CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 13341	**Date: July 31, 2025**
	Change Request 14185

SUBJECT: Effective Date Change for Bypass of Common Working File (CWF) Edits on Inpatient Ancillary 12X Claims for Part A Benefits Exhaust

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to correct the effective date for the bypass of CWF editing on inpatient Part B ancillary 12X claims previously added with CR 13810. The bypass allows ancillary claims to be processed for payment consideration when Part A benefits are exhausted during the inlier portion of an inpatient stay that has exceeded a cost outlier threshold. This CR changes the effective date of this logic to apply to claims ***processed*** on or after January 5, 2026, allowing the Medicare Administrative Contractors (MACs) to process resubmitted claims that were previously rejected in error. This CR also includes an update to allow the MACs the functionality to override CWF Crossover Reject C7050.

EFFECTIVE DATE: January 5, 2026 - Effective for any date of service processed on or after January 5, 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
N/A	N/A

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:

One Time Notification

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 13341	Date: July 31, 2025	Change Request: 14185

SUBJECT: Effective Date Change for Bypass of Common Working File (CWF) Edits on Inpatient Ancillary 12X Claims for Part A Benefits Exhaust

EFFECTIVE DATE: January 5, 2026 - Effective for any date of service processed on or after January 5, 2026.
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 5, 2026

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to correct the effective date for the bypass of CWF editing on inpatient Part B ancillary 12X claims previously added with CR 13810. The bypass allows ancillary claims to be processed for payment consideration when Part A benefits are exhausted during the inlier portion of an inpatient stay that has exceeded a cost outlier threshold. This CR changes the effective date of this logic to apply to claims ***processed*** on or after January 5, 2026, allowing the Medicare Administrative Contractors (MACs) to process resubmitted claims that were previously rejected in error. This CR also includes an update to allow the MACs the functionality to override CWF Crossover Reject C7050.

II. GENERAL INFORMATION

A. Background: All items and non-physician services furnished to inpatients must be furnished directly by the hospital or billed through the hospital under arrangements. This provision applies to all hospitals, regardless of whether they are subject to the prospective payment system (PPS). Medicare pays under Part B for the limited set of non-physician medical and other health services provided in Pub. 100-02, Medicare Benefit Policy Manual, chapter 6, §10.2 (that is, when furnished by a participating hospital to an inpatient of the hospital who is not entitled to benefits under Part A, has exhausted his or her Part A benefits, or receives services not covered under Part A).

Currently, the Common Working File (CWF) performs editing to detect and prevent duplicate billing of non-physician outpatient services considered included in an inpatient hospital admission in the same facility or in another facility. A bypass of this editing is allowed for inpatient Part B ancillary services billed on the 12X claim for dates of service after the beneficiary has exhausted their Part A benefits, when the inpatient claim received a cost outlier payment. Under Change Request (CR) 13810 "Correction to Editing for Inpatient Part B Ancillary 12X Claims When Part A Benefits Exhaust and Manual Updates for Billing of Inpatient Pre-Entitlement Days," an additional bypass was added for situations where the beneficiary has exhausted their Part A benefits during the inpatient confinement, a cost outlier threshold is exceeded on the inpatient claim, and the beneficiary has no lifetime reserve (LTR) days available. Service dates outside the inlier portion of the stay, as reported with occurrence span code 70, are allowed to process for payment consideration. This CR updates the effective date of this bypass logic to claims for any dates of service ***processed*** on or after January 5, 2026. This CR also adds functionality for the Part A MACs to override CWF edit C7050.

B. Policy: This CR does not include new policy.

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	
14185.1	CWF shall update the effective date of the bypass logic added in CR 13810 for A/B crossover edits to apply to claims for any dates of service ***processed*** on or after January 5, 2026. This bypass allows an incoming outpatient claim ('12x') to process for payment consideration when the following is present: • The line-item service dates are ***after*** the occurrence span code 70 days reported on an IPPS, Long Term Care Hospital (LTCH) or Inpatient Rehabilitation Facility (IRF) history claim (excluding the discharge date) and, • Part A benefits exhaust date is present (Occurrence code A3, B3 or C3) on the history inpatient claim and, • The history inpatient claim does not indicate outlier payment, but has exceeded a cost outlier threshold (occurrence Code 47 is present indicating the first full day of cost outlier status). **Note:** Effective date change only. All other existing edit and bypass criteria shall remain the same.								X	
14185.1.1	CWF shall update any applicable informational unsolicited response (IUR) edit logic to include the updated bypass criteria effective date change.								X	

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
14185.2	CWF shall bypass edit C7050 on the incoming claim when the edit is present in the header override field.	X							X	

IV. PROVIDER EDUCATION

Medicare Learning Network® (MLN): CMS will develop and release national provider education content and market it through the MLN Connects® newsletter shortly after we issue the CR. MACs shall link to relevant information on your website and follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 for distributing the newsletter to providers. When you follow this manual section, you don't need to separately track and report MLN content releases. You may supplement with your local educational content after we release the newsletter.

Impacted Contractors: A/B MAC Part A

V. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
1	Contractors should review CWF edits 7050 and 7070 which may be impacted.

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):
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ATTACHMENTS: 0