BCRC Detailed Error Report

NCPDP Error File Layout - (Detail Record)

Field	Description	Field Size	Record Location
1	Date	8	1-8
2	Batch Number	7	9-15
3	COBA ID	5	16-20
4	Medicare ID	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 (23 bytes used)
14	CCN	23	249-271
15	Filler	18	272-289

NCPDP Error File Layout - (Summary Record)

Field	Description	Field Size	Record Location
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')
10	Filler	524	63-289

If the BCRC has rejected back to the A/B MAC and DME MAC shared system for 2 or more COBA Identification Numbers (IDs), the shared system shall receive a separate error record for each COBA ID. Also, if a file submission from a shared system to the BCRC contains multiple provider, subscriber, or patient level errors for one COBA ID, the shared 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

A/B MACs and DME MACs, or their shared systems, shall use all information supplied in the BCRC 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.

2. Time Frames for Notification of All MACs Financial Management Staff and Providers

A/B MACs and DME MACs, or their shared systems, shall provide notification to MAC financial management staff for purposes of maintaining an effective reconciliation of crossover fee/ complementary credits received within five (5) business days of receipt of the BCRC Detailed Error Report.

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

a) Special Automated Provider Correspondence

A/B MACs and DME MACs, 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 BCRC (Test/Production Indicator=P). After an A/B MAC or DME MAC, or its shared system, has received a BCRC Detailed Error Report that contains claims with error source codes of “111” (flat file error), “222” (HIPAA ASC X12 error), or “333” (trading partner dispute), it shall take the following two specified actions within five (5) business days:

1. Notify the physician/practitioner, supplier, or provider via automated letter or other electronic or automated method that the claim did not cross over. The letter or report/notification shall include specific claim information, not limited to, Internal Control Number (ICN)/Document Control Number (DCN), Medicare beneficiary identifier, 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.

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

   NOTE: A/B MACs or DME MACs, or their shared systems, are not required to reference the COBA trading partner's name on the above described automated letter or report/notification, 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 or report.

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

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

   Effective with the July 7, 2009, release, upon receipt of the BCRC Detailed Error Report (DER), the A/B MAC (A) and A/B MAC (HH) shared system shall configure the existing 114 report, as derived from the BCRC DER, so that it: 1) continues to display in landscape format; and 2) includes a cover page that contains the provider's correspondence mailing address.

b) Special Exemption from Generating Provider Notification Letters/Reports

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

   NOTE: When suppressing their provider notification letters or reports/notifications for the foregoing qualified situations, the A/B MACs and DME MACs shall also not update their claims histories to reflect the non-crossing over of the associated claims. A/B MACs and DME MACs should, however, continue to account for the volume of claims that they are suppressing for financial reconciliation purposes.

Effective with October 6, 2008, when the BCRC returns the "222" error code "N22225" to A/B MACs and DME MACs via the BCRC Detailed Error Report, the A/B MACs and DME MACs' shared systems shall suppress generation of the special provider notification letters or reports/notifications that they would normally issue in accordance with CRs 3709 and 5472.

When suppressing their provider notification letters or reports/notifications following their receipt of a "N22225" error code, the A/B MACs' and DME MACs' shared systems shall also not update their claims histories to reflect the non-crossing over of the associated claims. A/B MACs and DME MACs should, however, continue to account for the volume of claims that they are suppressing for financial reconciliation purposes.

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

1) Suppress generation of the special provider letters or reports/notifications; and

2) Not update their affiliated A/B MACs and DME MACs' claims histories to indicate that the BCRC will **not** be crossing the affected claims over.