Coordination of Benefits Agreement (COBA)

Implementation User Guide

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Coordination of Benefits Agreement (COBA) Implementation User Guide

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Coordination of Benefits Agreement (COBA) Technical Implementation Guide

OVERVIEW

The purpose of the COBA Implementation User Guide is to communicate directly with staff affiliated with each Trading Partner about the administrative, technical, and financial requirements for implementing the Coordination of Benefits Agreement (COBA). Emphasis is given to preparing and testing data files to and from the Coordination of Benefits Contractor (COBC). This guide includes six sections:

- **COBA PROGRAM:**

  This section introduces the Coordination of Benefits program—its goals and expected benefits. A checklist is provided to guide the Trading Partner through the steps required to implement the COB Agreement and its Attachment. Two timelines—one for the COBA program and one for Trading Partners—display the current schedule for the COBA program implementation.

- **COBA:**

  The section includes a glossary of 13 claims selection criteria, comments from beta test participants with CMS responses, and a sample Trading Partner Profile Report.

- **COBA TECHNICAL:**

  This section details the required process and formats for testing with current Eligibility and Claims File. Specifications for tape transfers and electronic transmissions are listed, and a chapter covers the required file formats and emphasizes that all COBA participants must use HIPAA-standard transactions and code sets rules for claims. Also, contained in this section is the necessary procedure to contact the COBC in the event of a missing or indecipherable file along with other useful Web sites addresses pertaining to HIPAA transaction and code sets.

Overview

- **COBA FINANCIAL:**

  Trading Partners under the COBA program may choose billing and payment remittance options. This section explains the options and displays a sample COBA invoice. The process for resolving disputes over invoices is discussed.
  [This section is currently unavailable.]

- **COBA CUSTOMER ASSISTANCE:**

  This section lists points of contact and useful resources for additional information about the COBA program.

Coordination of Benefits Agreement (COBA)

COBA PROGRAM

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Coordination of Benefits Agreement (COBA)

Introduction to COBA

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Introduction to COBA

INTRODUCTION TO COBA

Background

Today, Medicare Contractors individually negotiate and execute Trading Partner Agreements (TPAs) with other insurers and benefit programs—i.e., with Medigap plans, employer supplemental plans, Tricare for Life, and State Medicaid Agencies—that, are doing business within their geographic jurisdiction for the electronic transfer of Medicare paid claims information. These TPAs are entered into on a voluntary basis.

The Centers for Medicare & Medicaid Services (CMS) recently developed a model contract, called the Coordination of Benefits Agreement (COBA), for use in negotiating new and renegotiating existing local TPAs. COBAs will standardize the way that eligibility and Medicare claims payment information is exchanged. COBAs will permit other insurers and benefit programs to send eligibility information to and receive Medicare paid claims data for processing supplemental insurance benefits for Medicare beneficiaries from CMS' national crossover contractor, the Coordination of Benefits Contractor (COBC).

Purpose

The new COBA program establishes a uniform national contract between CMS and other health insurers and benefit programs. The COBA program also introduces a standard processing across the national Medicare community.

Implementation of COBA means that other health insurers and benefit programs that are eligible to receive Medicare paid claims information from CMS for purposes of calculating their supplemental payment will no longer have to sign separate crossover agreements with individual Medicare Contractors. Moreover, they will no longer need to send separate eligibility files to individual Medicare Contractors and receive separate claims crossover files from Medicare Contractors.

Coordination of
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Implementation Checklist

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Implementation Checklist

IMPLEMENTATION CHECKLIST

This checklist is designed to give you a clear overview of the COBA Implementation process and, at the same time, serve as a step-by-step guide to fulfilling the requirements of the COBA program. For further information, please refer to the Customer Assistance section in this guide.

Enrollment

- Contact the COBC. The Trading Partner may contact the COBC to discuss the COBA service options, which will be customized for its organization and specified in the COBA Attachment.
- Execute COBA (s). Sign two original agreements. Upon receipt, the COBC will sign both originals and return one original to you for your records.
- Complete the Attachment. This form provides specific information to install your COBA such as what type of insurer or benefits program you are, primary points of contact, and claims selection options.
- Forward each signed COBA and Attachment to the COBC at the mailing address specified in the Customer Assistance section in this guide.
- Obtain COBA Identification Number (s) from the COBC. Upon receipt and successful processing of your COBA and Attachment, the COBC will generate a Profile Report assigning your COBA ID (s).
- Notify the COBC of your approval of the Profile Report after reviewing it for accuracy. Follow the notification instructions accompanying the Profile Report.
- Obtain the appropriate deinstallation procedures and lead times from Medicare intermediaries and carriers with whom you have existing agreements. It is the Trading Partner's responsibility to

ensure that all current agreements are terminated prior to COBA implementation with the COBC.

Implementation Checklist

Testing

- Obtain a test date from the COBC. Upon receipt of each signed COBA and Attachment, the COBC will provide you with the next available date to commence testing.
- Provide data transfer information. For tape transfer of COBA information, complete the Tape Transfer Form; otherwise, complete the Electronic Transmission Form contained in this guide. Return the form to the COBC as indicated in the Customer Assistance section of this guide.
- Set up connectivity test. Coordinate testing of two-way transmission capability with the COBC, if applicable.
- Create test eligibility file (s). Eligibility files must be generated in the required COBA Eligibility File Format using your assigned COBA ID (s) as furnished to you by the COBC.
- Submit your test eligibility file (s) to the COBC. You may transmit your eligibility file (s) electronically or mail your test eligibility file (s) to the COBC. Refer to the mailing address specified in the Customer Assistance section in this guide.
- Review your test eligibility results. The COBC will forward an Eligibility Detail Report, which confirms receipt of an eligibility file; summarizes the number of records submitted; lists the number of adds, updates, and deletes; lists all eligibility errors, if any; and explains the reason for each error.
- Review test Claims File (s) from the COBC. The COBC will create and forward Claims Files in the required formats for all claims matching eligibility information and claims selection criteria.
- Sign off on the test process with the COBC. Once you are satisfied with the test results, call the COBC's EDI department and request a Test Sign-off Form. Follow the instructions as outlined on this form.

Implementation Checklist

Implementation

- Obtain an implementation date from the COBC. Upon receipt of your Test Sign-off Form, the COBC will provide you with the next available date to implement your COBA (s).
- Terminate existing TPAs. Notify Medicare intermediaries and carriers of your COBA implementation date. It is the Trading Partner's responsibility to ensure that **all** current agreements are terminated, or as applicable amended, prior to COBA implementation with the COBC.
- Create and submit production eligibility file (s) to the COBC.
- Review and follow instructions as provided in the Finance section of this guide for billing and payment remittance.

Coordination of Benefits Agreement (COBA)

Implementation Timeline

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Implementation Timeline

IMPLEMENTATION TIMELINE

COBA Program Timeline

The CMS has opted to test the Coordination of Benefits Agreement (COBA) technical operations with a small group of trading partners (a pilot) prior to full-scale implementation of the consolidation of the consolidated claim crossover process. The COBA beta testing period begins on July 6 and continues through September 30, 2004. This will give CMS, the COBC, and the trading partner an opportunity to thoroughly test the planned technical operations for the COBA initiative.

During the period from October 1, 2004, through April 30, 2005, trading partners will be transitioned from their current crossover process with individual Medicare contractors to the COBA consolidated process.

COBA Trading Partner Timeline

The following list the major milestones and estimated durations in implementing the COBA Program with the COBC:

Task	Estimated Duration
Negotiate and execute COBA	30 days
Receive COBA ID (s) and approve Profile Report	5 days
Data Transfer Setup	5 days
Generate test eligibility file (s)	10 days
Review test claims files	10 days
Provide test sign-off	1 day
Termination of existing agreements	1-90 days

Coordination of **Benefits Agreement (COBA)**

COBA

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COBA

COB AGREEMENT (COBA) AND ATTACHMENT

The COBA is a contract between the Centers for Medicare & Medicaid Services' (CMS) contractor and other health insurers or benefit programs. The COBA specifies all of the essential functions to allow eligible insurers or benefit programs to receive Medicare paid claims automatically after Medicare releases claims from the payment floor.

An electronic copy of this document may be downloaded from the COB Web site. Refer to the Technical Reference section in this guide for more information.

COBA

COBA CLAIMS SELECTION GLOSSARY

This section defines the 13 claims selection criteria as outlined in Section IV of the COBA Attachment.

1. Type of Bill (TOB)—A 3-digit type of bill used by providers to identify the nature of the health care service received in a facility or institutional health care setting. The 3-digit type of bill is included on claims that are submitted to Part A Medicare claims processing contractors known as intermediaries.

2. Non-assigned claim—A claim on which the physician, practitioner, specialty physician, or supplier did not accept the assignment of a beneficiary's Medicare claim.

3. Original Medicare claims paid at 100%--A claim on which all line items were paid at 100% of the Medicare allowed or approved amount without deductible or co-insurance amounts remaining.

4. Original Medicare claims paid at greater than 100% of the submitted charges—A claim, such as a claim for the professional charges incurred at an Ambulatory Surgical Center (ASC) [type of service=F], that is paid at greater than 100% of the charges submitted by the provider of service.

5. 100% Denied Claims, with no additional beneficiary liability—A claim that is completely denied and for which the liability rests with the provider of service rather than the beneficiary.

6. 100% Denied Claims, with additional beneficiary liability—A claim that is completely denied but for which liability rests with the beneficiary.

7. Adjustment claims, monetary—A claim on which the original financial information, such as the amount approved or allowed or the amount paid, was modified.

8. Adjustment claims, non-monetary/statistical—A claim that is modified for the purpose of correcting dates of service and other non-monetary changes but on which the original financial outcome remains unchanged.

9. Medicare Secondary Payer (MSP) claims—Claims that Medicare receives for purposes of making secondary payment.

10. Provider Identification Number—Claims that may be either included or excluded from the crossover process on the basis of provider identification number. Note that this option only applies to claims processed by a Medicare Part A contractor.

11. Provider State—Claims that may either be included or excluded from the crossover process on the basis of the state in which the provider of service is located. These claims will be identified by the first two positions of the provider identification number, which represent state code. Note that this option only applies to claims processed by a Medicare Part A contractor. Part B provider states may be included or excluded by Medicare Contractor Identification Number. DMERC claims may be excluded by specific processing region.

12. Other Insurance—This option applies when a State Medicaid Agency does not wish to receive claims when a beneficiary has other insurance, (Medigap -supplemental policy, TRICARE, or other) that can pay before Medicaid.

13. National Council for Prescription Drug Programs (NCPDP) claims—This option applies when a Trading Partner wishes to exclude NCPDP Batch version 5.1 claims from the crossover process. (Available in the future)

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COBA Profile Report

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COBA Profile Report

COBA PROFILE REPORT

The COBA Profile Report displays COBA information as provided by the Trading Partner in the COBA Attachment and lists the Trading Partner's assigned COBA ID (s).

TP CONTACT ID: 999999999 Name: Last First, MI Company: TIN: 999999999
COBA ID: 9999999999 LOB: Contract Date 99/99/9999 Status: Status Date: 99/99/9999

Contact Information:

Administrative

Name
Title/position
Company Name
Address 1
Address 2
City/State/Zip
Phone/Fax
Email

Technical

Name
Title/position
Company Name
Address 1
Address 2
City/State/Zip
Phone/Fax
Email

Invoice

Name
Title/position
Company Name
Address 1
Adress 2
City/State/Zip
Phone/Fax
Email

Eligibility File

Frequency:
Type:
Media

Claims File

Frequency:
Trans Day:
Media:

ISA Qualifier:
ISA Receiver:
NCP Receiver:

Print name on MSN? -

Part A rate code: **Rate:** **Part A Specific Rate:**
Part B rate code: **Rate:** **Part B Specific Rate:**

Contractor(s) employed **Contractor(s) TIN**

TP CONTACT ID: 999999999 Name: Last First, MI Company: TIN: 999999999
COBA ID: 9999999999 LOB: Contract Date 99/99/9999 Status: Status Date: 99/99/9999

Part A Inclusion/Exclusion Criteria
_____ 'X' receive all types of bills.
'X' Exclude Description
Fiscal Intermediary TOBs:
___11 Hospital: Inpatient Part A
___12 Hospital: Inpatient Part B
___13 Hospital: Outpatient
___14 Hospital: Other Part B (Non-patient)
___18 Hospital: Swing Bed
___21 Skilled Nursing Facility: Inpatient Part
___22 Skilled Nursing Facility: Inpatient Part
___23 Skilled Nursing Facility: Outpatient
___71 Clinic: Rural Health
___72 Clinic: Freestanding Dialysis
___74 Clinic: Outpatient Rehabilitation Facility
___75 Clinic: (CORF)
___76 Clinic: Comprehensive Mental Health Clinic
___83 Special Facility: Ambulatory Surgical Center
___85 Primary Care Hospital
Specialty Fiscal Intermediary TOBs
___24 SNF: Other Part B (Non-patient)
___28 SNF: Swing Bed
___41 Christian Science/Religious Non-Medical (Hospital)
___73 Clinic: Federally qualified Health Center
___79 Clinic: Other
Fiscal Intermediary/RHHI TOBs:
___32 Home Health: Part B Trust Fund
___33 Home Health: Part A Trust Fund
___34 Home Health: Outpatient
___81 Special Facility: Hospice Non-Hospital
___82 Special Facility: Hospice Hospital
_____Check here if you wish to receive claims for all providers and all states.
Include or Exclude:
Provider Identification Number or Provider State:

Print in this space the provider number or provider states:

Part B Inclusion/Exclusion Criteria
_____ Check here if you wish to receive claims for all provider states.

Otherwise: Include or Exclude:

List all provider states to be included or excluded as indicated above

_____ Check here if you wish to receive all DMERC type of claims.

Otherwise: 'X' Exclude the following:

_____Region A
_____Region B
_____Region C
_____Region D

Common Inclusion/Exclusion Criteria
_____ Check here if you wish to receive all types of claims listed below.

Otherwise: 'X' Exclude the following:

_____ Non-Assigned.
_____ Original Medicare claims paid at 100%.
_____ Original Medicare claims paid at greater than 100% of submitted charges
_____ 100% denied claims, with no additional beneficiary liability
____ 100% denied claims, with additional beneficiary liability
____ Adjustment claims, monetary.
____ Adjustment claims, non-monetary/statistical.
____ Medicare Secondary Payer (MSP) claims.
____ Claims if other insurance exists for beneficiary
____ NCPDP

Coordination of Benefits Agreement (COBA)

COBA TECHNICAL

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Test Procedures

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Test Procedures

TEST PROCEDURES

Requirements

This section outlines the necessary steps for eligibility and claims file testing with the COBC. The Trading Partner is required to complete all preliminary steps as defined under COBA in the Implementation Check List section of this guide prior to initiating testing with the COBC. Refer to the Implementation Checklist section within this guide more information regarding implementation requirements.

- Obtain a test date from the COBC. Upon receipt of the COBA and Attachments, the COBC will provide you with the next available date to commence testing.

- Provide data transfer information. For tape transfer of COBA information, complete the Tape Transfer Form; otherwise, complete the Electronic Transmission Form contained in this guide. Return the form to the COBC as indicated in the Customer Assistance section of this guide.

- Set up connectivity test. Coordinate testing two-way transmission capability with the COBC, if applicable.

- Create test eligibility file (s). Eligibility files must be generated in the required COBA Eligibility File Format using your assigned COBA ID (s) as furnished to you by the COBC.

- Submit your test eligibility file (s) to the COBC. You may transmit your eligibility file (s) electronically or mail your test eligibility file (s) to the COBC. Refer to the mailing address specified in the Customer Assistance section in this guide.

- Review your test eligibility results. The COBC will forward an Eligibility Detail Report, which confirms receipt of an eligibility file; summarizes the number of records submitted; lists the number of adds, updates, and deletes; lists all eligibility errors, if any; and explains the reason for each error.

Test Procedures

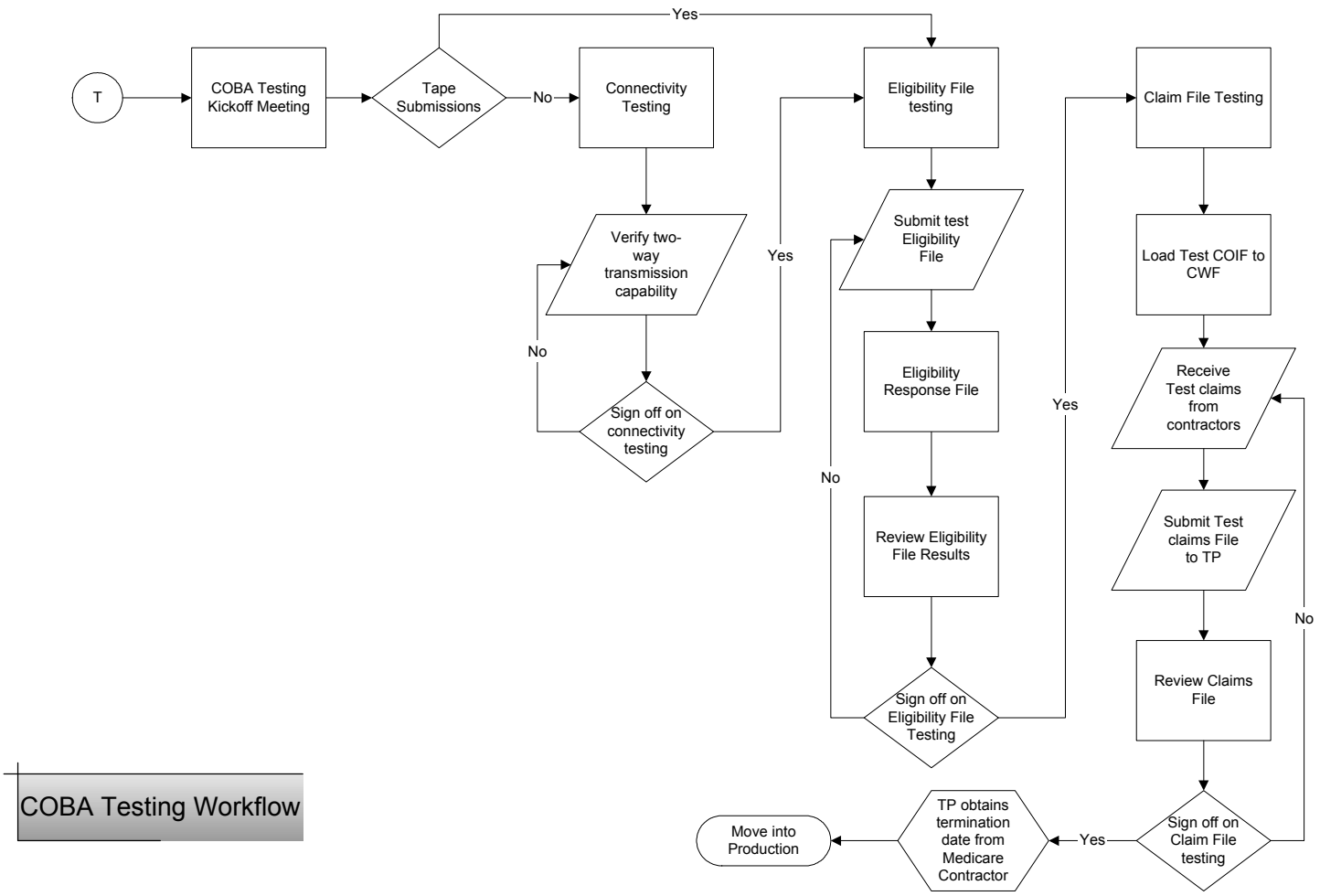
- Review test Claims File (s) from the COBC. The COBC will create and forward Claims Files in the required formats for all claims matching eligibility information and claims selection criteria.
- Sign-off on the test process with the COBC. Once you are satisfied with the test results, call the COBC's EDI department and request a Test Sign off Form. Follow the instructions as outlined on this form.

Test Procedures

TEST PROCEDURES

Flowchart

The following page displays the flowchart for the COBA test process.



COBA Testing Workflow

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Tape Transfer

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Tape Transfer

SPECIFICATIONS

The following information is applicable to those Trading Partners that will be using tape to tape transfer for COBA information.

1. Tape cartridges must be a 9-track.
2. The sender must use IBM standard label.
3. Block size must be maximum.
4. If cartridges are used, they must be 3480.
5. 6250 BPI is preferred for reel tapes.

Tape Transfer

TRANSFER FORM

Trading Partners that elect to send/receive files on tape must complete and return this form to the COBC. If using multiple claims file locations, copy and complete separate Tape Transfer Forms.

Forward all Eligibility Files to the address below

Medicare-Coordination of Benefits
Attn: COBA Program/EDI Department
PO Box 660
New York, NY 10274-0660

or

Medicare-Coordination of Benefits
Attn: COBA Program/EDI Department
25 Broadway (12th Floor)
New York, NY 10004
(NOTE: Please be sure to use the full address when files information overnight to the COBC)

The COBC will forward all Claims Files to the address below

Trading Partner Name: _____

Attention: _____

COBA ID (s): _____

Address1: _____

Address2: _____

City/State/Zip: _____

Tape Transmittal

TRANSMITTAL LETTER

Trading Partners that elect to submit eligibility files on tape must accompany each tape with a transmittal letter. If your organization does not have a standard form, please use this form.

Trading Partner Name: _____

Attention: _____

COBA ID (s): _____

Address: _____

Volume/Serial #: _____

Data Set Name: _____

Record Count: _____

Media Type: _____ 3480 Cartridge _____6250 BPI
_____ 1600 BPI

Date Mailed: _____

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Electronic Transmission

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Electronic Transmission

SPECIFICATIONS

The AT&T Global Network Service (AGNS), called AGNS or Advantis, is like a private internet. Only subscribers to that network can participate in sessions with other subscribers entities. The network uses an encryption scheme of triple DES as a default to keep the physical transport of the data source.

Electronic Transmission

CONNECT DIRECT FORM

If you will be using the AT & T Global Network Service (AGNS) to send and receive information via transmission, please provide us with the following network information:

_____ Check here if the following represents transmission information for both Eligibility Files submission and Claims Files receipt.

Otherwise, copy and complete separate Connect Direct Forms and indicate, below, the following file representation:

_____ Eligibility File Submission or
_____ Claims File Receipt

Trading Partner's Information

Trading Partner Name: _____

COBA IDs: _____

Account ID: _____

Node ID: _____

Net ID: _____

Appl ID: _____

Trading Partners or Trading Partner contractors must provide the following Data Set Names (DSN) to the COBC for receipt of the Eligibility Detail Report and Claims Files (unless excluded in Section IV of the COBA Attachment:

Eligibility Detail Report:

Eligibility Detail Report Test: _____

Eligibility Detail Report Production: _____
(Note: If submitting multiple Eligibility Files, please provide multiple DSNs)

Electronic Transmission

ANSI 837 Version 4010A1 (Institutional):

Claims File Test: _____

Claims File Production: _____

ANSI 837 Version 4010A1 (Professional):

Claims File Test: _____

Claims File Production: _____

NCPDP Batch Version 5.1:

Claims File Test: _____

Claims File Production: _____

Coordination of Benefits Contractor's Information

Account ID: BXGH

Node ID: GHINY

Net ID: NETGHI

Appl ID: A08NDM

Trading Partners or Trading Partner contractors will need to use the following Data Set Names (DSN) for submitting eligibility files for COBA processing via Connect Direct:

Test
TCOB.BA.NDM.COBA.CBXXXXX.ELIG(+1)

Where XXXXX = the last five digits of the Trading Partner's COBA ID.

Electronic Transmission

Production
Production files will be prefixed with “PCOB” instead of “TCOB”.

When submitting production files to the COBC, you should execute the following trigger jobs: TECHXA.CA7.JOBLIB(COBAELGT). However, there are no trigger jobs required during testing.

Questions or Special Instructions:
If you have any technical questions or need assistance with establishing this transmission link, please contact our EDI Help Desk at (646) 458-6740. EDI Representatives will be available after July 6, 2004, to answer your questions.

Coordination of Benefits Agreement (COBA)

Eligibility File

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Eligibility File

PROCESS

The Trading Partner or the Trading Partner's contractor will transfer eligibility files to the COBC based on the terms defined within its COBA for all Medicare beneficiaries for whom it provides insurance coverage. The COBA process allows for two separate eligibility file update methodologies: Adds, Changes, and Deletes and Full File Replacement.

Validation of the Eligibility file

The COBC will provide a detail-level report back to the trading partner identifying eligibility records received, accepted, and denied. If the file has a fatal error, it is the Trading Partner's responsibility to resend the corrected file. The entire file will fail if:

- No header or trailer records are present.
- The COBA ID is invalid.
- The trailer record count does not match the actual record count.
- The file contains less than 70% of the records currently in our database. For Trading Partners that elect full file replacement this condition will result in a delayed processing of the Trading Partners eligibility file.
- More than 20% of the file contains errors.

For those eligibility files that do not contain a fatal error, the COBC will attempt to process each eligibility record on the file.

Eligibility Update Process

Adds, Changes, and Deletes

The CWF system is ideally suited for processing adds, changes, and deletes. Thus, the preferred eligibility update methodology for the COBA process is adds, changes, and deletes. Although full file replacement is not a preferred methodology for updating eligibility files, it will nevertheless be supported under the COBA process.

The following defines adds, changes, and deletes and provides an example of each:

Eligibility File

PROCESS CONT:

Adds: New information the Trading Partner provides the COBA process on a covered individual for whom the Trading Partner provides supplemental coverage. This information was never provided to the COBA process previously.

Example: Insurance plan X provides individual information for the first time to the COBC to identify John Smith as a covered individual under its plan for receipt of Medicare paid claims information.

Changes: Update to a covered individual record that was previously provided to the COBA process.

Example: Jane Doe was previously posted to the COBA eligibility database as a covered individual by insurer Y (add). Three months later, Jane Doe ceased coverage with that insurer. The insurer Y sends this change to the COBA process in the next update eligibility file.

Deletes: Removal of a record that was previously posted to the COBA eligibility database in error.

Example: John Doe was previously added to the COBA eligibility database as a covered individual by insurer Z. However, insurer Z determined that it had erroneously identified John Doe as a covered individual through its employer retiree plan. In reality, John Doe was actively employed.

Full File Replacement

CWF will treat a full file replacement as add, change, and delete. In the case of a full file replacement the COBA process will compare existing eligibility information against incoming eligibility information to determine if an add, change, or delete action is required. A delete action will occur for any record existing on the COBA eligibility database that is not readable or does not have a matching record on the incoming eligibility file.

PROCESS CONT:

Example: Insurance plan Y provides the COBA process with an eligibility file using the full file replacement methodology. This file is processed and contains six unreadable records, which are rejected by the COBA process. These six records representing covered individuals on the existing COBA eligibility database will be deleted. It is the responsibility of the Trading Partner to correct the error records and resend the eligibility records. These corrections may be done outside of the frequency for the eligibility file submission as specified in the COBA Attachment Section III.A.

For full file replacement Trading Partners must be especially careful to ensure that, in addition to the Health Insurance Claim Number (HICN), at least three of the following matching criteria are present: First Name (1st initial), Surname (1st six characters), Date of Birth, and Sex Code. If, in addition to the HICN, fewer than three of the four matching criteria are accurately reflected on the eligibility file, CWF will interpret this as a delete action for the eligibility records involved.

When all records in the eligibility file have been processed, a detailed eligibility report will be generated and available to the Trading Partner. Each eligibility reply report will specify the COBA ID and the File ID that uniquely identifies the report. Total counts will be given for number of eligibility records submitted; number of add, update, and delete records accepted; and total number of errors. See COBA Eligibility Detail Report in this section.

Each record that receives one or more errors will be included in the detail section of the report. The detail section will specify HICN, Beneficiary Surname, Date of Birth, Sex Code, Effective Date, BO Error (the first one) and BO Description. Records with the following errors will not be processed:

- BO01 – Invalid or missing HICN
- BO02 – Invalid or missing beneficiary surname
- BO03 – Invalid or missing beneficiary date of birth
- BO04 – Invalid or missing beneficiary sex code
- BO14 – Invalid insurance effective date
- BO15 – Invalid insurance termination date

It is the responsibility of the Trading Partner to correct the error records and resend the eligibility records.

Eligibility File

PROCESS CONT:

Data Set Names

Connect Direct users refer to the Electronic Transmission section. Tape users must properly label tapes and forward a Tape Transmittal Letter indicating the appropriate data set name.

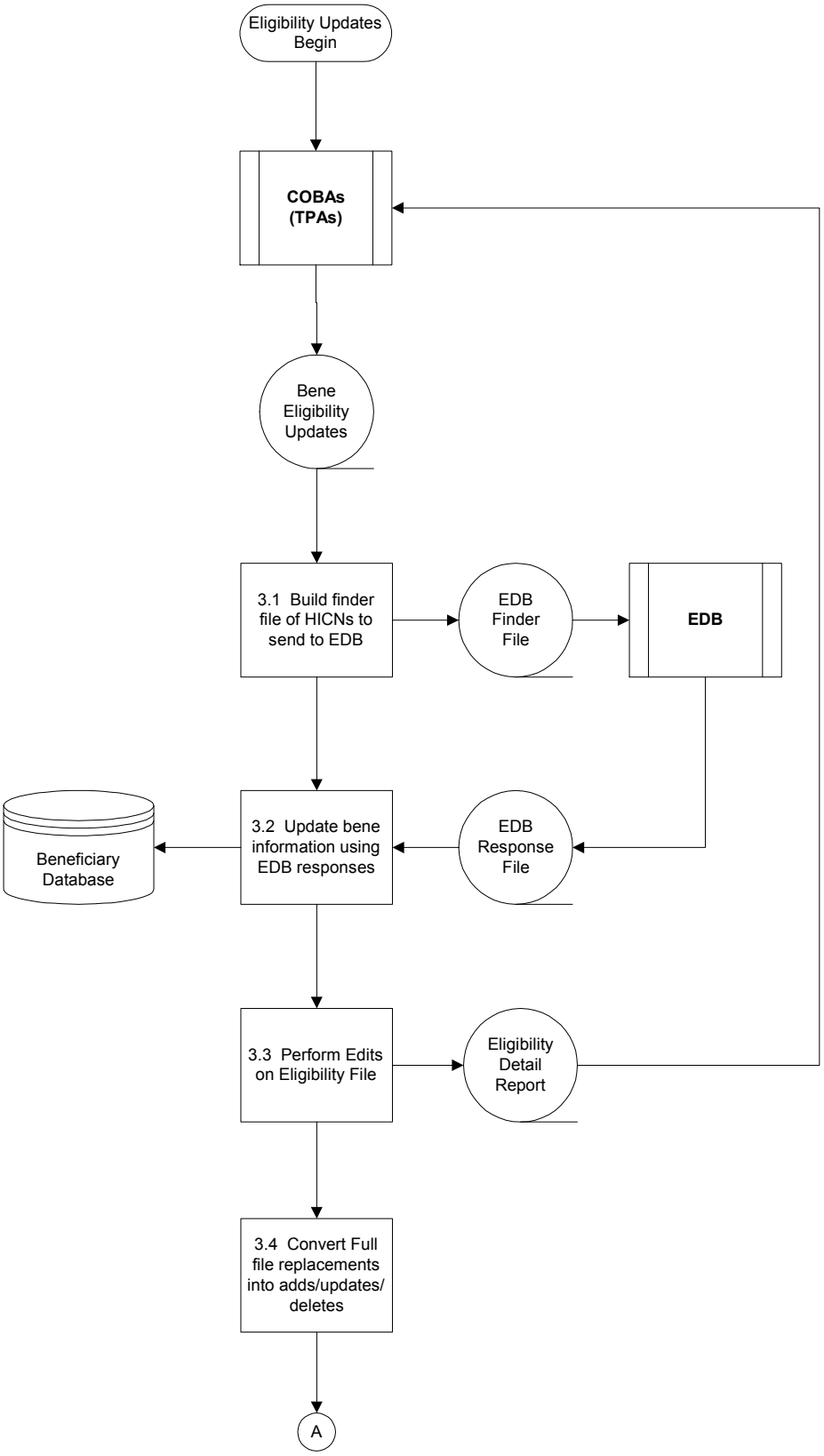
Creating a single eligibility file for use of multiple COBA IDs

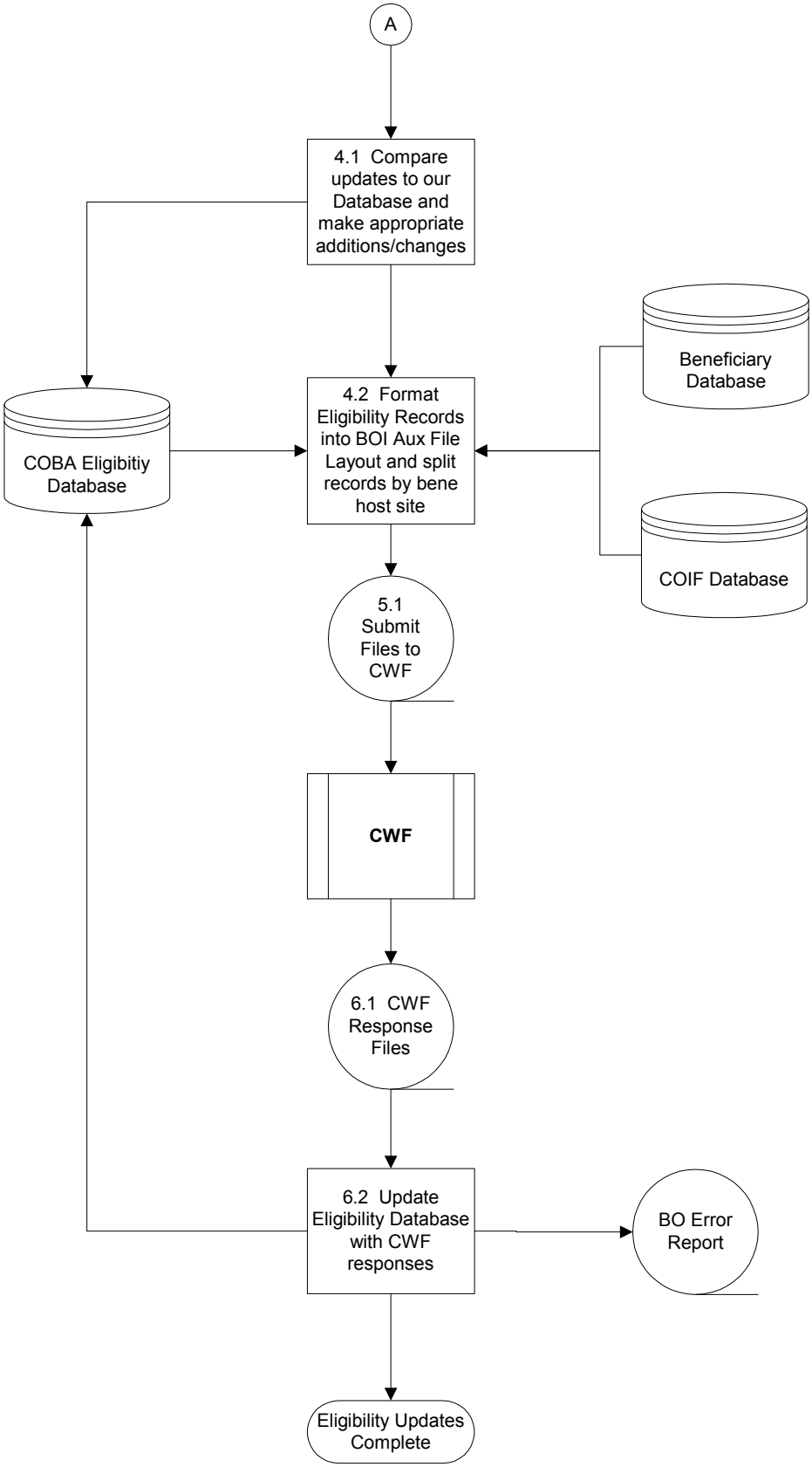
The COBC will allow Trading Partners or Trading Partner's contractors that have been assigned multiple IDs the option to combine all of their eligibility records with multiple COBA IDs into a single file. The COBA process requires that all beneficiary records **must** be separated by a new header and trailer within the file. Here is an example for a Trading Partner or Trading Partner contractor with multiple COBA IDs:

Header record contains COBA ID 000012345
Detail record contains COBA ID 000012345
Detail record contains COBA ID 000012345
Detail record contains COBA ID 000012345
Detail record contains COBA ID 000012345
Detail record contains COBA ID 000012345
Trailer record contains COBA ID 000012345
Header record contains COBA ID 000067890
Detail record contains COBA ID 000067890
Detail record contains COBA ID 000067890
Detail record contains COBA ID 000067890
Detail record contains COBA ID 000067890
Detail record contains COBA ID 000067890
Trailer record contains COBA ID 000067890

FLOWCHART

The following flowchart displays how the COBC's COBA Eligibility File Process will edit, validate, and process Trading Partner's eligibility files.


Eligibility Updates Begin
COBAs (TPAs)
Bene Eligibility Updates
3.1 Build finder file of HICNs to send to EDB
EDB Finder File
EDB
Beneficiary Database
3.2 Update bene information using EDB responses
EDB Response File
3.3 Perform Edits on Eligibility File
Eligibility Detail Report
3.4 Convert Full file replacements into adds/updates/ deletes
A


A
4.1 Compare updates to our Database and make appropriate additions/changes
Beneficiary Database
4.2 Format Eligibility Records into BOI Aux File Layout and split records by bene host site
COBA Eligibitiy Database
COIF Database
5.1 Submit Files to CWF
CWF
6.1 CWF Response Files
6.2 Update Eligibility Database with CWF responses
BO Error Report
Eligibility Updates Complete

Eligibility File

FORMAT

The following file layout provides the required COBA Eligibility File Format which will be used by Trading Partners to identify their eligible beneficiaries to receive Medicare paid claims information for their supplemental payment processing. All Trading Partners must use the following format. No other Eligibility File Format will be accepted for COBA processing.

COORDINATION OF BENEFITS AGREEMENT (COBA)
ELIGIBILITY FILE LAYOUT

DATA ELEMENT	DESCRIPTION	FIELD LENGTH	M O	FIELD LOCATION
HEADER RECORD TYPE	**Value - E00**	3X	O	E00.001
HEADER COBA ID	COBA ID assigned by the COBC	9X	O	E00.002
HEADER CREATION DATE	Date the record was created; format: (CCYYMMDD)	8X	O	E00.003
HEADER BENEFICIARY STATE CODE	Beneficiary State of residence **NOTE: This field will not be used by the COBA Process**	2X	O	E00.004
FILLER	Blank Field. Value is spaces.	178X	O	E00.005

X = ALPHA NUMERIC = LEFT JUSTIFY SPACE FILL
N = NUMERIC = RIGHT JUSTIFY ZERO FILL

M = MANDATORY
O = OPTIONAL

COORDINATION OF BENEFITS AGREEMENT (COBA)
ELIGIBILITY FILE LAYOUT

DATA ELEMENT	DESCRIPTION	FIELD LENGTH	M O	FIELD LOCATION
RECORD TYPE	**Value - E01**	3X	M	E01.001
COBA ID	Coordination of Benefits Agreement Identification Number **NOTE: Use only the last five bytes of the COBA ID and left justify.**	9X	M	E01.002
FILE EFFECTIVE DATE	Effective date of file; format: (CCYYMMDD)	8X	M	E01.003
FILE UPDATE INDICATOR	Type of update values: A-Add, C-Change, D-Delete **NOTE: This field will not be used by the COBA Process for Full File Replacement**	1X	O	E01.004
*BENEFICIARY SURNAME	Beneficiary last name	20X	M	E01.004
*BENEFICIARY FIRST	Beneficiary first name	12X	M	E01.005
BENEFICIARY MIDDLE INITIAL	Beneficiary middle initial	1X	O	E01.006
*BENEFICIARY BIRTH DATE	Beneficiary date of birth; format: (CCYYMMDD)	8X	M	E01.007
*BENEFICIARY SEX CODE	Beneficiary sex code values: M = Male F = Female **NOTE: If unknown default to M**	1X	M	E01.008
BENEFICIARY HIC NUMBER	Beneficiary Medicare Health Insurance Claim Number	12X	M	E01.009
BENEFICIARY SUPPLEMENTAL ID NUMBER	Supplemental ID on file with sender. Should be the same as what is submitted on the claim.	25X	O	E01.010
BENEFICIARY GROUP POLICY NUMBER	Supplemental policy number on file. Should be the same as what is submitted on the claim.	20X	O	E01.011

X = ALPHA NUMERIC = LEFT JUSTIFY SPACE FILL
N = NUMERIC = RIGHT JUSTIFY ZERO FILL

M = MANDATORY
O = OPTIONAL

COORDINATION OF BENEFITS AGREEMENT (COBA)
ELIGIBILITY FILE LAYOUT

DATA ELEMENT	DESCRIPTION	FIELD LENGTH	M O	FIELD LOCATION
BENEFICIARY SUPPLEMENTAL ELIGIBILITY FROM DATE-1	Medicare supplemental "from" date; format: (CCYYMMDD)	8N	M	E01.012
BENEFICIARY SUPPLEMENTAL ELIGIBILITY TO DATE-1	Medicare supplemental "to" date; format: (CCYYMMDD)	8N	M	E01.013
BENEFICIARY SUPPLEMENTAL ELIGIBILITY FROM DATE-2	Medicare supplemental "from" date; format: (CCYYMMDD)	8N	O	E01.014
BENEFICIARY SUPPLEMENTAL ELIGIBILITY TO DATE-2	Medicare supplemental "to" date; format: (CCYYMMDD)	8N	O	E01.015
BENEFICIARY SUPPLEMENTAL ELIGIBILITY FROM DATE-3	Medicare supplemental "from" date; format: (CCYYMMDD)	8N	O	E01.016
BENEFICIARY SUPPLEMENTAL ELIGIBILITY TO DATE-3	Medicare supplemental "to" date; format: (CCYYMMDD)	8N	O	E01.017
BENEFICIARY SUPPLEMENTAL ELIGIBILITY FROM DATE-4	Medicare supplemental "from" date; format: (CCYYMMDD)	8N	O	E01.018
BENEFICIARY SUPPLEMENTAL ELIGIBILITY TO DATE-4	Medicare supplemental "to" date; format: (CCYYMMDD)	8N	O	E01.019
BENEFICIARY SUPPLEMENTAL ELIGIBILITY FROM DATE-5	Medicare supplemental "from" date; format: (CCYYMMDD)	8N	O	E01.020
BENEFICIARY SUPPLEMENTAL ELIGIBILITY TO DATE-5	Medicare supplemental "to" date; format: (CCYYMMDD)	8N	O	E01.021

X = ALPHA NUMERIC = LEFT JUSTIFY SPACE FILL
N = NUMERIC = RIGHT JUSTIFY ZERO FILL

M = MANDATORY
O = OPTIONAL

COORDINATION OF BENEFITS AGREEMENT (COBA)
ELIGIBILITY FILE LAYOUT

DATA ELEMENT	DESCRIPTION	FIELD LENGTH	M O	FIELD LOCATION
TRAILER RECORD TYPE	**Value - E99**	3X	M	E99.001
TRAILER RECORD COUNT	Total number of records in the file **excluding E00 and E99**.	7N	M	E99.002
FILLER	Blank Field. Value is spaces.	190X	M	E99.003

*Note: The matching criteria will be on (1) Beneficiary Surname (first six characters), (2) Beneficiary First Name, (3) Beneficiary Birth Date, and (4) Beneficiary Sex Code. Trading Partners should use the value code representation of "M" as a default for the Beneficiary's Sex Code, if sex is unknown. Beneficiary records matching on three out of the four matching criteria will pass.

X = ALPHA NUMERIC = LEFT JUSTIFY SPACE FILL
N = NUMERIC = RIGHT JUSTIFY ZERO FILL

M = MANDATORY
O = OPTIONAL

Eligibility File

DETAIL REPORT

The following displays the COBA Eligibility Detail Report. Refer to the Eligibility File Process as described above for more information regarding the generation and purpose of this report.

PROGRAM: XXXXX99
REPORT#: D046

COB REPORT
COBA ELIGIBILITY DETAIL REPORT

CYCLE DATE: MM/DD/YY
RUN DATE: MM/DD/YY
PAGE: 999

COBA ID: XXXXXXXXXX FILE ID: XXXXXXXXXXXX

HICN	SURNAME	DATE OF BIRTH	SEX CODE	EFF. DATE	SUPPLEMENTAL ID	BO ERROR
XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXX	MMDDCCYY	X	MMDDCCYY	XXXXXXXXXXXXXXXXX	BOXX
XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXX	MMDDCCYY	X	MMDDCCYY	XXXXXXXXXXXXXXXXX	BOXX
XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXX	MMDDCCYY	X	MMDDCCYY	XXXXXXXXXXXXXXXXX	BOXX
XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXX	MMDDCCYY	X	MMDDCCYY	XXXXXXXXXXXXXXXXX	BOXX
XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXX	MMDDCCYY	X	MMDDCCYY	XXXXXXXXXXXXXXXXX	BOXX
XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXX	MMDDCCYY	X	MMDDCCYY	XXXXXXXXXXXXXXXXX	BOXX
XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXX	MMDDCCYY	X	MMDDCCYY	XXXXXXXXXXXXXXXXX	BOXX
XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXX	MMDDCCYY	X	MMDDCCYY	XXXXXXXXXXXXXXXXX	BOXX
XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXX	MMDDCCYY	X	MMDDCCYY	XXXXXXXXXXXXXXXXX	BOXX
XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXX	MMDDCCYY	X	MMDDCCYY	XXXXXXXXXXXXXXXXX	BOXX
XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXX	MMDDCCYY	X	MMDDCCYY	XXXXXXXXXXXXXXXXX	BOXX
XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXX	MMDDCCYY	X	MMDDCCYY	XXXXXXXXXXXXXXXXX	BOXX
XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXX	MMDDCCYY	X	MMDDCCYY	XXXXXXXXXXXXXXXXX	BOXX
XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXX	MMDDCCYY	X	MMDDCCYY	XXXXXXXXXXXXXXXXX	BOXX

TOTAL NUMBER OF RECORDS SUBMITTED : 999,999,999
NUMBER OF ADD RECORDS ACCEPTED : 999,999,999
NUMBER OF UPDATE RECORDS ACCEPTED : 999,999,999
NUMBER OF DELETE RECORDS ACCEPTED : 999,999,999
TOTAL NUMBER OF BO ERRORS : 999,999,999

Coordination of Benefits Agreement (COBA)

Claims File

Implementation User Guide

Claims File

PROCESS

Medicare Contractors will submit all claims for crossover to the COBC nightly via 837 flat file formats and/or NCPDP. The COBC will cross the claim to the appropriate Trading Partner using the COBA ID provided by the Medicare Contractors (from CWF), after referencing the frequency, and media type specifications established in the COBA data base for the Trading Partner. All electronic claims, with the exception of NCPDP transfer claims, must be received in ANSI 837 Version 4010A1 (Institutional/Professional). NCPDP will be sent in NCPDP Batch Version 5.1 format.

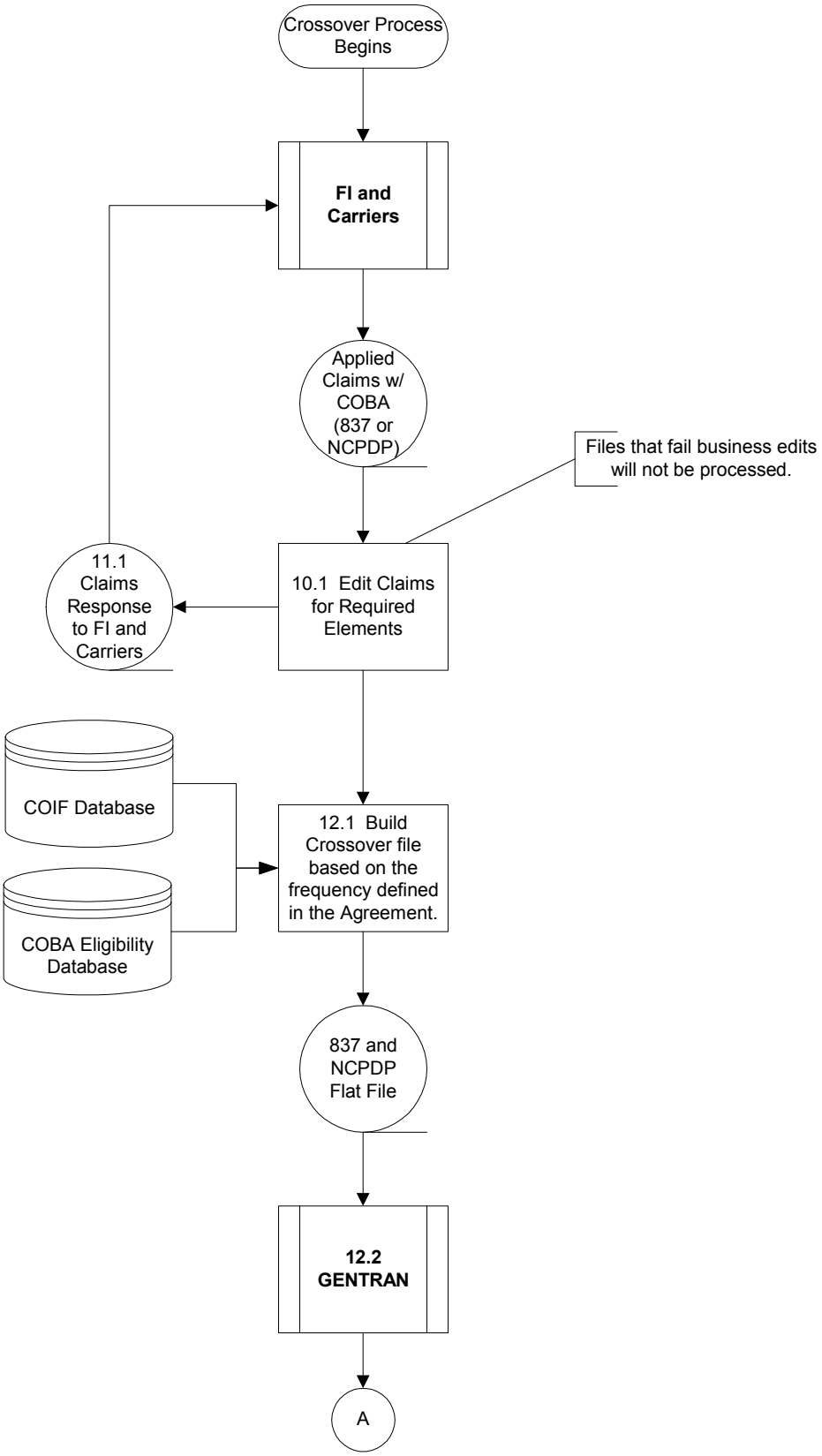
Prior to crossing, each claim is edited. Because the Medicare Contractors will not know the Trading Partner's Contractor associated with the COBA IDs, the COBA subsystem will populate the Trading Partner's Contractor data in the appropriate loops. If data are populated by the Medicare Contractor, these fields will not be overlaid by the COBA subsystem.

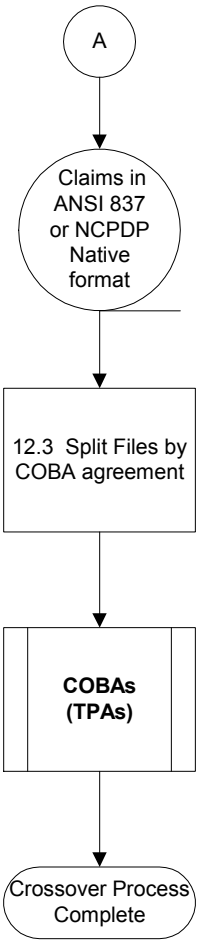
The COBC will maintain claim counts by Trading Partner for claims crossed and will send updates to the accounting system for the creation of monthly invoices to each Trading Partner. These invoices will specify the number of claims, type of claims and payment due. Adjustments to claims crossed will be accepted and updated in the accounting system and sent to the COBA subsystem.

Claims File

FLOWCHART

The following flowchart displays the COBA Claims File Process necessary to create routine production claims files for Trading Partners.


Crossover Process Begins
FI and Carriers
Applied Claims w/ COBA (837 or NCPDP)
Files that fail business edits will not be processed.
11.1 Claims Response to FI and Carriers
10.1 Edit Claims for Required Elements
COIF Database
COBA Eligibility Database
12.1 Build Crossover file based on the frequency defined in the Agreement.
837 and NCPDP Flat File
12.2 GENTRAN
A


A
Claims in ANSI 837 or NCPDP Native format
12.3 Split Files by COBA agreement
COBAs (TPAs)
Crossover Process Complete

Claims File

FORMATS

The COBC will forward all COBA claims in the following American National Standards Institute (ANSI) X12N file formats—ANSI 837 Version 4010A1 (Institutional) and ANSI 837 4010A1 (Professional)—and the National Council for Prescription Drug Programs (NCPDP) standard format for drug claim transactions.

The following guides provide comprehensive technical details for HIPAA implementation. They define the specific activities related to each transaction and directions for how data should be moved electronically from one entity to another according to HIPAA electronic standards requirements:

- The ASC X12N 837: Professional Implementation Guide
- The ASC X12N 837: Institutional Implementation Guide
- The NCPDP: Retail Pharmacy Transactions (Batch Version 5.1)

Refer to the Technical Reference section in this guide for the appropriate Web site location.

Claims File

CLAIMS RE-CREATION

As stated in Article III.C of the Coordination of Benefits Agreement (COBA), “If the Eligibility File or Claims File is lost, damaged, not readable, or the receiving party deems the data to be invalid, incorrect, or insufficient, the receiving party agrees to notify the sender within five (5) business days.

The receiving party shall have forty (40) business days from the estimated date of delivery to notify the sender that a Claim File was lost, damaged, not readable, or the receiving party deems the data to be invalid, incorrect, or insufficient. The sender shall retransmit a Claim File to the receiving party, at no additional cost, within five (5) business days from the date of notification by the receiver if the previously transmitted Claim File was lost, damaged, not readable, or contained invalid, incorrect, or insufficient data.”

Therefore, in the event of missing or indecipherable COBA claims files, please contact the COBC within the required time frame as stated above to avoid replacement charges as incurred by the COBC. Refer to the Customer Assistance section within this guide for contact information.

Coordination of Benefits Agreement (COBA)

Technical References

Implementation User Guide

Technical References

TECHNICAL REFERENCES

837 Implementation Guides

The standard ANSI ASC X12N formats have been published and are available at Washington Publishing Company at http://www.wpc-edi.com.

NCPDP Implementation Guides

The NCPDP Web site www.ncpdp.org contains information on NCPDP implementation guides.

Companion Guides

The standard Institutional, Professional, and NCPDP Coordination of Benefits (COB) Companion Documents are available on the Internet at _____. (This web site location will be made available in the future)

Claims Adjustment Reason Codes and Remittance Advice Remark Codes

The following HIPAA required codes are available on the Internet at Washington Publishing Company at http://www.wpc-edi.com.

- **Claim Adjustment Reason Codes**: These codes communicate why a claim or service line was "adjusted" (or paid differently that it was billed).

- **Remittance Advice Remark Codes**: Remark Codes add greater specificity to an adjustment reason code.

COBC Web Site

For more information regarding the COBA Program, visit our Web site at www.cms.hhs.gov/medicare/cob.

Coordination of Benefits Agreement (COBA)

COBA Financial

Implementation User Guide

Finance

FINANCIAL

The following pages consist of a high level overview of the COBA financial process. An extensive detail packet will be made available in the future.

A. Introduction:

Thank you for participating in the Coordination of Benefits Contractors (COBC) db-eBills on-line payment system.

As you know, The Coordination of Benefits Agreement (COBA) program crossover consolidation initiative will initially be implemented on a small-scale during the period from July 6, 2004, to October 1, 2004. During this time, ten COBA trading partners that will serve as beta-site testers and participate in a COBA pilot testing period. Implementation of the COBA program will begin on a larger scale in October 2004.

You will now be given access to the db-eBills on-line service to access and pay your invoices.

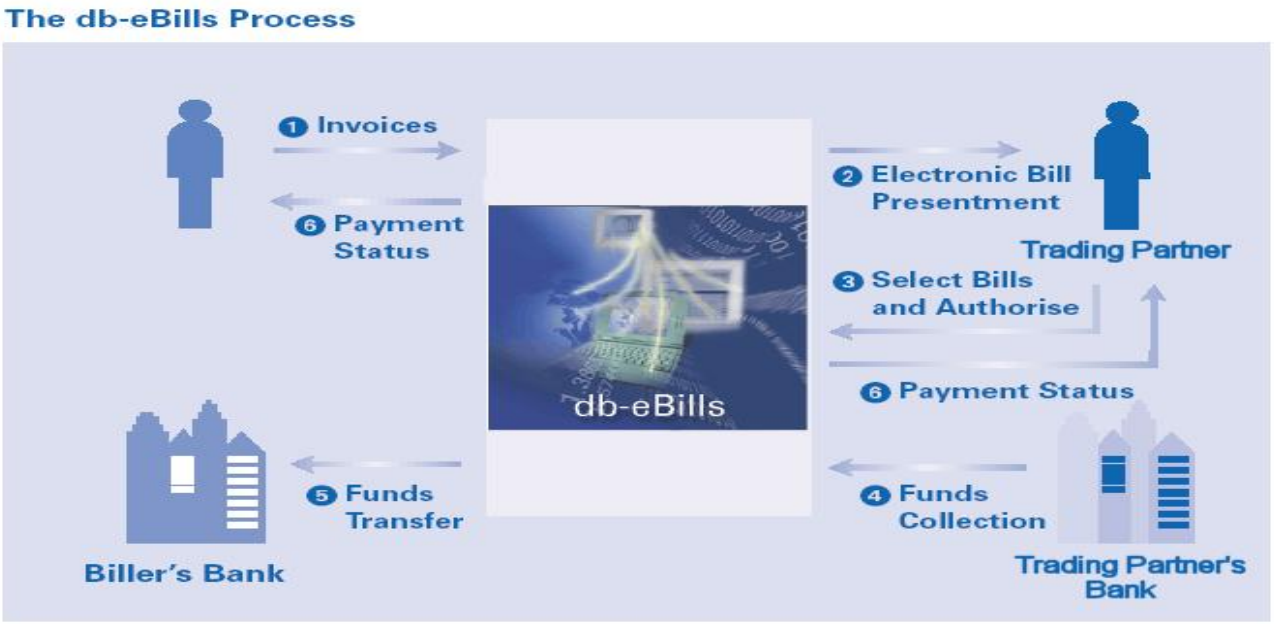
B. What is db-eBills?

db-eBills is an Electronic invoice Presentment and Payment (EIPP) System. COBC will present your invoices via db-eBills, notifying you of payments due. You can now access payments on-line to review, dispute and approve transactions.

You can decide when to pay, how much to pay, which bank account and payment method to use. To ensure a high level of security and reliability, db-eBills incorporates digital certificates and electronic identity verification mechanisms.

You can view invoices online and make payments electronically via the Automated Clearing House (ACH) or via check issuance.

C. High Level Overview



Step	Task	Responsible
(1)	The Electronic Invoice Presentment and Payment (EIPP) process begins with COBC transmitting an electronic file, containing invoice data, to their Bank. The invoice data is then loaded into the db-eBills system.	COBC
(2)	Once invoices are successfully loaded, db-eBills will generate email notifications to you, informing you of the invoices waiting your review, and processing.	db-eBills
(3)	When you access db-eBills, you can view your invoices from COBC online. You can then perform the following processing actions on these invoices: • View the invoice • Raise disputes on the invoice or line item level • Apply credit notes to the invoice, if available • Approve the invoice, after checking for validity and accuracy • Perform payment preparation • Perform payment authorization	Trading Partner
(4)	Once the payments have been authorized, db-eBills will direct debit your account.	db-eBills
(5)	Once the funds have been received, db-eBills will credit	db-eBills

	COBC's account	
(6)	db-eBills will reconcile the payment information, and update the payment status, and inform both COBC and yourself that funds have been received and that the invoice has been successfully paid.	db-eBills

Coordination of Benefits Agreement (COBA)

Customer Assistance

Implementation User Guide

Customer Assistance

CUSTOMER ASSISTANCE

All tapes and correspondence should be forwarded to the following address:

Mailing Address

Medicare-Coordination of Benefits
Attn: COBA Program
PO Box 660
New York, NY 10274-0660

or

Medicare-Coordination of Benefits
Attn: COBA Program
25 Broadway (12th Floor)
New York, NY 10004

(NOTE: This address must be used for all overnight mail deliveries)

Facsimile

Documents can be transmitted to Attn: COBA EDI Department at 1-646-458-6761.

Customer Service

The COBC's EDI Representatives are available to provide you with high-quality and efficient service from 8:00 a.m. through 5:00 p.m., Eastern Time (EST), Monday through Friday, except holidays. Contact the EDI Department via e-mail at cobva@ghimedicare.com or call 1-646-458-6740.

Note: EDI Representatives will be available after July 6, 2004, to answer your questions.