CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 98 **Date: February 6, 2004**

CHANGE REQUEST 3109

I. SUMMARY OF CHANGES: The CMS is in the process of consolidating the claims crossover function under one contractor, the Medicare Coordination of Benefits Contractor (COBC). Under the new process, Medicare contractors will no longer execute Agreements and receive eligibility files from coordination of benefits (COB) trading partners. The trading partners will now execute national Coordination of Benefit Agreements (COBAs) with and send COB eligibility files to the COBC. Upon execution of a national COBA, each COB trading partner will be assigned a unique 5-digit COBA ID. Claim-based trading partners will also be assigned unique 5-digit COBA IDs. For eligibility file-based crossover, each COBA ID, together with all other eligibility file data elements, will be stored on the Common Working File (CWF) in the recently established Beneficiary Other Insurance (BOI) auxiliary file.

Under the COBA process, CWF will be equipped to apply each COB trading partner's claims selection criteria against processed Medicare claims and to post a one-digit claims crossover disposition indicator summarizing the results of the claims selection process on the various detailed Health Insurance Master Record (HIMR) history screens (i.e., INPH, OUTH, HOSH, PTBH, DMEH, HHAH). In addition, CWF will return a BOI reply trailer 29 to Medicare intermediaries and carriers **only** if they are to send processed claims information, via flat files, to the COBC to be crossed over to the COB trading partner. The BOI reply trailer will contain the COBA's trading partner name and associated ID (COBA ID) for purposes of printing crossover actions (e.g., the claim was sent to Trading Partner X.) on the HIPAA ANSI X12N 835 Electronic Remittance Advice, and on the Medicare Summary Notice.

Through this instruction, providers and suppliers will receive instruction to include CMS' 5-digit claim-based COBA ID on incoming claims if: the beneficiary has assigned benefits to the provider/supplier, and/or 2) the provider/supplier accepts assignment on the claim. Carriers and DMERCs will be required to validate that the provider or supplier that reported a claim-based Medigap or Medicaid ID on an incoming claim participates with the Medicare Program. And, if a validate claim-based COBA ID is present on the claim, the Carrier or DMERC shall report that ID in field 36 of the HUBC or HUDC query that is sent to CWF. The CWF, in turn, will search the Coordination of Benefits Agreement Insurance File (COIF) that it will receive on a weekly basis from the COBC to locate a corresponding claim-based COBA ID. If CWF locates the reported claim-based COBA ID **and** if the beneficiary's claim is to be sent to the COBC to be crossed over, it will return a Claim-based reply trailer 37 to the carrier or DMERC. Carriers or DMERCs that receive a Claim-based reply trailer 37 are to include the claim on which a claim-based COBA ID was reported on their 837 COB flat file or NCPDP file submissions to the COBC.

NEW/REVISED MATERIAL - EFFECTIVE DATE: July 1, 2004
***IMPLEMENTATION DATE:** July 6, 2004

Disclaimer: 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 only receive the new\revised information, and not the entire table of contents.

II. SCHEDULE OF CHANGES (R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	24/70/ Crossover Claims Requirements
R	24/70.1/ FI Requirements
R	24/70.2/ Carrier/DMERC Requirements
R	27/ Table of Contents
N	27/80.14/ Consolidated Claims Crossover Process
N	27/80.15/ Claims Crossover Disposition Indicators
R	28/ Table of Contents
R	28/20/ Assignment of Claims and Transfer Policy
R	28/20.1/ Beneficiary Insurance Assignment Selection
R	28/30.1/ Form CMS-1500 (ANSI X12N 837 COB (Version 4010)
R	28/50/ Remittance Advice Messages
R	28/60/ Returned Medigap Notices
R	28/70/ Coordination of Medicare with Medigap and Other Complementary Health Insurance Policies
R	28/70.3/ Standard Medicare Charges for COB Records
N	28/70.6/ Consolidation of the Claims Crossover Process
R	28/80/ Electronic Transmission – General Requirements
R	28/80.2/ ANSI X12N 837 COB (Version 4010) Transaction Fee Collection
R	28/80.3/ Medigap Electronic Claims Transfer Agreements
R	28/80.3.1/ Intermediary Crossover Claim Requirements
R	28/80.3.2/ Carrier/DMERC Crossover Claim Requirements

III. FUNDING: *Medicare contractors only:

These instructions should be implemented within your current operating budget.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Special Notification

Business Requirements

Pub. 100-04	Transmittal: 98	Date: February 6, 2004	Change Request 3109

SUBJECT: Consolidation of the Claims Crossover Process: Additional Common Working File (CWF) Functionality

I. GENERAL INFORMATION

A. Background: This instruction revises several of the business requirements provided in Transmittal R-28 (Change Request 2962), which expanded the business requirements in Transmittal R-29 (Change Request 2961). Where there are no changes to a business requirement as stated in Transmittals R-28 and R-29, "no change" will appear in the numbered requirement. Where a requirement has been deleted, "delete" will appear in that numbered requirement. Where a requirement has been revised, "revised" will appear in that numbered requirement, together with the associated revisions. And, finally, where a new requirement has been added, "new" will appear in that numbered requirement.

As the result of input from affected stakeholders in the health insurance industry, CMS has decided that it will expand the capabilities of its CWF system to allow for a more effective implementation of the COBA process. The changes to CWF, outlined below, address important customer service concerns that may have arisen from beneficiaries, providers/ suppliers, and other key stakeholders following the implementation of the COBA process. The revised COBA process also ensures that CMS fulfills the requirements imposed by the HIPAA ANSI-X12 835 (Electronic Remittance Advice) Implementation Guide with respect to communication of crossover information to its Medicare providers and suppliers. This instruction also outlines CMS' claim-based crossover process, which applies to carriers and Durable Medical Equipment Regional Carriers (DMERCs) only. The CMS' recovery of the claims process under COBA will be addressed via a separate Change Request.

By April 5, 2004, the Common Working File (CWF) system maintainer shall effect the Health Insurance Master Record (HIMR) changes, as listed in the revised Attachment F (see attached), and begin analysis on the process for CWF to apply claims selection criteria, as outlined in the requirements in this transmittal.

By July 6, 2004, all system maintainers shall have completed the analysis and coding of all requirements below, including those claim-based requirements that will not go into production until October 4, 2004. The COBA claim-based crossover process will begin on October 4, 2004, when providers and suppliers begin sending COBA claim-based IDs on incoming claims as instructed.

B. Policy: CMS' CWF system will: 1) House the Beneficiary Other Insurance (BOI) auxiliary file, which provides details about a beneficiary's eligibility for crossover to a given COBA trading partner; 2) Apply each trading partner's claims selection criteria; and 3) Return a BOI reply trailer and/or Claim-based reply trailer in those instances where a claim is to be sent to the COBC for crossover.

C. Provider Education: Contractors will be required to inform affected provider/ supplier communities of the forthcoming consolidation of the claims crossover process, as described in Requirement 10 below. In addition, in the next several weeks, CMS will issue

an information packet and separate instructions to describe provider and supplier responsibilities relating to the COBA claim-based process.

II. BUSINESS REQUIREMENTS

NOTE: APASS is waived from implementation of these requirements in light of the completion of the transition of APASS users to FISS by May 2004.

Requirement #	Requirements	Responsibility
Ch. 28, Sec. 70.6 Requirement 1	Revised. You shall send processed claim information to the COBC for crossover to a COBA trading partner in response to the receipt of a CWF BOI. You will only receive a CWF BOI reply trailer for claims that the COBA trading partner has selected to receive via the crossover process. You will not receive copies of the COBA Insurance File (COIF) to perform crossover claim selection criteria. The CWF will perform crossover claim selection criteria for COBA trading partners, including claim-based and eligibility file-based trading partners.	Intermediaries, Carriers, and DMERCs
Ch. 28, Sec. 70.6 Requirement 2	Revised. When a BOI reply trailer is received, the COBA ID will identify the type of crossover (see modified data element 24, Attachment A). Although each COBA ID will consist of a 5-digit prefix that will be all zeroes, you are only responsible for picking up the last 5 digits within these ranges, which will be right justified in the COBA number field. When you receive a BOI reply trailer (trailer 29), you shall annotate your claims history to show that the beneficiary's claim was selected to be crossed over. If you receive a Claim-based reply trailer (trailer 37), you shall annotate your claims history to show that the beneficiary's claims was selected to be crossed over. Claim-based	Intermediaries, Carriers, and DMERCs Carriers and DMERCs

	COBA IDs that will be returned via a trailer 37 will fall either in the claim-based Medigap range (55000-59999) or in the claim-based Medicaid range (78000-79999).	
Ch. 28, Sec. 70.6 Requirement 3	Revised. Follow these rules when you receive a BOI reply trailer and there is some other indication of crossover eligibility, e.g., Medigap information, supplied on the claim: 1. If you receive a BOI reply trailer 29 with a COBA ID that falls in the Medigap eligibility-based range (30000-54999), you shall **not** cross over claims based on an existing Medigap TPA or when Medigap information is reported on the claim. (See claim-based requirements beginning with number 21 for further information). Instead, send the claim to the COBC (based on the BOI reply trailer) on the 837 v4010A1 flat file or National Council for Prescription Drug Programs (NCPDP) file for crossover by the COBC to the COBA trading partner. (**NOTE:** The assumption is that a beneficiary will have only one true Medigap insurer.) 2. If you receive a BOI reply trailer 29 with a COBA ID that falls in the Medicaid range (70000-77999), you shall **not** cross over claims based on an existing Medicaid TPA or when Medicaid information is reported on the claim. (See claim-based requirements beginning with number 21 for further information). Instead, send claims to the COBC (based on receipt of a BOI trailer) on the 837 v4010A1 flat file or NCPDP file for crossover by the COBC to the COBA trading partner. You shall not change your current procedures regarding suppression of Medicaid claims when a beneficiary has non-Medigap and/or Medigap insurance, including, for example, supplemental or Medigap insurers identified by a BOI trailer COBA ID.	Intermediaries, Carriers, and DMERCs (**NOTE**: Medigap claim-based scenarios do not apply to Intermediaries)

	3. If you receive a COBA ID via a BOI trailer 29 that falls in the Supplemental range (00001-29999) and you have an existing TPA with a supplemental insurer for the beneficiary, you shall transmit the claim to the COBC for crossover to the COBA trading partner **and** cross the claim to your existing trading partner. 4. Prior to October 4, 2004, if you receive a COBA ID via a BOI reply trailer that falls in the Supplemental range (00001-29999), and you also receive Medigap crossover information on the claim, you shall cross the claim to the Medigap insurer identified on the claim **and** transmit the claim to the COBC for crossover to the COBA trading partner based on the Supplemental COBA ID. Effective October 4, 2004, follow requirements beginning with number 21 when a Medicaid and/or Medigap claim-based COBA ID is reported on an incoming claim. **NOTE:** For all scenarios above, the trading partner shall be responsible for canceling any existing TPA that it has with you once it has signed a COBA with the Coordination of Benefits Contractor (COBC). However, if you determine that a crossover trading partner has not cancelled its TPA with you, you shall create a report that identifies that trading partner and request that it cancel its TPA and cease sending you eligibility files.	
Ch. 28, Section 70.6 Requirement 4	No change. You shall transmit all non-NCPDP claims received with a COBA ID on the BOI trailer to the COBC in an 837 v4010A1 flat file, as described in Transmittal AB-03-060. In a separate transmission, send the claims received in the NCPDP file format to the COBC in that same format. You shall enter the COBA ID in the l000B loop of the NM1 segment in the NM109 field. In a situation where multiple COBA IDs are received for a claim, you shall send a separate 837 or NCPDP transaction to the COBC for each COBA ID. You shall	Intermediaries, Carriers, and DMERCs

	perform the transmission at the end of the regular batch cycle, when claims come off the payment floor, to ensure crossover claims are not processed by the COBA trading partner prior to Medicare final payment. Transmission should occur via Network Data Mover (NDM) over AGNS (AT&T Global Network Service). Refer to Attachment C for a listing of your specific responsibilities for populating the 837 flat files that you will send to the COBC. To assist the COBC in resolving any file transmission or other related problems, each contractor shall provide a technical contact (i.e., contractor name, contact name, telephone number, and e-mail address) to the COBC**.** Each contractor shall be required to send its technical contact information to Brian Pabst at CMS (bpabst@cms.hhs.gov) no later than January 1, 2004.	
Ch. 28, Section 70.6 Requirement 5	Revised. After you have transmitted claims to the COBC, you will receive a returned response file, via NDM, that indicates the number of claims received and whether the entire file was accepted or rejected. When you receive the reject indicator "R" via the Claims Response File, you are to retransmit the entire file to the COBC. If you receive an acceptance indicator "A," this confirms that your entire COB flat file or NCPDP file transmission was accepted. Refer to Attachment D for a copy of the Claims Response File Layout (80 bytes) and possible edits that will affect COBC's decision to return a reject indicator "R" to the Medicare contractor. Note that if you submit daily claim files to the COBC, you will also receive claim response files daily. The claims response files returned to you by the COBC will be assigned the file names that appear below. These file names will be created as part of the NDM set-up process. As COBC will potentially receive 3 types of files, a separate response will be generated for each file: PCOB.BA.NDM.COBA.Cxxxx.PARTA(+1)	Intermediaries, Carriers, and DMERCs

	[Used for Institutional Claims] PCOB.BA.NDM.COBA.Cxxxx.PARTB(+1) [Used for Professional Claims] PCOB.BA.NDM.COBA.Cxxxx.NCPDP(+1). [Used for Drug Claims] Note that "xxxxx" denotes the Medicare contractor number. Test files will be prefixed with "TCOB" instead of "PCOB." Files transmitted to COBA trading partners by the COBC will be stored for 50 business days from the date of transmission. Files transmitted by you to the COBC shall be stored for 51 business days from the date of transmission.	Intermediaries, Carriers, and DMERCs
Ch. 28, Sec. 70.6 Requirement 6	Revised. You shall keep your present crossover process in place, including invoicing for claims crossed to current trading partners, until each of your present trading partners has been transitioned to the COBA process. As trading partners are signed on to national COBAs, they will be advised that it is their responsibility to simultaneously cancel current agreements with you and to cease submission of eligibility files to you. The CMS expects to complete the transition of current eligibility-based trading partners to COBAs by January 31, 2005.	Intermediaries, Carriers, and DMERCs
Requirement 7	Deleted.	Intermediaries, Carriers, and DMERCs
Ch. 28, Sec. 70.6 Requirement 8	Revised. Your customer service personnel shall answer provider/supplier and beneficiary questions about a claim's crossover status by referring to your internal claims history (see Requirement 2, above). Your customer service staff shall access information regarding why a claim did not cross by referring to the detailed history	Intermediaries, Carriers, and DMERCs

	screens on HIMR (e.g., INPH, OUTH, HOSH, PTBH, DMEH, and HHAH). These screens will also display indicator "A" when a claim was selected to be crossed over to the COBA ID shown. The BOI auxiliary file will identify the name associated with the COBA ID. The CWF maintainer will issue instructions on the use of the new HIMR screens as part of the April 5, 2004, release.	 CWF maintainer
Ch. 28, Sec. 70.6 Requirement 9	No change. For workload reporting, you shall provide separate counts, by trading partner, for claims you cross to current trading partners (including Medicaid), as you currently report. You shall track claims transmitted to the COBC for crossover to COBA trading partners for future reporting requirements by COBA ID.	Intermediaries, Carriers, and DMERCs
Requirement 10	Revised. A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article to their Web site, and include it in a listserv message if applicable, within one week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin.	Intermediaries, Carriers, and DMERCs
Requirement 11	Deleted.	CWF
Requirement 12	Deleted.	COBC, CWF
Ch. 27, Sec. 80.15 Requirement 13	Revised. The CWF shall annotate each claim with an indicator that will inform all users of the claim's crossover status (see Attachment F). In addition, CWF shall annotate each claim with a 10-position COBA ID (5-digit COBA ID preceded by 5 zeroes) to identify the entity to which the claim was crossed or not crossed, in	CWF

	accordance with the COBA.	
Requirement 14	Revised The CWF shall allow for the repeating of Requirement 13, so that up to ten (10) COBA IDs may be posted with each individual claim, as applicable.	CWF
Ch. 27, Sec. 80.14 and Ch 28, Sec. 70.6 Requirement 15	New. On a weekly basis, the nine (9) CWF host sites shall accept a Coordination of Benefits Agreement Insurance File (COIF) from the COBC to facilitate completion of the requirements 16 and 17 below. (The file layout for the COIF, which includes all available COBA claims selection criteria, appears in Attachment G.)	CWF
Ch. 27, Sec. 80.14 and Ch. 28, Sec. 70.6 Requirement 16	New. The CWF shall load the initial COIF submission from COBC as well as all future updates. Upon receipt of a claim, CWF shall take the following actions: 1) Search for a COBA eligibility record on the BOI auxiliary record for each beneficiary and obtain the associated COBA ID(s) [**NOTE:** There may be multiple COBA IDs]; 2) Refer to the COIF associated with each COBA ID (note: CWF shall pull the COBA ID from the BOI auxiliary record) to obtain the COBA trading partner's name and claims selection criteria; 3) Apply the COBA trading partner's claims selection criteria; and 4) Transmit a BOI reply trailer to the Medicare contractor only if the claim is to be sent to COBC for crossover.	CWF

Ch. 27, Sec. 80.14 and Ch. 28, Sec. 70.6 Requirement 17	New. The CWF maintainer shall modify the BOI reply trailer 29 (see Attachment B) to include, in addition to COBA ID, the COBA trading partner name(s), an "A" crossover indicator, which specifies that the contractor is to send a claim to the COBC, and the insurer effective and termination dates. (See requirement 19, below, for more details about CWF's handling of non-assigned Medicaid claims.) Following receipt of a BOI reply trailer, you shall transmit the claim to the COBC in accordance with Requirement 4 of this instruction. When you receive a BOI reply trailer, which indicates that a particular claim should be sent to COBC for crossover, you shall use the returned BOI trailer information to take the following actions on the provider's 835 Electronic Remittance Advice: 1) Record code 19 in the CLP-02 (Claim Status Code) in the 2100 Loop (Claim Payment Information) of the 835 ERA (v. 4010-A1). 2) Update the 2100 Loop (Crossover Carrier Name) on the 835 ERA as follows: • NM101 [Entity Identifier Code]—Use "TT," as specified in the 835 Implementation Guide. • NM102 [Entity Type Qualifier]—Use "2," as specified in the 835 Implementation Guide. • NM103 [Name, Last or Organization Name]—Use the COBA trading partner's name that accompanies the first sorted COBA ID returned to you on the BOI reply trailer. (See requirement 19 for more information.) • 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.)	CWF Intermediaries, Carriers, and DMERCs Intermediaries, Carriers, and DMERCs

Ch. 28, Sec. 50 Ch. 27, Sec. 80.14 and Ch. 28, Sec. 70.6	You shall include the revised language for crossover message "MA 18" on your provider remittance advices. The new language for "MA 18" reads as follows: "The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them." The CWF maintainer shall also modify the BOI reply trailer 29 to include a 1-character indicator (Y or N) specifying whether the COBA trading partner's name should appear on the Medicare Summary Notice (MSN). The CWF shall receive this information via the weekly COIF update (see Attachment G). If you receive an "N" indicator from the BOI reply trailer for the MSN trading partner name field, you shall print your current generic crossover message(s) on the MSN rather than including the trading partner's name.	Intermediaries, Carriers, and DMERCs CWF
Requirement 18 Ch. 27, Sec. 80.14 and Ch. 28, Sec. 70.6	New. When a beneficiary's claim is associated with more than one COBA ID, the CWF shall sort the COBA IDs and trading partner names in the following order: 1) Eligibility-based Medigap, 2) Supplemental, 3) TRICARE, 4) Others, and 5) Eligibility-based Medicaid. When two or more COBA IDs fall in the same range (see Attachment A, element 24), CWF shall sort numerically within the range. When a claim is returned with multiple COBA IDs on the BOI trailer 29, you shall print the name of the first sorted COBA ID on the 835 ERA. (See Requirement 17 for detailed 835 instructions.)	 CWF Intermediaries, Carriers, and DMERCs
Requirement 19 Ch. 27, Sec. 80.14 and Ch. 28, Sec. 70.6	New. If CWF receives a non-assigned Medicare claim for a beneficiary whose BOI auxiliary file contains a COBA ID in the Medicaid eligibility-based range (70000-77999), it shall reject the claim. The CWF shall return an edit	 CWF and Carriers and DMERCs

	to the carrier or DMERC that specifies that non-assigned Medicare claims cannot be sent to Medicaid. At the same time, CWF shall also return a Medicaid reply trailer 36 to the carrier or DMERC (See Attachment H) that contains the trading partner's COBA ID and beneficiary's effective dates and termination dates under Medicaid. If the carrier or DMERC determines that the non-assigned claim's service dates fall during a period when the beneficiary is eligible for Medicaid, it shall convert the assignment indicator from "non-assigned" to "assigned" and retransmit the claim to CWF. After the claim has been retransmitted, CWF will only return a BOI reply trailer to the carrier or DMERC if the claim is to be sent to the COBC to be crossed over.	
Ch. 28, Sec. 70.6 Requirement 20	New. Before the implementation of the claim-based COBA process on October 4, 2004, CMS shall issue an information packet to carriers and DMERCs describing the COBA claim-based process for the benefit of Part B and DME participating providers and suppliers. The CMS plans to issue these materials to carriers and DMERCs well before July 2004. Included in the information packet will be a listing of the newly established claim-based COBA IDs for each claim-based crossover partner. Once CMS issues a listing of newly assigned 5-digit claim-based COBA IDs for Medigap insurers and State Medicaid Agencies, you shall publish a listing of those identifiers in your provider/supplier newsletters or on your provider education Web site. You shall include CMS' COBA claim-based crossover information packet on your Web site and shall reference the availability of that information in any communications they have with providers and suppliers. Over time, Medigap insurers and State Medicaid Agencies that had initially decided not to execute COBAs may decide they now	 CMS Carriers and DMERCs Carriers and DMERCs

	want to sign COBAs. When this occurs, CMS will issue a revised listing to you of all Medigap insurers and State Medicaid Agencies that have COBA claim-based IDs. You shall publish the revised listing in your provider/supplier newsletters or on your provider education Web site.	
Ch. 28, Sec. 20.1, Ch. 28, Sec. 30.1, and Ch. 28, Sec. 70.6 Requirement 21	New. Effective with claims received on October 4, 2004, you shall cease your existing claim-based crossover processes. The CWF process to return a Claim-based reply trailer 37, which indicates that CWF has found a claim-based COBA ID on the COIF **and** the claim is to be sent to the COBC to be crossed over, will not become operational until October 4, 2004. Therefore, you shall cross processed claims that were tagged for crossover to non-eligibility file-based Medicaid or Medigap trading partners prior to the October 4, 2004, implementation date. As established in Requirement 20 above, by October 4, 2004, all participating Part B and DME providers/suppliers shall have received a listing of all Medigap companies and State Medicaid Agencies that have been assigned claim-based COBA IDs. They are to include the 5-digit COBA ID on incoming HIPAA 837 Professional and NCPDP claims when a beneficiary presents his/her health insurance card on which the company or State Medicaid Agency is identified **and** if the following conditions are met: 1) The beneficiary has assigned Medigap benefits to the provider or supplier on the claim, as demonstrated by a "Y" privacy release indicator; **and/or** 2) The provider or supplier is participating with the Medicare Program. **(Note:** This condition applies both to Medigap and Medicaid claim-based crossover.)	 Carriers and DMERCs Carriers, DMERCs, providers and suppliers

	If Part B and DME providers or suppliers determine that it is appropriate to include the claim-based COBA ID on incoming claims, they shall report that ID in block 9-D of the CMS Form 1500 or in field NM109 of the NM1 segment in loop 2330B of the HIPAA 837 Professional claim or in field 301-C1 of the T04 segment of the NCPDP claim. Providers and suppliers shall **not** report the CMS issued claim-based COBA ID on incoming claims before October 4, 2004.	
Ch. 28, Sec. 70.6 Requirement 22	New. For claim-based COBA crossover, you shall perform the following: 1) Validate that the provider or supplier is participating with the Medicare Program; 2) If the provider or supplier is participating with the Medicare Program, you shall read block 9-D of the CMS Form 1500 or field NM109 of the NM1 segment in loop 2330B of the HIPAA 837 Professional claim or field 301-C1 of the T04 segment of the NCPDP claim to determine whether a 5-digit claim-based COBA ID has been reported; 3) Report only COBA IDs that identify Medigap (55000-59999) or Medicaid (78000-79999) claim-based crossovers in field 36 (Payer ID) of the HUBC or HUDC query to CWF. If the incoming claim-based COBA ID falls outside of the claim-based ranges specified, do **not** report the COBA ID in field 36. The 5-digit claim-based COBA ID shall be right-justified and prefixed with zeroes when placed in field 36 (Payer ID) of the HUBC or HUDC query. If you receive a claim for a non-participating provider or supplier, do **not** include a claim-based COBA ID in field 36 of the HUBC or HUDC query.	Carriers and DMERCs

Ch. 28, Sec. 70.6 Requirement 23	If the COBA ID reported on the claim falls in the Medigap claim-based range (55000–59999), you shall print crossover messages on the MSN (as currently instructed) and on the ERA (specifying name of the Medigap insurer, as required by the HIPAA 835 requirements) if CWF returns a Claim-based reply trailer 37 (Attachment I) to you. (**NOTE**: Multiple COBA IDs may appear on the Claim-based reply trailer 37.) There will be instances where both a BOI reply trailer 29 and a Claim-based reply trailer 37 are returned to you. For purposes of printing ERA crossover messages, the information returned via the BOI reply trailer 29 shall take precedence over the information returned via the Claim-based reply trailer 37. If CWF returns an alert XXXX (4 position code) on the "01" response via the Claim-based alert trailer 21 (see Attachment J) that indicates that the Medigap claim-based COBA ID was **not** located on the COIF, you shall print the MSN and ERA messages indicated below. <u>MSN Message:</u> MSN #35.3 – "A copy of this notice will not be forwarded to your Medigap insurer because the Medigap information was incomplete or invalid. Please submit a copy of this notice to your Medigap insurer." <u>ERA Message:</u> MA 19- "Information was not sent to the Medigap insurer due to incorrect/invalid information you submitted concerning the insurer. Please verify your information and submit your secondary claim directly to that insurer." If you do **not** receive a Claim-based reply trailer 37 that includes a COBA ID in the Medicaid claim-based range (78000-79999), you shall print nothing on the MSN or ERA. In such situations, CWF did **not** return a Claim-	Carriers and DMERCS

	based reply trailer 37 to you because 1) the reported claim-based Medicaid COBA ID was not located on the COIF, and/or 2) the claim is not to be included on your 837 flat file or NCPDP file submission to the COBC for purposes of being crossed over .	
Ch. 27, Sec. 80.14 and Ch. 28, Sec. 70.6 Requirement 24	New. The CWF shall load the initial COIF submission from COBC as well as all future updates that pertain to claim-based Medigap insurers and State Medicaid Agencies. For claim-based crossover, CWF shall **only** search the COIF if the carrier or DMERC has included a claim-based Medigap ID (55000—59999) or claim-based Medicaid ID (78000-79999) in field 36 of the HUBC or HUDC query. If claim-based COBA IDs are entered in field 36 of the HUBC or HUDC query, CWF shall: 1) Search the COIF to locate the claim-based Medicaid and/or Medigap COBA ID and corresponding COBA Trading Partner Name; 2) Apply the Medigap claim-based trading partner's claims selection criteria; 3) Return a Claim-based reply trailer 37 that includes values for claim-based COBA ID (sorted by Medigap, then Medicaid), COBA Trading Partner Name, and MSN Indicator when a claim-based COBA ID is found on the COIF **and** the claim is to be sent to the COBC to be crossed over; 4) Return an alert XXXX (4 position code) on the "01" response via a Claim-based alert trailer 21 to the carrier or DMERC, as specified in Requirement 23 above, if a claim-based COBA ID in the Medigap claim-based range (55000-59999) is **not** located on the COIF; 5) Return nothing to the carrier or DMERC if a Medicaid claim-based COBA ID (78000-79999) is not found on the COIF.	CWF

Ch. 28, Sec. 70.6 Requirement 25	For claim-based crossover, you will **only** receive a Claim-based reply trailer 37 that includes values for COBA ID, COBA Trading Partner Name, and MSN Indicator (See Attachment I) if: 1) CWF locates a matching COBA claim-based ID on the COIF, and 2) the claim is to be sent to the COBC for crossover. When you receive a Claim-based reply trailer 37, transmit the claim to the COBC as described in Requirement 4 of this instruction.	Carriers and DMERCs
Ch. 28, Sec. 70 Requirement 26	New. Carriers or DMERCs shall continue to pursue collection of unpaid debts from COB trading partners, even if such entities have been transitioned to the COBA process.	Carriers and DMERCs
Ch. 28, Sec. 70.6 Requirement 27	New. Given CMS' newly targeted COBA implementation date of July 6, 2004, you shall continue to execute new crossover agreements (Trading Partner Agreements or TPAs) for trading partners that wish to go into live production by May 1, 2004. These new TPAs and extensions of existing TPAs shall allow for future termination no later than January 31, 2005. Trading partners that either wish to go into live crossover production after May 1, 2004, or have current questions regarding the COBA process shall be referred to the COBC at 1-800-999-1118.	Intermediaries, Carriers, and DMERCs

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

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

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: July 1, 2004 **Implementation Date:** July 6, 2004 **Pre-Implementation Contact(s):** Donna Kettish (410-786-5462) or Brian Pabst (410-786-2487) **Post-Implementation Contact(s):** Donna Kettish (410-786-5462) or Brian Pabst (410-786-2487)	**These instructions shall be implemented within your current operating budget.**

Attachments: 10

Attachment A

Common Working File (CWF) Beneficiary Other
Insurance (BOI) Auxiliary (aux) File

The BOI aux file will contain information about other insurance that a beneficiary has that pays after Medicare. The BOI aux file is needed in the CWF to store information about other insurance that beneficiaries have, accept changes to the information from the COB Contractor (COBC), and provide the means for delivering the information with the claims reply to intermediaries and carriers.

The CWF maintainer will:

- Develop the capability to allow the BOI aux file to accept maintenance transactions containing changes, additions, and deletions, from the COBC. The file will allow for up to 40 occurrences of other insurer types;
- Develop consistency edits for the maintenance transactions;
- Add the number 11120 to the CWF table of contractor numbers to identify the COBC as the submitter of BOI maintenance transactions;
- Create the CWF BOI aux file that will contain other insurer information for each beneficiary. The required data elements are listed in the attachment;
- Create a trailer, containing insurer information that pays after Medicare, that will be attached to a basic claim reply record to be sent to the intermediaries and carriers;
- Develop a HIMR screen to be used by intermediaries and carriers to provide customer service and conduct research on crossovers to a beneficiary's other insurer;
- Document the BOI aux file, including the user's guide for CWF hosts, intermediaries, and carriers; and
- Release the BOI aux files to the CWF hosts for installation. Data are not available to load at this time.

(NOTE: The functionality for this requirement was already created in CR 20297.)

Data Elements Required for the BOI Aux File Record

DATA ELEMENT	REMARKS
1. Record Type	CWF BOI other insurer maintenance (**Mandatory)**
2. Health Insurance Claim (HIC) Number	Beneficiary's HIC/Railroad Board number (**Mandatory)**
3. Beneficiary's Surname	Beneficiary's surname (**Mandatory)**
4. Beneficiary's First Initial	Initial of first name of beneficiary (**Mandatory)**
5. Beneficiary's Date of Birth	Beneficiary's date of birth (CCYYDDD)
6. Beneficiary's Sex Code	Beneficiary's sex code 0 = Unknown 1 = Male 2 = Female
7. Contractor Number	Identifies COB contractor applying maintenance
8. Creation Date	Date record created (CCYYDDD)
9. Deletion Date	Date record deleted (CCYYDDD)
10. Document control	Document control number
11. Action Type	Identifies type of maintenance (**Mandatory)** 0 = Add insurance data transaction 1 = Change insurance data transaction 2 = Delete insurance data transaction
12. Update Indicator	Date maintenance applied (CCYYDDD)
13. Insurance Code	Insurance coverage type (**Mandatory)** A = Supplemental B = TRICARE C = Medicaid
14. Insurer's Name	Insurer's name
15. Insurer's Address - 1	Insurer's address line 1
16. Insurer's Address – 2	Insurer's address line 2
17. Insurer's City	Insurer's city
18. Insurer's State	Insurer's State

Attachment A (concluded)

DATA ELEMENT	REMARKS
19. Insurer's Zip Code	Insurer's zip code
20. Policy Number	Insurer's policy number of insured
21. Insurance Effective Date	Effective date of insurance coverage (CCYYDDD) (One or more occurrences) (**Mandatory)**
22. Insurance Termination Date	Termination date of insurance coverage (CCYYDDD) (One or more occurrences) (**Mandatory, if applicable)**
23. Identifier Number Assigned by Supplemental Insurer	Number assigned to insured by supplemental insurer
24. Coordination of Benefits Agreement (COBA) Number	COBA ID assigned to other insurer by the COB Contractor. Numbers will be right justified and will fall into these ranges based on type of COBA trading partner: Supplemental 00001-29999 Eligibility-Based Medigap 30000-54999 TRICARE 60000-69999 Eligibility-Based Medicaid 70000-77999 Others 80000-89999 Unassigned 90000-99999 (**Mandatory)**
25. NPlanID	The CMS national plan identifier assigned to the insurer (**Mandatory when available)**
26. Other Insurer Number	Other number assigned to an insurer by an FI or carrier under a former trading partner agreement (One or more occurrences)
27. Filler	Filler (includes 25 characters for future expansion)

CWF BOI Trailer Requirements — Attachment B

CWF must create a new Trailer '29.' Trailer '29' will display the following:

```
01  :X:-29-TRAILER.
    05  :X:-29-TRLR-CODE        PIC  X(02).
    05  :X:-29-OCCURANCES       PIC  9(02).
    05  :X:-29-COBA-CROS-IND    PIC  X(01).
    05  :X:-29-DATA             OCCURS 1 TO 10 TIMES,
                                DEPENDING ON X:-29-OCCURRENCES
                                INDEXED :X:-29-INDEX.


        10 :X:-29-COBA-NUM      PIC  X(10).
        10 :X:-29-COBA-NAME     PIC  X(32).
        10 :X:-29-COBA-MSN-IND  PIC  X(01).
        10 :X:-29-COBA-EFF-DATE PIC S9(07) COMP-3.
        10 :X:-29-COBA-TRM-DATE PIC S9(07) COMP-3.
```

837 COB Flat File Process Rules   Attachment C

Part B and DMERC (Professional)

1. The following segments shall not be passed to the COBC:
    a) ISA (Interchange Control Header Segment)
    b) IEA (Interchange Control Trailer Segment)
    c) GS (Functional Group Header Segment)
    d) GE (Functional Group Trailer Segment)

2. The 1000B loop of the NM1 segment denotes the crossover partner. If multiple COBA IDs are received via the BOI reply trailer, a separate 837 transaction should be submitted for each COBA ID received. As the crossover partner information will be unknown to the standard systems, the following fields should be formatted as indicated for the NM1 segment:
    a) NM103—Use spaces.
    b) NM109—Include COBA ID.

3. The 2010BA loop denotes the subscriber information. If available, the subscriber name, address, and policy number should be used to complete the NM1, N3, and N4 segments. If unknown, the segments should be formatted as follows, with COBC completing any missing information:
    a) NM1 segment—For NM103, NM104, NM105, and NM107, use spaces.
    b) NM1 segment—For NM109, include HICN.
    c) N3 segment—Use all spaces
    d) N4 segment—Use all spaces.

4. The 2010BB loop denotes the payer name. Per the HIPAA Implementation Guide (IG), this loop should define the secondary payer when sending the claim to the second destination payer. Consequently, given that the payer related to the COBA ID will be unknown by the standard systems, the NM1, N3, and N4 segments should be formatted as follows, with COBC completing any missing information:
    a) NM1 segment—For NM103, use spaces.
    b) NM1 segment—For NM109, include the COBA ID.
    c) N3 segment—Use all spaces.
    d) N4 segment—Use all spaces.

5. The 2330B loop denotes other payers for the claim. If multiple COBA IDs are returned via the BOI reply trailer, payer information for the additional COBA IDs will be unknown. As with the 2010BB loop, the NM1 segment should be formatted as follows, with COBC completing any missing information:
    a) NM103—Use spaces.
    b) NM109—Include COBA ID.

6. The 2320 loop defines 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. COBC will inspect these values for COBA related eligibility based claims and overlay as appropriate. If unknown, spaces may be used.
   --SBR01 – treat as you currently do.

Part A (Institutional)

1. As the ISA, IEA, and GS segments are included in the '100' record with other required segments, the '100' record must be passed to the COBC. However, as the values for these segments will be recalculated, spaces may be placed in all of the fields related to the ISA, IEA, and GS segments.

2. The 1000B loop of the NM1 segment denotes the crossover trading partner. If multiple COBA IDs are received via the BOI reply trailer, 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:
   a) NM103—Use spaces.
   b) NM109—Include COBA ID.

3. The 2010BA loop denotes the subscriber information. If available, the NM1, N3, and N4 segments. If unknown, the segments should be formatted as follows for the '300' record, with COBC completing any missing information:
   a) NM1 segment – For NM103, NM104, NM105, and NM107, use spaces.
   b) NM1 segment—For NM109, include HICN.
   c) N3 segment—Use all spaces.
   d) N4 segment—Use all spaces.

4. The 2010BC loop denotes the payer name. Per the HIPAA IG, this loop should define the secondary payer when sending the claim to the second destination payer. Consequently, since the payer related to the COBA ID will be unknown to the standard systems, the NM1, N3, and N4 segments should be formatted as follows for the '300' record, with COBC completing any missing information:
   a) NM1 segment—For NM103, use spaces.
   b) NM1 segment—For NM109, include COBA ID.
   c) N3 segment—Use all spaces.
   d) N4 segment—Use all spaces.

5. The 2330B loop of the '575' record denotes other payers for the claim. If multiple COBA IDs are returned via the BOI reply trailer, payer information for the additional COBA IDs will be unknown. As with the 2010BC loop, the NM1 segment should be formatted as follows, with COBC completing any missing information:
   a) NM103—Use spaces.
   b) NM109—Include COBA ID.

6. The 2320 loop defines 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. COBC will inspect these values for COBA related eligibility based claims and overlay as appropriate. If unknown, spaces may be used.
   -- SBR01 – treat as you currently do.

Attachment D

Claims Response File Layout (80 bytes)				
Field	***Name***	***Size***	***Displacement***	***Description***
1.	Contractor Number	5	1-5	Contractor Identification Number
2.	Transaction Set Control Number/Batch Number	9	6-14	Found within the ST02 data element from the ST segment of the ANSI 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 ANSI 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 ANSI 837 flat file or NCPDP file in CCYYMMDD format
5.	Accept/Reject indicator	1	32	Indicator of either the acceptance or rejection of the ANSI 837 flat file or NCPDP file. Values will either be an "A" for accepted or "R" for rejected.
6.	Filler	48	33-80	Spaces

837 Institutional Edits by the COBC

Assumption: Intermediaries will forward HIPAA compliant 837v4010A1 flat file layout crossover claims files to the COBC.

Record 100 exists
The value in the field SUBMITTER ETIN is a valid MEDA FI
The value in the field RECEIVER NAME is spaces
The value in the field RECEIVER ETIN is a valid COBA id
Record 200 exists
Record 300 exists
The value in the field SUBSCRIBER PRIMARY ID is a HICN (alphanumeric and not greater than 12 bytes long)
Spaces in the fields SUBSCRIBER LAST NAME, SUBSCRIBER FIRST NAME, SUBSCRIBER MIDDLE INITIAL, SUBSCRIBER NAME SUFFIX, SUBSCRIBER ADDRESS LN 1, SUBSCRIBER ADDRESS LN 2, SUBSCRIBER CITY, SUBSCRIBER STATE, SUBSCRIBER ZIP CODE and SUBSCRIBER COUNTRY CODE is valid
The value in the field PAYER NAME is spaces
The value in the field PAYER ID NUMBER is a valid COBA id
The value in the fields PAYER ADDRESS LN 1, PAYER ADDRESS LN 2, PAYER CITY, PAYER STATE, PAYER ZIP CODE, PAYER COUNTRY CODE is spaces
At least one record 500 exists for each record 300
There is no more than 100 record 500s for each record 300
There is at least one record 575 for each record 500
At least one iteration of the record 575 must have field PAYER RESPONSIBILITY SEQUENCE CODE equal to the value of ‘P’
There is at least one record 590 for each record 575
If there is only one record 575(meaning Medicare is the primary payer), the following must be set:
The field PAYER RESPONSIBILITY SEQUENCE CODE is the value of ‘P’
The field PATIENT RELATIONSHIP TO INSURED is the value of ‘18’
The field SOURCE PAY CODE is the value of ‘MA’
One of the record 590s associated with record 575 has:
The field OTHER PAYER ID CODE QUAL is the value of ‘PI’
The field OTHER PAYER ID NUMBER is equal to the value in the field SUBMITTER ETIN in record 100
The field OTHER SUBSCRIBER/INSURED 2NDARY ID QUAL is the value of ‘F8’
The field OTHER SUBSCRIBER/INSURED SECONDARY ID is greater than space (Intermediary’s claim control number)
There is at least one record 600 for each record 500
There is no more than 999 record 600s for each record 500
If there is a record 650, the number of record 650s cannot exceed 25 for each record 600. (Assumption: There can only be 25 occurrences of the record type 650 for each record 600.)

For the iteration of record 650 that is the Medicare adjudication information, field PAYER IDENTIFICATION is equal to the Intermediary's number
Record 999 exists

837 Professional Edits by the COBC

Assumption: Carriers and DMERCs will forward HIPAA compliant 837v4010A1 flat file layout crossover claims files to the COBC.

Segment ST exists
Segment BHT exists
Segment REF exists
There is only one iteration of the 1000A loop per ST/SE envelope (record set)
The value in 1000A.NM109 is equal to a valid MEDB or DMERC Carrier ID
There is only one iteration of the 1000B loop per ST/SE envelope (record set)
The value in 1000B.NM103 is equal to spaces
The value in 1000B.NM109 is equal to a valid COBA id
There is at least one iteration of the 2000A loop
There is only one iteration of the 2010AA loop per 2000A loop
There is at least one iteration of the 2000B loop
There is only one iteration of the 2010BA loop per 2000B loop
The value is 2010BA.NM103 is equal to spaces
The value in 2010BA.NM104 is equal to spaces
The value in 2010BA.NM105 is equal to spaces
The value in 2010BA.NM107 is equal to spaces
The value is 2010BA.NM109 is a HICN (alpha-numeric and not greater than 12 bytes long)
The value in 2010BA.N3 is spaces
The value in 2010BA.N4 is spaces
There is only one iteration of the 2010BB loop per 2000B loop
The value in 2010BB.NM103 is equal to spaces
The value is 2010BB.NM109 is equal to the value in 1000B.NM109
The value in 2010BB.N3 is spaces
The value in 2010BB.N4 is spaces
There are no 2010BD loops
There are no 2000C loops
There is at least one 2300 loop per 2000B loop
There is no more than one hundred (100) 2300 loops per 2000B loop
There is at least one 2320 loop per 2300 loop
The first iteration of the 2320 loop must have 2320.SBR01 equal to P
There is only one iteration of the 2330A loop per 2320 loop
There is only one iteration of the 2330B loop per 2320 loop
If there is only one iteration of the 2320 loop (meaning Medicare is the primary payer), the

following must be set:
2320.SBR01 is equal to the value of P
2320.SBR02 is equal to the value of 18
2320.SBR05 is equal to the value of MB
2320.SBR09 is equal to the value of MB
2330B.NM108 is equal to the value of PI
2330B.NM109 is equal to the value in 1000A.NM109
At least one iteration of 2330B.REF where:
2330B.REF01 is equal to the value of F8
2330B.REF02 is greater than spaces (Carrier or DMERC's claim control number)
For occurrences where 2330B.NM103 is equal to spaces (meaning crossing to another COBA ID), the following must be set:
2330B.NM109 is equal to a valid COBA ID and is not equal to the value in 1000B.NM109
2320.SBR02 is equal to the value of S
There is at least one iteration of the 2400 loop
There is not more than 50 iterations of the 2400 loop per 2300 loop
If there is a 2430 loop, the number of 2430 loops cannot be greater than the number of 2320 loops.
For the iteration of the 2430 loop (i.e., the Medicare adjudication information), 2430.SVD01 is equal to 2330B.NM109.
Segment SE exists

NCPDP Edits by the COBC

Assumption: DMERCs will forward to compliant NCPDP flat file layout crossover claims files to the COBC.

1. The Batch Header (B00) exists
2. There is only one Batch Header per B00 – B99 (Batch Trailer) set
3. The value in 880-K1 (Sender ID) in the B00 is a valid DMERC carrier id
4. The value in 880-K7 (Receiver ID) in the B00 is a valid COBA id
5. There is at least one Transaction Header (T00) in the B00 – B99 set
6. There is only one Patient (T01) record per T00 record
7. There is only one Insurance (T04) record per T00 record
8. If the value in 880-K7 in the B00 is a Medigap COBA ID, then the value in 301-C1 (Group ID) in the T04 must be equal to the value in 880-K7
9. There is at least one Claim (T07) record, but no more than 4 T07s per T00
10. For every iteration of a T07 record, there is one Pricing (T11) record
11. For every iteration of the a T07 record, there is one COB/Other Payment (T05) record
12. Within the T05 record, there is at least one occurrence of the COB-INFO
13. If there is only one occurrence of the COB-INFO in the T05, then 338-5C (Other payer coverage type) is equal to 01 and the value in 340-7C (Other payer ID) is equal to 880-K1 of the B00
14. The Batch Trailer (B99) exists
15. There is only one B99 per B00- B99 set

Claims Crossover Extract File **Attachment E**

****Note: This Attachment, together with Requirement 12, is now deleted.**

ATTACHMENT F

CROSSOVER CLAIM DISPOSITION INDICATORS

Claims Crossover Disposition Indicator	Definition/Description
A	This claim was selected to be crossed over.
B	This Type of Bill (TOB) excluded.
C	Non-assigned claim excluded.
D	Original Medicare claims paid at 100%.
E	Original Medicare claims paid at greater than 100% of the submitted charges excluded.
F	100% denied claims, with no additional beneficiary liability excluded.
G	100% denied claims, with additional beneficiary liability excluded.
H	Adjustment claims, monetary, excluded.
I	Adjustment claims, non-monetary/statistical, excluded
J	MSP claims excluded.
K	This Claim contains a provider identification number (ID) or provider state that is excluded by the COBA trading partner.
L	Claims from this Contractor ID excluded
M	The beneficiary has other insurance that pays before Medicaid. Claim excluded by Medicaid.
N	NCPDP claims excluded.

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

COBA INSURANCE FILE

ATTACHMENT G

Field	Start	Length	End	Description
COBA ID	1	10	10	Unique identifier for each COB Agreement
COBA TIN	11	9	19	Tax Identification Number of COBA
COBA Name	20	32	51	Name of COBA Partner (Equivalent to Insurer Name on BOI Auxiliary File)
COBA Address 1	52	40	91	Address 1 of COBA
COBA Address 2	92	40	131	Address 2 of COBA
COBA City	132	25	156	Address city of COBA
COBA State	157	2	158	Postal State Abbreviation of COBA
COBA Zip	159	9	167	Zip plus 4 of COBA
Common Claim Exclusions				**The following fields are 1 byte indicators dictating type of claim exclusions. A value of 'Y' in any of the following fields indicates those types of claims should be excluded.**
Non-assigned	168	1	168	Non-assigned claims
Orig. Claims Paid at 100%	169	1	169	Original claims paid at 100%
Orig. Claims Paid at >100%	170	1	170	Original claims paid at greater than 100% of submitted charge
100% Denied, No Additional Liability	171	1	171	100% denied claims, with no additional beneficiary liability
100% Denied, Additional Liability	172	1	172	100% denied claims, with additional beneficiary liability
Adjustment Claims, Monetary	173	1	173	Adjustments, monetary claims
Adjustment Claims, Non-Monetary/Statistical	174	1	174	Adjustments, non-monetary/statistical claims
Medicare Secondary Payer Claims	175	1	175	Medicare Secondary Payer (MSP) claims
Other Insurance	176	1	176	Claims if other insurance exists for beneficiary. **Applies to State Medicaid Agencies only.**
NCPDP Claims	177	1	177	National Council Prescription Drug Program Claims
Filler	178	10	187	Future
Hospital Inpatient A	188	1	188	TOB 11 - Hospital: Inpatient Part A
Hospital Inpatient B	189	1	189	TOB 12 - Hospital: Inpatient Part B
Hospital Outpatient	190	1	190	TOB 13 - Hospital: Outpatient
Hospital Other B	191	1	191	TOB 14 - Hospital: Other Part B (Non-patient)
Hospital Swing	192	1	192	TOB 18 - Hospital: Swing Bed
SNF Inpatient A	193	1	193	TOB 21 - Skilled Nursing Facility: Inpatient Part A
SNF Inpatient B	194	1	194	TOB 22 - Skilled Nursing Facility: Inpatient Part B
SNF Outpatient	195	1	195	TOB 23 - Skilled Nursing Facility: Outpatient
SNF Other B	196	1	196	TOB 24 - Skilled Nursing Facility: Other Part B (Non-patient)
SNF Swing Bed	197	1	197	TOB 28 - Skilled Nursing Facility: Swing Bed
Home Health B	198	1	198	TOB 32 - Home Health: Part B Trust Fund
Home Health A	199	1	199	TOB 33 - Home Health: Part A Trust Fund
Home Health Outpatient	200	1	200	TOB 34 - Home Health: Outpatient

Religious Non-Med Hospital	201	1	201	TOB 41 - Christian Science/Religious Non-Medical Services (Hospital)
Clinic Rural Health	202	1	202	TOB 71 - Clinic: Rural Health
Clinic Freestanding Dialysis	203	1	203	TOB 72 - Clinic: Freestanding Dialysis
Clinic Fed Health Center	204	1	204	TOB 73 - Clinic: Federally Qualified Health Center
Clinic Outpatient Rehab	205	1	205	TOB 74 - Clinic: Outpatient Rehabilitation Facility
Clinic CORF	206	1	206	TOB 75 - Clinic: Comprehensive Outpatient Rehabilitation Facility (CORF)
Clinic Comp Mental Health	207	1	207	TOB 76 - Clinic: Comprehensive Mental Health Clinic
Clinic Other	208	1	208	TOB 79 - Clinic: Other
SF Hospice Non-Hospital	209	1	209	TOB 81 - Special Facility: Hospice Non-Hospital
SF Hospice Hospital	210	1	210	TOB 82 - Special Facility: Hospice Special Facility: Hospice Hospital
Ambulatory Surgical Center	211	1	211	TOB 83 - Special Facility: Ambulatory Surgical Center
Primary Care Hospital	212	1	212	TOB 85 - Primary Care Hospital
Filler	213	10	222	Future
Part A/RHHI Provider Inclusion/Exclusion				**Part A/RHHI claims may be included or excluded by providers by specifying the Inclusion/Exclusion type. Inclusion or exclusion may be limited by either provider ID or provider state.**
Inclusion/Exclusion Type	223	1	223	Indicates whether providers are to be included or excluded (I - Inclusion or E - Exclusion)
Provider Qualifier	224	1	224	Indicates whether providers are identified by state or by provider ID (P - Provider number or S - Provider state)
Provider ID (P)	225	650	874	Specific providers IDs to be included or excluded (occurs 50 times--13-digit alpha/numeric provider number.
Provider State (S)	875	100	974	Specific provider states to be included or excluded (occurs 50 times—2-digit code)
Filler	975	10	984	Future
Part B Contractor Inclusion/Exclusion				**Specific contractors may be included or excluded on Part B claims by specifying the Inclusion/Exclusion type.**
Inclusion/Exclusion Type	985	1	985	Indicates whether contractors are to be included or excluded (I – Inclusion or E - Exclusion)
Contractor ID	986	250	1235	Specific contractors to be included or excluded (occurs 50 times).
Filler	1236	10	1245	Future
DMERC Contractor Exclusion				**Specific contractors may be excluded on DMERC claims.**
Contractor ID	1246	20	1265	Specific contractors to be excluded on DMERC claims (occurs 4 times).
Filler	1266	10	1275	Future
Medicare Summary Notice (MSN) Indicator for Trading Partner Name				
MSN Indicator for Printing of Trading Partner Name	1276	1	1276	Indicates whether the COBA trading partner wishes its name to appear on the MSN. (Y=Yes N=No).

CWF Medicaid Reply Trailer Requirements **Attachment H**

CWF must create a new Medicaid Reply Trailer '36.' Trailer '36' will display the following:

```
01  :X:-36-TRAILER.
   05  :X:-36-TRLR-CODE        PIC  X(02).
   05  :X:-36-COBA-NUM         PIC  X(10).
   05  :X:-36-COBA-EFF-DATE    PIC S9(07) COMP-3.
   05  :X:-36-COBA-TRM-DATE    PIC S9(07) COMP-3.
```

NOTE: This trailer will be returned, along with an accompanying rejection edit, when a carrier or DMERC submits a non-assigned claim that falls in the Medicaid COBA range (70000—77999).

CWF Claim-based Reply Trailer Requirements Attachment I

CWF must create a new Claim-based Reply Trailer ’37.’ Trailer ‘37’ will display the following:

```
01  :X:-37-TRAILER.
    05  :X:-37-TRLR-CODE        PIC  X(02).
    05  :X:-37-OCCURS          PIC  9(01).
    05  :X:-37-DATA            OCCURS 1 TO 3 TIMES,
                               DEPENDING ON
                               :X:-37-OCCURS

        10 :X:-37-COBA-NUM      PIC  X(10).
        10 :X:-37-COBA-NAME     PIC  X(32).
        10 :X:-37-COBA-MSN-IND  PIC  X(01).
```

CWF Claim-Based Alert Trailer — Attachment J

CWF must create a new Trailer '21.' Trailer '21' will display the following:

```
05  WS-ALERT-TRLR.
    10  WS-ALERT-TRLR-CODE         PIC 9(02)  VALUE 21.
    10  WS-ALERT-CODE              PIC X(04)  VALUE SPACES.
    10  FILLER                     PIC X(14)  VALUE SPACES.
```

80 - Electronic Transmission - General Requirements

(Rev 98, 2-6-04)

PM-A-01-20, PM-A-01-63, PM-B-01-06, B3-4707

Until an intermediary or carrier receives notice from a Medigap plan that it has signed a national Coordination of Benefits Agreement (COBA) with CMS' Coordination of Benefits Contractor (COBC) and thus has requested cancellation of its existing Trading Partner Agreement with that Medicare contractor (see §70.6 of this chapter for more information), intermediaries/carriers will continue to enter into formal agreements with individual Medigap insurers for the transmission of claim information electronically (see §80.3). The agreement should specify whether the Medigap insurer will submit an eligibility file. If the Medigap insurer wants to send a periodic eligibility file the agreement must specify how Medicare costs are to be paid by the Medigap insurer.

The CMS requires that the outbound format for the transfer of Health Care claim information is the ANSI X12N 837 COB (version 4010), or for transmissions before the required implementation date for X12N, the NSF or UB-92 outbound format may be used. Also, if the recipient wants electronic attachments, attachment data must be furnished in UB-92 or NSF format because X12N does not support electronic attachments (e.g., UB-92 RTs 74, 75, 76). Only the attachment records will be furnished in UB-92 or NSF format after X12N becomes mandatory. Other data will be in the X12N format. The recipient must coordinate any attachments received with the claim record.

Detailed specifications on the electronic formats can be obtained at http://www.cms.hhs.gov/providers/edi/edi3.asp.

The outbound COB transaction is a post-adjudicative transaction. This transaction includes the incoming claim data as well as the COB data. The intermediary or carrier is required to receive all possible data on the incoming 837, although they do not have to process non-Medicare data. However, the shared system must store that data in a store-and-forward repository (SFR). This repository file is designed and maintained by the shared system. This data must be reassociated with the Medicare claim and payment data in order to create a compliant outbound COB transaction using the Medicare Claim/COB flat file as input. The shared system is to use post-adjudicative Medicare data (data used from history and reference files to adjudicate the claim) instead of data received when building the outbound COB transaction. This is to show any changes in data element values as a result of claims adjudication. The shared system must retain the data in the SFR for a minimum of six months.

The Medicare Claim/COB flat file is the format to be used to reassociate all data required to map to the COB transaction. The FI/Carrier's translator will built its outbound COB transaction from the Medicare Claim/COB flat file.

The CMS recommends the FI/Carrier send the outbound COB transaction over a wire connection. However, tape or diskettes may be sent to those trading partners that do not wish to receive transmissions via wire. The FI/Carrier and its trading partners will need to reach agreement on telecommunications protocols. It is the FI/Carrier choice as to whether it wishes to process the X12N 997 Functional Acknowledgment from its COB trading partners.

Data on claims that the intermediary or carrier receives from its keyshop or image processing systems may not be included on the SFR, depending on the shared system design. The FI/Carrier will create the Medicare claim/COB flat file using data available from claims history and reference files. Since some data will not be available on these "paper" claims, the outbound COB transaction will be built as a "minimum "data set. It will contain all "required" COB transactions segments and post-adjudicative Medicare data. For a Medicare Claim/COB flat file layout see http://www.cms.hhs.gov/providers/edi/hipaadoc.asp.

The steps from receipt of the incoming claim to creation of the outbound COB are summarized below:

- Contractor's translator performs syntax edits and maps incoming claim data to the X12N flat file;
- Standard system creates implementation guide and Medicare edits for the flat file data;
- Medicare data on ANSI X12N flat file is mapped to the core system;

NOTE: There are no changes in core system data fields or field sizes.

Non-Medicare data (and Medicare data elements where field sizes are in excess of the core system) are written to the SFR; and adjudicated data is combined with repository data to create the outbound COB. *Under the COBA process, the COBC will receive flat files containing processed Medicare claims. After applying each trading partner's claims selection criteria, the COBC will then transmit outbound COB transactions to the COBA trading partner. Implementation of this process will occur throughout the period July 6, 2004, to January 31, 2005. Refer to §70.6 of this chapter for more details.*

80.2 - ANSI X12N 837 COB (Version 4010) Transaction Fee Collection

(Rev 98, 2-6-04

The intermediary or carrier charges Medigap and other complementary insurers (but not Medicaid) for the cost of preparing and sending COB transactions. The transfer agreement must include a description of data elements on the invoice (bill). (See §70.3 above.) *Once CMS has fully consolidated the claims crossover process under the COBC on February 1, 2005, that entity will have exclusive responsibility for the collection and*

reconciliation of crossover claim fees for those Medigap and non-Medigap claims that are sent to the COBC to be crossed over.

If a Medigap insurer refuses to pay or does not pay it regularly and completely, the FI/Carrier should notify the appropriate State insurance commission that the Medigap insurer is not complying with the payment provisions of §4081 of OBRA 1987. First, the FI/Carrier should contact the insurance department of the State in which the policyholder resides. If that State insurance department does not accept jurisdiction, the FI or carrier informs the appropriate RO. The RO contacts CMS Central Office for assistance in determining the department of jurisdiction. If, after contacting the insurance department recommended by CMS, the problem is unresolved, the FI or carrier treats it as a CMS debt under 42 CFR 401.601-401.625. *(NOTE: As of February 1, 2005, the COBC will assume the role of notifying the appropriate state insurance commission when a Medigap insurer fails to pay for the crossover service.)*

The requirements in §§20 - 30.1 do not supplant existing agreements which the intermediary or carrier may have with any other insurer to exchange complementary insurance information except for possible amendment to recognize the beneficiary's right to assign Medigap payment to participating physicians and suppliers on a claim-by-claim basis. The intermediary or carrier should modify these agreements to state that it is the beneficiary's right to designate a particular insurer to receive a notice for payment. If the FI/Carrier has transmitted an ANSI X12N 837 COB (Version 4010) Transaction to a designated Medigap insurer based on a properly executed assignment, that insurer should send claims information to other insurers under complementary arrangements.

80.3 - Medigap Electronic Claims Transfer Agreements

(Rev 98, 2-6-04

B3-4709, B4-2110.1

For electronic transfers occurring on a frequent basis, Medigap and other insurers must enter into agreements with the intermediary or carrier. These agreements may alter the procedures applying to existing agreements with complementary insurers, including Medigap assignment provisions.

At a minimum, all transfer agreements include:

- Functions of the carrier;
- Functions of the Medigap insurer;
- Fees and payment schedules;
- Confidentiality/Disclosure of information furnished;
- Office of Inspector General (OIG) review access;
- Contract periods and automatic renewal provisions;
- Contract termination provisions; and
- Dated signatures of authorized carrier/Medigap insurer representatives

FIs/carriers can negotiate other provisions that the Medigap insurer may want but are not required to by §§20 - 80. The standard formats as described by these sections must be used.

Effective February 1, 2005, all electronic transfer agreements [formally known as Coordination of Benefits Agreements (or COBAs)] will be negotiated and administered by the COBC, working on behalf of CMS. The COBAs will be executed between health insurers and health benefit programs that pay after Medicare and CMS rather than between intermediaries/carriers and these entities. Refer to §70.6 in this chapter for more details.

80.3.1 - Intermediary Crossover Claim Requirements

(Rev 98, 2-6-04

A-01-20, A-02-069, A-02-077, A-02-078, AB-02-20

Outbound COB

The outbound COB transaction is a post-adjudicative transaction. This transaction includes the incoming claim data as well as COB data. Intermediaries are required to receive all possible data on the incoming ANSI X12N 837 although they do not have to process non-Medicare data. However, the shared system must store that data in a SFR. This repository file will be designed and maintained by the shared system. This data must be re-associated with Medicare claim and payment data in order to create an IG compliant outbound COB transaction using the Medicare Part A Claim/COB flat file as input. The shared system is to use post-adjudicated Medicare data (data used from history and reference files to adjudicate the claim) instead of data received when building the outbound COB transaction. The shared system must retain the data in the SFR for a minimum of six months.

The Medicare Part A Claim/COB flat file is the format to be used to reassociate all data required to map to the COB transaction. The translator will build the outbound COB transaction from the Medicare Part A Claim/COB flat file.

Intermediaries are not required to process an incoming ANSI X12N 997. They may create and use their own proprietary report(s) for feedback purposes.

The shared system maintainer must accommodate the COB transaction.

The flat file creation process and responsibility for sending outbound COB files to crossover trading partners will change appreciably once CMS' COBA process is implemented. The implementation of COBA is scheduled to begin July 6, 2004, and conclude by January 31, 2005. See §70.6 for details about intermediary verses COBC responsibilities under the COBA process.

Summary of Process

The following summarizes all intermediary steps from receipt of the incoming claim to creation of the outbound COB:

- Intermediary's translator performs syntax edits, IG edits, and Medicare edits and maps incoming claim data to the Medicare Part A Claim/COB flat file;

- Medicare data on the Medicare Part A Claim/COB flat file is mapped to the core system by the shared system.

NOTE: No changes are being made to core system data fields or field sizes;

- Non-Medicare data (and Medicare data elements where field sizes are in excess of the core system) are written to the SFR by the intermediary's shared system; and

- Adjudicated data is combined with SFR data to create the outbound COB transaction.

For specifics on how the claims crossover process will change, as early as July 6, 2004, under the COBA initiative, refer to §70.6 in this chapter.

80.3.2 - Carrier/DMERC Crossover Claim Requirements

(Rev 98, 2-6-04

B-01-32, B-01-06, OCR/ICR definition created through outside IS text

Outbound Coordination of Benefits (COB)

The outbound COB transaction is a post-adjudicative transaction. This transaction includes incoming claim data as well as COB data. Carriers are required to receive all possible data on the incoming ANSI X12N 837 although they do not have to process non-Medicare data. However, they must store that data in a store-and-forward repository (SFR). This repository will be designed by the shared system. This data must be reassociated with Medicare claim and payment data in order to create an outbound ANSI X12N 837 COB transaction. The shared systems maintainer is to use post-adjudicated Medicare data (data used from history and reference files to adjudicate the claim) instead of data received when building the outbound COB transaction. Carriers must retain the data in the SFR for a minimum of six months.

The ANSI X12N-based flat file is the format to be used to reassociate all data required to map to the outbound ANSI X12N 837 (4010A1). The translator will build the outbound ANSI X12N 837 COB from the ANSI X12N-based flat file.

The shared system maintainer must create the outbound ANSI X12N 837.

The flat file creation process and responsibility for sending outbound COB files to crossover trading partners will change appreciably once CMS' COBA process is implemented. The implementation of COBA is scheduled to begin July 6, 2004, and conclude by January 31, 2005. See §70.6 of this chapter for details about carrier/DMERC versus COBC responsibilities under the COBA process.

Summary of Process

The following summarizes all the steps from receipt of the incoming claim to creation of the outbound COB:

- Carrier's translator performs syntax edits and maps incoming claim data to the ANSI X12N flat file;

- Standard system creates implementation guide and Medicare edits for the flat file data;

- Medicare data on ANSI X12N flat file is mapped to the core system;

  NOTE: No changes are being made to core system data fields or field sizes.

- Non-Medicare data (and Medicare data elements where field sizes are in excess of the core system) are written to the store-and-forward repository; and

- Adjudicated data is combined with repository data to create the outbound COB.

For specifics on how the claims crossover process will change, as early as July 6, 2004, under the COBA initiative, refer to §70.6 in this chapter.

70 - Crossover Claims Requirements

A3-3602.3

(Rev. 98, 2-06-04)

Currently, each supplemental insurer specifies *the* criteria related to the claims it *wants* the carrier or FI to transfer. Examples of claims most frequently excluded from the crossover process are:

- Totally denied claims;
- Claims denied as duplicates or for missing information;
- Adjustment claims;
- Claims reimbursed at 100 percent; and
- Claims for dates of services outside the supplemental policy's effective and end dates.

*Until a trading partner has signed a national Coordination of Benefits Agreement (COBA), t*he carrier or FI will *continue to* provide the claim payment information in either the UB-92 or NSF COB flat file or ANSI X12N COB format. This information will be transferred no less frequently than weekly.

Under HIPAA the carrier or FI will provide only the ANSI X12N COB format.

On July 6,2004, CMS will begin to transfer claims crossover responsibilities from intermediaries and carriers to a national claims crossover contractor, the Coordination of Benefits Contractor (COBC). This initiative is termed the Coordination of Benefits Agreement (COBA) process. Under this process, intermediaries and carriers will receive confirmation via a Common Working File (CWF) Beneficiary Other Insurance (BOI) auxiliary reply trailer that a trading partner has selected a beneficiary's claim for crossover. Upon receipt of a BOI reply trailer, the intermediary or carrier will transfer the processed claim to the COBC via an 837 COB flat file or National Council for Prescription Drug Programs (NCPDP) file to be crossed over to the trading partner.

Refer to Pub. 100-4, Chapter 28, §70.6 for further details about specific intermediary and carrier responsibilities under the consolidated crossover (or COBA) claims process.

70.1 - FI Requirements

(Rev. 98, 2-06-04)

A-01-20, A-02-069, A-02-077, A-02-078, AB-02-20, A-01-63

Shared System Claim/COB flat file

If the shared system detects an improper flat file format/size (incorrect record length, record length exceeding 32,700 bytes, etc.), the flat file will be rejected back to the file's

submitter (FI or data center) by the shared system with an appropriate error message. If a syntax error occurs at the standard level, FIs must return the entire transmission (ISA to IEA) to the submitter via the ANSI X12N 997.

The date of receipt is to be generated upon receipt of a claim, prior to transmission of the data to the data center. The FI has the responsibility to ensure the correct date of receipt is populated onto the Medicare Part A Claim/Coordination of Benefit (COB) flat file (flat file) **before** the file gets to the shared system. The shared system will process the date of receipt reported in the flat file. If the flat file contains an incorrect date of receipt (e.g., all zeros), the flat file will be rejected back to the flat file's submitter (FI or data center) by the shared system with an appropriate error message.

Intermediary responsibilities related to the COB flat file will be significantly modified under the COBA process beginning with July 6, 2004. Refer to Pub.100-4, Chapter 28, §70.6 for details.

Outbound COB

The outbound COB transaction is a post-adjudicative transaction. This transaction includes the incoming claim data as well as COB data. FIs are required to receive all possible data on the incoming 837 although they do not have to process non-Medicare data. However, the shared system must store that data in a SFR. This repository file will be designed and maintained by the shared system. This data must be reassociated with Medicare claim and payment data in order to create an IG compliant outbound COB transaction using the Medicare Part A Claim/COB flat file as input. The shared system is to use post-adjudicated Medicare data (data used from history and reference files to adjudicate the claim) instead of data received when building the outbound COB transaction. The shared system must retain the data in the SFR for a minimum of 6 months.

The Medicare Part A Claim/COB flat file is the format to be used to reassociate all data required to map to the COB transaction. The translator will build the outbound COB transaction from the Medicare Part A Claim/COB flat file.
FIs are not required to process an incoming ANSI X12N 997. They may create and use their own proprietary report(s) for feedback purposes.

The shared system maintainer must accommodate the COB transaction.

The flat file creation process and responsibility for sending outbound COB files to crossover trading partners will change appreciably once CMS' COBA process is implemented. The implementation of COBA is scheduled to begin July 6, 2004, and conclude by January 31, 2005. Refer to Pub.100-4, Chapter 28, §70.6 for details regarding intermediary versus Coordination of Benefits Contractor (COBC) responsibilities under the COBA process.

Summary of Process

The following summarizes all FI steps from receipt of the incoming claim to creation of the outbound COB:

- FI's translator performs syntax edits, IG edits, and Medicare edits and maps incoming claim data to the Medicare Part A Claim/COB flat file;

- Medicare data on the Medicare Part A Claim/COB flat file is mapped to the core system by the shared system.
  NOTE: No changes are being made to core system data fields or field sizes;

- Non-Medicare data (and Medicare data elements where field sizes are in excess of the core system) are written to the SFR by the FI's shared system; and

- Adjudicated data is combined with SFR data to create the outbound COB transaction.

For specifics on how the claims crossover process will change, as early as July 6, 2004, under the COBA initiative, refer to Pub.100-4, Chapter 28, §70.6.

70.2 - Carrier/DMERC Requirements

(Rev. 98, 2-06-04)

B-01-32, B-01-06, OCR/ICR definition created through outside IS text

Outbound Coordination of Benefits (COB)

The outbound COB transaction is a post-adjudicative transaction. This transaction includes incoming claim data as well as COB data. Carriers are required to receive all possible data on the incoming ANSI X12N 837 although they do not have to process non-Medicare data. However, they must store that data in a store-and-forward repository (SFR). This repository will be designed by the shared system. This data must be reassociated with Medicare claim and payment data in order to create an outbound ANSI X12N 837 COB transaction. The shared systems maintainer is to use post-adjudicated Medicare data (data used from history and reference files to adjudicate the claim) instead of data received when building the outbound COB transaction. Carriers must retain the data in the SFR for a minimum of six months.

The ANSI X12N-based flat file is the format to be used to reassociate all data required to map to the outbound ANSI X12N 837 (HIPAA version). The translator will build the outbound ANSI X12N 837 COB from the ANSI X12N-based flat file.

The shared system maintainer must create the outbound ANSI X12N 837.

The flat file creation process and responsibility for sending outbound COB files to crossover trading partners will change appreciably once CMS' COBA process is implemented. The implementation of COBA is scheduled to begin July 6, 2004, and conclude by January 31, 2005. Refer to Pub.100-4, Chapter 28, §70.6 for details regarding intermediary verses Coordination of Benefits Contractor (COBC) responsibilities under the COBA process.

Summary of Process

The following summarizes all the steps from receipt of the incoming claim to creation of the outbound COB:

- Carrier's translator performs syntax edits and maps incoming claim data to the ANSI X12N flat file;

- Shared system creates implementation guide and Medicare edits for the flat file data;

- Medicare data on ANSI X12N flat file is mapped to the core system;
  NOTE: No changes are being made to core system data fields or field sizes.

- Non-Medicare data (and Medicare data elements where field sizes are in excess of the core system) are written to the store-and-forward repository; and

- Adjudicated data is combined with repository data to create the outbound COB.

For specifics on how the claims crossover process will change, as early as July 6, 2004, under the COBA initiative, refer to Pub.100-4, Chapter 28, §70.6.

Medicare Claims Processing Manual

Chapter 28 - Coordination With Medigap, Medicaid, and Other Complementary Insurers

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20 - Assignment of Claims and Transfer Policy

(Rev. 98, 2-06-04)

B3-4702, B3-3047

A Medicare beneficiary who has a Medigap policy may authorize the participating physician, provider, or supplier of services to file a claim on his or her behalf and to receive payment directly from the insurer instead of through the beneficiary. In such cases, the intermediary or carrier must transfer Medicare claims information to the Medigap insurer. The Medigap insurer pays the physician/provider/supplier, and must pay the intermediary or carrier for their costs in supplying the information subject to limitations.

Paid claims from participating physicians or providers/suppliers for beneficiaries who have assigned their right to payment under a Medigap policy, regardless of whether or not it is in or from a State with an approved Medigap program, are to result in the transfer of claim information to the specified insurers.

The carrier systems must have the capability to distinguish between claims of participating and nonparticipating physicians and suppliers. This is because Medigap assignment of claims and transfer policy does not apply to nonparticipating physicians or non-participating suppliers.

Effective with the implementation of CMS' consolidated Medigap claim-based crossover initiatives on October 4, 2004, the process for reporting Medigap information on incoming claims will change. Each Part B and DME provider and supplier will ***only*** *include the CMS-issued Medigap claim-based COBA ID, which will be assigned by CMS' Medicare Coordination of Benefits Contractor (COBC), if: 1) the provider or supplier participates in the Medicare Program* ***and*** *2) the beneficiary has assigned his/her rights to payment under a Medigap policy to that provider or supplier. As of October 4, 2004, CMS will require participating Part B and DME providers and suppliers to include the CMS-issued Medigap claim-based COBA ID on an incoming claim if they wish to have their patients' Medicare claims crossed over to a Medigap insurer that does not supply an eligibility file to identify its insureds. See §70.6 of this Chapter for more details.*

20.1 - Beneficiary Insurance Assignment Selection

(Rev. 98, 2-06-04)

B3-4702.1, B3-3047, B4-2110.1

Beneficiaries indicate that they have assigned their Medigap benefits to a participating physician or supplier by signing block #13 on the Form CMS-1500. This authorization is in addition to their assignment of Medicare benefits as indicated by their signature in block #12.

The UB-92 makes no provision for the provider to indicate that the beneficiary has assigned benefits because the UB-92 is used only for institutional claims, for which payment is generally assigned to the provider of services. For claims the institutional provider submits to carriers for physician payments for physician employees; hospitals, SNFs, HHAs, OPTs, CORFs, or ESRD facilities may maintain a beneficiary statement in file instead of submitting a separate statement with each claim. This authorization must be insurer specific.

If the beneficiary has a Medigap policy, the following statement should be signed:

HICN

NAME OF BENEFICIARY MEDIGAP POLICY NUMBER

> I request that payment of authorized Medigap benefits be made either to me or on my behalf to _______________ for any services furnished me by that physician/provider/supplier. I authorize any holder of medical information about me to release to (name of Medigap insurer) any information needed to determine these benefits or the benefits payable for related services.

Since the beneficiary may selectively authorize Medigap assignments, caution providers about routinely stamping block #13 of the Form CMS-1500 “signature on file.” The Medigap assignment on file in the participating doctor/supplier’s office must be insurer specific. However, it may state that the authorization applies to all occasions of services until it is revoked.

Once CMS’ COBA claim-based Medigap process becomes effective on October 4, 2004, participating Part B and DME providers and suppliers will only include the CMS-assigned Medigap claim-based COBA ID on an incoming claim if confirmation that a beneficiary has authorized Medigap assignment has been obtained.

30.1 - Form CMS-1500 (ANSI X12N 837 COB (Version 4010))

(Rev. 98, 2-06-04)

B1-2010 - 2010.3, B3-4702, PM-A-01-20, PM-A-01-63

Participating physicians and suppliers must enter information required in item 9 and its subdivisions if requested by the beneficiary. Participating physicians/suppliers sign an agreement with Medicare to accept assignment of Medicare benefits for **all** Medicare patients. A claim for which a beneficiary elects to assign his/her benefits under a Medigap policy to a participating physician/supplier is called a mandated Medigap transfer. Medigap information is entered on the 1500 as follows:

Item 9a - The policy and/or group number of the Medigap insured preceded by **MEDIGAP, MG, or MGAP.** Note - item 9d must be completed if a policy and/or group number is entered in item 9a.

9b - The Medigap insured's 8-digit date of birth (MMDDYYYY) and sex.

Item 9c - Blank if a Medigap Payer ID is entered in item 9d. Otherwise, the claims processing address of the Medigap insurer. An abbreviated street address, two-letter postal code, and ZIP code copied from the Medigap insured's Medigap identification card is entered. For example:

1257 Anywhere Street
Baltimore, Md. 21204

Is shown as

1257 Anywhere St. MD 21204

Item 9d - 9-digit PAYERID number of the Medigap insurer - If no PAYERID number exists, the Medigap insurance program or plan name.

All the information in items 9, 9a, 9 b, and 9d must be complete and accurate. Otherwise, the Medicare contractor cannot forward the claim information. If prior arrangements have been made, the intermediary or carrier forwards the Medicare information electronically to the private insurer. Otherwise, the intermediary or carrier forwards a hardcopy of the claim to the private insurer.

A participating physician/supplier lists other supplemental coverage in item 9 and its subdivisions at the time each Medicare claim is filed.

*Once CMS' COBA claim-based Medigap process becomes effective on October 4, 2004, participating Part B and DME providers and suppliers will be required to enter the CMS-assigned claim-based COBA ID in block 9-D of Form CMS-1500 or in field NM109 of the NM1 segment in loop 2330B of the HIPAA 837 Professional claim or in field 301-C1 of the T04 segment of the NCPDP claim. If a participating Part B or DME provider or supplier fails to include this identifier in the field just described, the claim will **not** be*

transferred to the Medigap claim-based crossover insurer. (See §70.6 of this Chapter for more details.)

*State Medicaid Agencies that participate in claim-based crossover will report the claim-based COBA ID assigned by CMS in block 9-D of Form CMS-1500 or in field NM109 of the NM1 segment in loop 2330B of the HIPAA 837 Professional claim or in field 301-C1 of the T04 segment of the NCPDP claim. If a participating Part B or DME provider or supplier fails to include this identifier in the field just described, the claim will **not** be transferred to the State Medicaid Agency. (See §70.6 of this Chapter for more details.)*

50 – Remittance *Advice* Messages

(Rev. 98, 2-06-04)

B3-4704, PM-AB-99-3, PM-B-01-35, PM-A-01-57

Carriers/FIs should include the following message on remittance notices sent to participating physicians and suppliers when Medigap benefits are assigned and the information in block #9 of the Form CMS-1500 (or FL50 of the UB-92, as appropriate) is completed:

MA 18 – *"The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them."*

If the information in block #9 of the Form CMS-1500 or FL50 of the 1450 is incomplete, or more than one Medigap insurer was entered, FIs/carriers do not transmit a transaction record to the Medigap insurer. In such case*s,*the following message is included on the on remittance notices

MA19 - "Information was not sent to the Medigap insurer due to incorrect/invalid information you submitted concerning the insurer. Please verify your information and submit your secondary claim directly to that insurer."

Beginning with July 6, 2004, implementation of the national COBA process, intermediaries and carriers shall follow the requirements specified in §70.6 of this Chapter with respect to the crossover information that is to be included on the provider's remittance advice.

60 - Returned Medigap Notices

(Rev. 98, 2-06-04)

B3-4705, AB-99-3

Notices sent to Medigap insurers may be returned to the intermediary or carrier by the post office or other mail carrier as undeliverable. FIs and carriers consider returned notices as a source of information for detecting processing problems that merit additional analysis or investigation. They use findings to improve the transmittal process with respect to proper identification of the insurer or to update their Medigap insurer files. The intermediary or carrier should develop procedures to advise beneficiaries, physicians and suppliers of their responsibility for filing Medigap claims when a notice is returned but not re-transmitted. They should re-transmit notices that are returned due to their error.

If an insurer refuses to accept valid notices, FIs and carriers follow the procedures detailed in §70.4.

Intermediaries and carriers shall cease this responsibility after CMS' Coordination of Benefits Contractor (COBC) has assumed full responsibility for claim-based Medigap process.

70 - Coordination of Medicare With Medigap and Other Complementary Health Insurance Policies

(Rev. 98, 2-06-04)

B1-4607, B3-4701, B3-4706, A1-1601; A3-3768 - 3769

For applicable policy on information sharing, see Pub 100-1, the Medicare General Information, Eligibility and Entitlement Manual, Chapter 6.

For applicable cost sharing policy, see Pub 100-6, the Medicare Financial Management Manual, Chapter 1.

A formal agreement is a prerequisite for the electronic transfer of such data. (See §80.3, "Medigap Electronic Claims Transfer Agreement").

The intermediary or Carrier should determine the frequency at which they routinely transmit notices to all Medigap insurers but must transmit not less often than monthly. (See §70.4)

Data elements and the formats to be used are described on the CMS EDI Web site, at http://www.cms.hhs.gov/providers/edi/hipaadoc.asp under formats/coordination of benefits. As changes are made that site will be updated.

The CMS will begin efforts to consolidate the claims crossover process under the Coordination of Benefits Contractor (COBC) starting on July 6, 2004. Refer to §70.6 for Medicare contractor requirements and responsibilities beginning with that date.

Carriers or DMERCs shall continue to pursue collection of unpaid debts from Medigap insurers and other COB trading partners, even if such entities have been transitioned to the COBA process.

70.3 - Standard Medicare Charges for COB Records

(Rev. 98, 2-06-04)

A1-1600, B1-4601

See Chapter 1 of Pub 100-6, the Medicare Financial Management Manual.

Once CMS has consolidated the claims crossover process under the Coordination of Benefits Contractor on February 1, 2005, that entity will have exclusive responsibility for the collection and reconciliation of crossover claim fees for those Medigap and non-Medigap claims that intermediaries and carriers send to the COBC to be crossed to trading partners.

70.6—Consolidation of the Claims Crossover Process

(Rev. 98, 2-06-04)

The CMS has decided to streamline the claims crossover process to better serve our customers. Under the consolidated claims crossover process, trading partners will be transitioned from the current Trading Partner Agreement (TPA) process with intermediaries and carriers to new agreements called Coordination of Benefits Agreements (COBA). These agreements, which will be negotiated on behalf of CMS by the Coordination of Benefits Contractor (COBC), will be entered into directly between CMS and the COBA trading partners. Through the COBA process, each COBA trading partner will send one national eligibility file that includes eligibility information for each Medicare beneficiary that it insurers to the COBC. The COBC will transmit the beneficiary eligibility file(s) to the Common Working File (CWF) via a maintenance transaction. The transaction is known as the Beneficiary Other Insurance (BOI) auxiliary file. (See Chapter 27, §80.14, of Publication 100-4, Medicare Claims Processing Manual, for more details about the contents of the BOI auxiliary file.)

The Common Working File (CWF) is being modified so that it will apply each COBA trading partner's claims selection criteria against processed claims with service dates that fall between the effective and termination date of one or more BOI records. After applying the claims selection options, CWF will return a BOI reply trailer 29 to the intermediary or carrier ***only*** *in those instances when the COBA trading partner expects to receive a Medicare processed claim from the COBC. Upon receipt of a BOI reply trailer 29 that contains (a) COBA ID (s) and other crossover information required on the HIPAA 835 Electronic Remittance Advice (ERA), Intermediaries and Carriers will send processed claims via an 837 COB flat file or National Council for Prescription Drug Programs (NCPDP) file to the COBC. The COBC, in turn, will cross the claims to the COBA trading partner. The CWF is also being modified so that it will receive claim-based Medigap and/ or Medicaid COBA IDs in field 36 of the HUBC or HUDC query; search the Coordination of Benefits Agreement Insurance File (COIF) to locate a matching COBA IDs; apply the Medigap claim-based trading partner's claims selection criteria; and return a Claim-based reply trailer 37 to the carrier or DMERC if a claim-based COBA ID has been located* ***and*** *the claim is to be sent to the COBC to be crossed over.*

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

The effort to consolidate the claims crossover function will be implemented via a phased-in approach, beginning with July 06, 2004, and ending on January 31, 2005.

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

Effective July 6, 2004, the COBC will begin to send initial copies of the COBA Insurance File (COIF) to the nine CWF host sites. The COIF will contain specific information that will identify the CPNA trading partner, including name, COBA ID, address, and tax identification number (TIN). It will also contain each trading partner's claims selection criteria along with an indicator (Y=Yes or N=No) of whether the trading partner wishes its name to be printed on the Medicare Summary Notice (MSN).

CWF shall load the initial COIF submission from the COBC as well as all future weekly updates.

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

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

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

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

4) Transmit a BOI reply trailer to the Medicare intermediary or carrier <u>only</u> if the claim is to be sent, via 837 COB flat file or NCPDP file, to the COBC to be crossed over.

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

1. BOI Reply Trailer Process

*For eligibility file-based crossover, intermediaries and carriers shall send processed claims information to the COBC for crossover to a COBA trading partner in response to the receipt of a CWF BOI reply trailer 29. Intermediaries or carriers 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, Intermediaries and Carriers 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. If a Medicare intermediary or carrier receives an "N" indicator from the BOI reply trailer designating that the trading partner's name is not to be printed on the MSN, the Medicare intermediary or carrier shall print its customary generic crossover message(s) on the MSN rather than including the trading partner's name.

When intermediaries or carriers receive a BOI reply trailer 29, they shall annotate their internal claims history to show that the beneficiary's claim was selected by CWF to be crossed over by the COBC.

When a beneficiary's claim is associated with more than one COBA ID (i.e., the beneficiary has more than one health insurer/benefit plan that pays after Medicare), CWF shall sort the COBA IDs and trading partner names in the following order on the returned BOI reply trailer 29: 1) Eligibility-based Medigap, 2) Supplemental, 3) TRICARE, 4) Others, and 5) Eligibility-based Medicaid. When two or more COBA IDs fall in the same range (see element 24 of the "Data Elements Required for the BOI Aux File Record" Table in Chapter 27, §80.14 for more details), CWF shall sort numerically within the same range.

2. Claim-based Reply Trailer Process

*For claim-based Medigap or Medicaid crossover, which applies to carriers and DMERCs only, the carrier or DMERC is to follow the procedures described in the "Claim-Based Process" section below. As described in that section, after validating that the provider or supplier that submitted the beneficiary's claim is participating with the Medicare Program, carriers or DMERCs are to read a specified field on the incoming HIPAA Professional or NCPDP claim to determine whether a 5-digit claim-based COBA ID has been reported. (**NOTE:** Valid COBA IDs for claim-based Medigap include 55000-59999; valid COBA IDs for claim-based Medicaid include 78000-79999.) After determining that a valid COBA ID has been reported on the incoming claim, the carrier or DMERC is to report that ID in field 36 of the HUBC or HUDC query that is sent to CWF. The CWF will only return a Claim-based reply trailer 37 if: 1) a valid claim-based COBA ID is found on the COIF, and 2) the claim is to be sent to the COBC to be crossed over.*

When carriers or DMERCs receive a Claim-based reply trailer 37, they shall annotate their internal claims history to show that the beneficiary's claim was selected by CWF to be crossed over by the COBC.

3. Populating the HIPAA 835 Provider Electronic Remittance Advice (ERA) Crossover Fields

When a Medicare intermediary or carrier receives a BOI reply trailer, which indicates that a particular claim is to be sent to the COBC to be crossed to the COBA trading partner, it shall use the returned BOI reply trailer information to take the following actions on the provider's 835 ERA:

1) *Record code 19 in the CLP-02 (Claim Status Code) in the 2100 Loop (Claim Payment Information); and*

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

    - *NM101 [Entity Identifier Code]—Use "TT," as specified in the 835 Implementation Guide (IG);*

    - *NM102 [Entity Type Qualifier]—Use "2," as specified in the 835 IG;*

    - *NM103 [Name, Last or Organization Name]—Use the COBA trading partner name that appears on the first sorted BOI reply trailer returned to you;*

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

    - *NM109 [Identification Code]—Use the COBA ID that appears on the first sorted BOI reply trailer returned to you.*

4. Business Rules for Receipt of a CWF BOI Reply Trailer When Other Indicators of Crossover Are Present

Intermediaries and carriers are to follow these rules when they receive a BOI reply trailer and there is some other indication of crossover eligibility, e.g., Medigap information, supplied on the claim:

1. *If you receive a BOI reply trailer 29 with a COBA ID that falls in the Medigap eligibility-based range (30000-54999), you shall not cross over claims based on an existing Medigap TPA or when Medigap information is reported on the claim. (See "Claim-Based Requirements" for details on claim-based processes that begin October 4, 2004.) Instead, send the claim to the COBC (based on the BOI reply trailer) on the 837 v4010A1 flat file or National Council for Prescription Drug Programs (NCPDP) file for crossover by the COBC to the COBA trading partner. (NOTE: The assumption is that a beneficiary will have only one true Medigap insurer.)*

2. *If you receive a BOI reply trailer 29 with a COBA ID that falls in the Medicaid range (70000-77999), you shall not cross over claims based on an existing Medicaid TPA or when Medicaid information is reported on the claim. (See "Claim-Based Requirements" for details on claim-based processes that begin October 4, 2004). Instead, send claims to the COBC (based on receipt of a BOI trailer) on the 837 v4010A1 flat file or NCPDP file for crossover by the COBC to the COBA trading partner.*

   You shall not change your current procedures regarding suppression of Medicaid claims when a beneficiary has non-Medigap and/or Medigap insurance, including, for example, supplemental or Medigap insurers identified by a BOI trailer COBA ID.

3. *If you receive a COBA ID via a BOI trailer 29 that falls in the Supplemental range (00001-29999) and you have an existing TPA with a supplemental insurer for the beneficiary, you shall transmit the claim to the COBC for crossover to the COBA trading partner and cross the claim to your existing trading partner.*

4. *Prior to October 4, 2004, if you receive a COBA ID via a BOI reply trailer that falls in the Supplemental range (00001-29999), and you also receive Medigap crossover information on the claim, you shall cross the claim to the Medigap insurer identified on the claim and transmit the claim to the COBC for crossover to the COBA trading partner based on the Supplemental COBA ID. Beginning with October 4, 2004, you shall follow the claim-based requirements that appear later in this section when a Medicaid and/or Medigap claim-based COBA ID is reported on an incoming claim.*

NOTE: *For all scenarios above, the trading partner shall be responsible for canceling any existing TPA that it has with you once it has signed a COBA with the Coordination of Benefits Contractor (COBC). However, if you determine that a crossover trading partner has not cancelled its TPA with you, you shall create a report that identifies that trading partner and request that it cancel its TPA and cease sending you eligibility files.*

C. CWF Processing of Non-Assigned Medicare Claims that Fall in a Medicaid COBA Range

If CWF receives a non-assigned Medicare claim for a beneficiary whose BOI auxiliary file contains a COBA ID in the Medicaid eligibility-based range (i.e., 70000-77999), it shall reject the claim. The CWF shall return an edit to the carrier or DMERC that specifies that non-assigned Medicare claims cannot be sent to Medicaid. At the same time, CWF shall also return a Medicaid Reply Trailer 36 to the carrier or DMERC that contains a COBA ID and the beneficiary's effective dates and termination dates under Medicaid. If the carrier or DMERC determines that the non-assigned claim's service dates fall during a period when the beneficiary is eligible for Medicaid, it shall convert

the assignment indicator from "non-assigned" to "assigned" and retransmit the claim to CWF. After the claim has been retransmitted, CWF will only return a BOI reply trailer to the carrier or DMERC if the claim is to be sent to the COBC to be crossed over.

D. Transmission of the COB Flat File or NCPDP File to the COBC

Intermediaries or carriers shall transmit all non-NCPDP claims received with a COBA ID via a BOI reply trailer to the COBC in an 837 v.4010A1 flat file, as described in Transmittal AB-03-060. In a separate transmission, DMERCs shall send the claims received in the NCPDP file format to the COBC. Intermediaries and Carriers shall enter the COBA ID in the 1000B loop of the NM1 segment in the NM109 field. In a situation where multiple COBA IDs are received for a claim, intermediaries and carriers shall send a separate 837 or NCPDP transaction to the COBC for each COBA ID. Intermediaries and carriers shall perform the transmission at the end of their regular batch cycle, when claims come off the payment floor, to ensure crossover claims are not processed by the COBA trading partner prior to Medicare's final payment. Transmission should occur via Network Data Mover (NDM) over AGNS (AT&T Global Network Services).

With respect to 837 COB flat file submissions to the COBC, Carriers and DMERCs shall observe these process rules:

1. *The following segments shall not be passed to the COBC:*

   a) ISA (Interchange Control Header Segment);

   b) IEA (Interchange Control Trailer Segment);

   c) GS (Functional Group Header Segment); and

   d) GE (Functional Group Trailer Segment).

2. *The 1000B loop of the NM1 segment denotes the crossover partner. If multiple COBA IDs are received via the BOI reply trailer, a separate 837 transaction should be submitted for each COBA ID received. As the crossover partner information will be unknown to the standard systems, the following fields should be formatted as indicated for the NM1 segment:*

   a) NM103—Use spaces; and

   b) NM109—Include COBA ID.

3. *The 2010BA loop denotes the subscriber information. If available, the subscriber name, address, and policy number should be used to complete the NM1, N3, and N4 segments. If unknown, the segments should be formatted as follows, with COBC completing any missing information:*

   a) NM1 segment—For NM103, NM104, NM105, and NM107, use spaces;

   b) NM1 segment—For NM109, include HICN;

c) N3 segment—Use all spaces; and

d) N4 segment—Use all spaces.

4. *The 2010BB loop denotes the payer name. Per the HIPAA Implementation Guide (IG), this loop should define the secondary payer when sending the claim to the second destination payer. Consequently, given that the payer related to the COBA ID will be unknown by the standard systems, the NM1, N3, and N4 segments should be formatted as follows, with COBC completing any missing information:*

   a) NM1 segment—For NM103, use spaces;

   b) NM1 segment—For NM109, include the COBA ID;

   c) N3 segment—Use all spaces; and

   d) N4 segment—Use all spaces.

5. *The 2330B loop denotes other payers for the claim. If multiple COBA IDs are returned via the BOI reply trailer, payer information for the additional COBA IDs will be unknown. As with the 2010BB loop, the NM1 segment should be formatted as follows, with COBC completing any missing information:*

   a) NM103—Use spaces; and

   b) NM109—Include COBA ID.

6. *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 COBC will inspect these values for COBA related eligibility based claims and overlay as appropriate. If unknown, spaces may be used.*

   ---SBR01—Treat as normally do.

With respect to 837 COB flat file submissions to the COBC, intermediaries shall observe these process rules:

1. *As the ISA, IEA, and GS segments are included in the '100' record with other required segments, the '100' record must be passed to the COBC. However, as the values for these segments will be recalculated, spaces may be placed in all of the fields related to the ISA, IEA, and GS segments.*

2. *The 1000B loop of the NM1 segment denotes the crossover trading partner. If multiple COBA IDs are received via the BOI reply trailer, 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:

   a) *NM103—Use spaces; and*

   b) *NM109—Include COBA ID.*

3. *The 2010BA loop denotes the subscriber information. If available, the subscriber name, address, and policy number should be used to complete the NM1, N3, and N4 segments. If unknown, the segments should be formatted as follows for the '300' record, with COBC completing any missing information:*

   a) *NM1 segment – For NM103, NM104, NM105, and NM107, use spaces;*

   b) *NM1 segment—For NM109, include HICN;*

   c) *N3 segment—Use all spaces; and*

   d) *N4 segment—Use all spaces.*

4. *The 2010BC loop denotes the payer name. Per the HIPAA IG, this loop should define the secondary payer when sending the claim to the second destination payer. Consequently, since the payer related to the COBA ID will be unknown to the standard systems, the NM1, N3, and N4 segments should be formatted as follows for the '300' record, with COBC completing any missing information:*

   a) *NM1 segment—For NM103, use spaces;*

   b) *NM1 segment—For NM109, include COBA ID;*

   c) *N3 segment—Use all spaces; and*

   d) *N4 segment—Use all spaces.*

5. *The 2330B loop of the '575' record denotes other payers for the claim. If multiple COBA IDs are returned via the BOI reply trailer, payer information for the additional COBA IDs will be unknown. As with the 2010BC loop, the NM1 segment should be formatted as follows, with COBC completing any missing information:*

   a) *NM103—Use spaces; and*

   b) *NM109—Include COBA ID.*

6. *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 COBC will inspect these values for COBA related eligibility based claims and overlay as appropriate. If unknown, spaces may be used.

---SBR01—Treat as normally do.

E. COBC Processing of COB Flat Files or NCPDP Files

When an intermediary or carrier receives the reject indicator "R" via the Claims Response File, it is to retransmit the entire file to the COBC. If the intermediary or carrier receives an acceptance indicator "A," this confirms that its entire COB flat file or NCPDP file transmission was accepted. Once COB flat files or NCPDP files are accepted and translated into the appropriate outbound format(s), COBC will cross the claims to the COBA trading partner. The format of the Claims Response File that will be returned to each intermediary or carrier by the COBC, following its COB 837 flat file or NCPDP file transmission, appears in the table below.

Claims Response File Layout (80 bytes)				
Field	*Name*	*Size*	*Displacement*	*Description*
1.	*Contractor Number*	*5*	*1-5*	*Contractor Identification Number*
2.	*Transaction Set Control Number/Batch Number*	*9*	*6-14*	*Found within the ST02 data element from the ST segment of the ANSI 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 ANSI 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 ANSI 837 flat file or NCPDP file in CCYYMMDD format*
5.	*Accept/Reject indicator*	*1*	*32*	*Indicator of either the acceptance or rejection of the ANSI 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 Medicare contractors after receipt and initial processing of a claim file. Thus, for example, if an intermediary or carrier sends a COB

flat file daily, the COBC will return a claim response file to that contractor on a daily basis.

The COBC plans to assign the following file names to claims response files returned to Medicare intermediaries or carriers. The file names will be created as part of the NDM set-up process. Since the COBC will potentially receive 3 types of files, a separate response will be generated for each file using the following file naming conventions:

PCOB.BA.NDM.COBA.Cxxxxx.PARTA(+1) [Used for Institutional Claims]

PCOB.BA.NDM.COBA.Cxxxxx.PARTB(+1) [Used for Professional Claims]

PCOB.BA.NDM.COBA.Cxxxxx.NCPDP(+1). [Used for Drug Claims]

Note that "xxxxx" denotes the Medicare contractor number. Test files will be prefixed with "TCOB" instead of "PCOB."

Files transmitted by the intermediary, carrier, or DMERC to the COBC shall be stored for 51 business days from the date of transmission.

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

F. Claim-Based Crossovers under COBA

Medigap insurers that meet the statutory definition of a Medigap supplemental insurer, as provided in §1882(g)(1) of Title XVIII of the Act, have historically been assigned unique IDs, known as OCNA or N-key Numbers, by Carriers and DMERCs for identification purposes in case their names or addresses are omitted on incoming claims. The CMS will continue with a similar practice as part of its COBA Medigap claim-based process. Medigap insurers that prefer not to submit eligibility files to identify their insureds will each be assigned unique 5-digit COBA IDs for official identification purposes. The key difference under the COBA claim-based crossover process will be that all Part B and DME providers and suppliers will now be ***required*** *to include the assigned COBA ID on the incoming claim as a precondition for the claim being crossed over to the Medigap trading partner. State Medicaid Agencies that participate in claim-based crossover will also be assigned a 5-digit COBA ID for official identification purposes.* ***IMPORTANT:*** *Claim-based Medigap and Medicaid crossover processes under COBA do not apply to intermediaries.*

Effective October 4, 2004, carriers and DMERCs shall cease their existing claim-based crossover processes. The CWF process to return a Claim-based reply trailer 37 to carriers and DMERCs, which indicates that the reported claim-based COBA ID was located on the COIF and the claim is to be sent to the COBC for crossover, will not become operational until October 4, 2004. Therefore, carriers and DMERCs shall cross

processed claims that were tagged for crossover to non-eligibility file-based Medigap or Medicaid trading partners prior to the October 4, 2004, implementation date.

For claim-based COBA crossover, carriers and DMERCs shall perform the following:

1) *Validate that the provider or supplier is participating with the Medicare Program;*

2) *If the provider or supplier is participating with the Medicare Program, you shall read block 9-D of the CMS Form 1500 or field NM109 of the NM1 segment in loop 2330B of the HIPAA 837 Professional claim or field 301-C1 of the T04 segment of the NCPDP claim to determine whether a 5-digit claim-based COBA ID has been reported;*

3) *Report only COBA IDs that identify Medigap (55000-59999) or Medicaid (78000-79999) claim-based crossovers in field 36 (Payer ID) of the HUBC or HUDC query to CWF. If the incoming claim-based COBA ID falls outside of the claim-based ranges specified, do not report the COBA ID in field 36;*

4) *Right-justify and include 5 zeroes before the claim-based COBA ID when placing it in field 36 of the HUBC or HUDC query; and*

5) *Not include a claim-based COBA ID in field 36 of the HUBC or HUDC query if the claim is for a non-participating provider or supplier.*

Printing of MSN Messages Following Receipt of a Claim-based Reply Trailer

If the COBA ID reported on the claim falls in the Medigap claim-based range (55000–59999), the carrier or DMERC shall print crossover messages on the MSN (as currently instructed) and on the ERA (specifying name of the Medigap insurer, as required by the HIPAA 835 requirements) when it receives a Claim-based reply trailer 37. (NOTE: Multiple COBA IDs may appear on the Claim-based reply trailer 37.)

There will be instances where a carrier or DMERC receives both a BOI reply trailer 29 and a Claim-based reply trailer 37. For purposes of printing ERA crossover messages, the carrier or DMERC's system shall ensure that the information returned via the BOI reply trailer 29 takes precedence over the information returned via the Claim-based reply trailer 37.

If CWF returns an alert XXXX (4 position code) on the "01" response via the Claim-based Alert Trailer 21 that indicates that the Medigap claim-based COBA ID was not located on the COIF, the carrier or DMERC shall print the MSN and ERA messages indicated below.

MSN Message:

MSN #35.3 – "A copy of this notice will not be forwarded to your Medigap insurer because the Medigap information was incomplete or invalid. Please submit a copy of this notice to your Medigap insurer."

ERA Message:

MA 19- "Information was not sent to the Medigap insurer due to incorrect/invalid information you submitted concerning the insurer. Please verify your information and submit your secondary claim directly to that insurer."

*If the carrier or DMERC does **not** receive a Claim-based reply trailer 37 that includes a COBA ID in the Medicaid claim-based range (78000-79999), it shall print nothing on the MSN or ERA. In such situations, the carrier or DMERC shall conclude that 1) a claim-based Medicaid COBA ID was not located on the COIF, and/or 2) the claim is not to be included on the carrier or DMERC's 837 flat file or NCPDP file submission to the COBC to be crossed over.*

G. Participating Provider and Supplier Processes for Reporting Claim-Based Medigap and Claim-Based Medicaid and Associated Carrier and DMERC Responsibilities

Before July 2004, CMS shall issue a listing of newly established claim-based COBA IDs to all Carriers and DMERCs. Each Carrier and DMERC shall publish a listing of these newly assigned identifiers in its provider/supplier newsletters or other publications and/or on its provider education Web site. Also, before July 6, 2004, CMS shall issue an information packet to Carriers and DMERCs that describes the COBA claim-based process for the benefit of their affiliated participating providers and suppliers. Carriers and DMERCs shall include CMS' COBA claim-based crossover information packet on their Web site and shall reference the availability of that information in any communications they have with providers and suppliers.

Over time, Medigap insurers and State Medicaid Agencies that had initially decided not to execute COBAs may decide to sign COBAs. When this occurs, CMS will issue a revised listing to carriers and DMERCs of all Medigap insurers and State Medicaid Agencies that now have COBA claim-based IDs. Carriers and DMERCs shall publish the revised listing in their provider/supplier newsletters or on their provider education Web site.

*Effective October 4, 2004, all participating Part B and DME providers/suppliers shall have received a listing of all Medigap insurers and State Medicaid Agencies that have been assigned **claim-based** COBA IDs. They are to include the 5-digit COBA ID on incoming HIPAA 837 Professional and NCPDP claims when a beneficiary presents his/her health insurance card on which the Medigap insurer or State Medicaid Agency is identified **and** if the following conditions are met:*

1) The beneficiary has assigned Medigap benefits to the provider or supplier on the claim, as demonstrated by a "Y" privacy release indicator; ***and/or***

*2) The provider or supplier is participating with the Medicare Program. (**NOTE:** This condition applies both to Medigap and Medicaid claim-based crossover.)*

If Part B and DME providers or suppliers determine that it is appropriate to include the claim-based COBA ID on incoming claims, they shall report that ID in block 9-D of the CMS Form 1500 or in field NM109 of the NM1 segment in loop 2330B of the HIPAA 837 Professional claim or in field 301-C1 of the T04 segment of the NCPDP claim. Providers and suppliers shall not report the CMS issued claim-based COBA ID on incoming claims before October 4, 2004.

H. Transition to the National COBA and Customer Service Issues

1. Maintenance of Current Crossover Processes, Including Entry into New Claims Crossover Agreements (also known as Trading Partner Agreements or TPAs)

Intermediaries and carriers shall keep their present crossover process in place, including invoicing for claims crossed to current trading partners, as described in Pub. 100-6, Financial Management, Chapter 1, §450 and §460, until each of their present trading partners has been transitioned to the COBA process. As trading partners are signed on to national COBAs, they will be advised that it is their responsibility to simultaneously cancel current agreements with intermediaries and carriers and to cease submission of eligibility files. If intermediaries or carriers subsequently determine that trading partners have failed to cancel their existing TPAs with them, they shall contact the trading partner to request that it cancel its TPA and cease sending you eligibility files. The CMS expects to complete the transition of current eligibility file-based trading partners to COBAs by January 31, 2005.

Given CMS' newly targeted COBA implementation date of July 6, 2004, you shall continue to execute new crossover agreements (Trading Partner Agreements or TPAs) for trading partners that wish to go into live production by May 1, 2004. These new TPAs and extensions of existing TPAs shall allow for future termination, allowing for appropriate notice, no later than January 31, 2005. Trading partners that either wish to go into live production after May 1, 2004, or have questions regarding the COBA process shall be referred to the COBC at 1-800-999-1118.

2. Workload Reporting In Light of COBA

For workload reporting purposes, intermediaries and carriers shall provide separate counts, by trading partner, for those claims that they individually cross to current trading partners (including Medicaid), in accordance with pre-COBA processes.

Intermediaries and carriers shall track claims transmitted to the COBC for crossover to the COBA trading partners for future reporting requirements by COBA ID.

3. Customer Service

Intermediary and carrier customer service personnel shall answer provider/supplier and beneficiary questions about a claim's crossover status by referring to the intermediary or carrier's internal claims history. The intermediary or carrier's claims history shall have been updated through the receipt of a CWF BOI reply trailer 29 and/or Claim-based reply trailer 37. The intermediary or carrier's internal claims history shall indicate that each claim on which a BOI reply trailer 29 or Claim-based reply trailer 37 was received was selected to be crossed over. Intermediary and carrier customer service staff shall access information regarding why a claim did not cross by referring to various detailed history screens on the Health Insurance Master File (e.g., INPH, OUTH, HOSH, PTBH, DMEH, and HHAH). [See Chapter 27, §80.15 of the Medicare Claims Processing Manual for a listing of all claims crossover disposition indicators.] In addition to specifying why a claim did not cross over to a COBA trading partner, the HIMR detailed listing screens will also display an indicator "A," which confirms that a claim was selected to be crossed over to the COBA ID shown. The BOI auxiliary file will identify the name associated with the COBA ID.

The intermediary and carrier will receive instructions on the use of the new HIMR screens from the CWF maintainer as part of the April 5, 2004, systems release. .

80 - Electronic Transmission - General Requirements

(Rev. 98, 2-06-04)

PM-A-01-20, PM-A-01-63, PM-B-01-06, B3-4707

Until an intermediary or carrier receives notice from a Medigap plan that it has signed a national Coordination of Benefits Agreement (COBA) with CMS' Coordination of Benefits Contractor (COBC) and thus has requested cancellation of its existing Trading Partner Agreement with that Medicare contractor (see §70.6 of this chapter for more information), intermediaries/carriers will continue to enter into formal agreements with individual Medigap insurers for the transmission of claim information electronically (see *§80.3*). The agreement should specify whether the Medigap insurer will submit an eligibility file. If the Medigap insurer wants to send a periodic eligibility file the agreement must specify how Medicare costs are to be paid by the Medigap insurer.

The CMS requires that the outbound format for the transfer of Health Care claim information is the ANSI X12N 837 COB (version 4010), or for transmissions before the required implementation date for X12N, the NSF or UB-92 outbound format may be used. Also, if the recipient wants electronic attachments, attachment data must be furnished in UB-92 or NSF format because X12N does not support electronic attachments (e.g., UB-92 RTs 74, 75, 76). Only the attachment records will be furnished in UB-92 or NSF format after X12N becomes mandatory. Other data will be in the X12N format. The recipient must coordinate any attachments received with the claim record.

Detailed specifications on the electronic formats can be obtained at http://www.cms.hhs.gov/providers/edi/edi3.asp.

The outbound COB transaction is a post-adjudicative transaction. This transaction includes the incoming claim data as well as the COB data. The intermediary or carrier is required to receive all possible data on the incoming 837, although they do not have to process non-Medicare data. However, the shared system must store that data in a store-and-forward repository (SFR). This repository file is designed and maintained by the shared system. This data must be reassociated with the Medicare claim and payment data in order to create a compliant outbound COB transaction using the Medicare Claim/COB flat file as input. The shared system is to use post-adjudicative Medicare data (data used from history and reference files to adjudicate the claim) instead of data received when building the outbound COB transaction. This is to show any changes in data element values as a result of claims adjudication. The shared system must retain the data in the SFR for a minimum of six months.

The Medicare Claim/COB flat file is the format to be used to reassociate all data required to map to the COB transaction. The FI/Carrier's translator will built its outbound COB transaction from the Medicare Claim/COB flat file.

The CMS recommends the FI/Carrier send the outbound COB transaction over a wire connection. However, tape or diskettes may be sent to those trading partners that do not wish to receive transmissions via wire. The FI/Carrier and its trading partners will need to reach agreement on telecommunications protocols. It is the FI/Carrier choice as to whether it wishes to process the X12N 997 Functional Acknowledgment from its COB trading partners.

Data on claims that the intermediary or carrier receives from its keyshop or image processing systems may not be included on the SFR, depending on the shared system design. The FI/Carrier will create the Medicare claim/COB flat file using data available from claims history and reference files. Since some data will not be available on these "paper" claims, the outbound COB transaction will be built as a "minimum "data set. It will contain all "required" COB transactions segments and post-adjudicative Medicare data. For a Medicare Claim/COB flat file layout see http://www.cms.hhs.gov/providers/edi/hipaadoc.asp.

The steps from receipt of the incoming claim to creation of the outbound COB are summarized below:

- Contractor's translator performs syntax edits and maps incoming claim data to the X12N flat file;
- Standard system creates implementation guide and Medicare edits for the flat file data;
- Medicare data on ANSI X12N flat file is mapped to the core system;

NOTE: There are no changes in core system data fields or field sizes.

Non-Medicare data (and Medicare data elements where field sizes are in excess of the core system) are written to the SFR; and adjudicated data is combined with repository data to create the outbound COB. *Under the COBA process, the COBC will receive flat files containing processed Medicare claims. After applying each trading partner's claims selection criteria, the COBC will then transmit outbound COB transactions to the COBA trading partner. Implementation of this process will occur throughout the period July 6, 2004, to January 31, 2005. Refer to §70.6 of this chapter for more details.*

80.2 - ANSI X12N 837 COB (Version 4010) Transaction Fee Collection

(Rev. 98, 2-06-04)

The intermediary or carrier charges Medigap and other complementary insurers (but not Medicaid) for the cost of preparing and sending COB transactions. The transfer agreement must include a description of data elements on the invoice (bill). (See §70.3 above.) *Once CMS has fully consolidated the claims crossover process under the COBC on February 1, 2005, that entity will have exclusive responsibility for the collection and*

reconciliation of crossover claim fees for those Medigap and non-Medigap claims that are sent to the COBC to be crossed over.

If a Medigap insurer refuses to pay or does not pay it regularly and completely, the FI/Carrier should notify the appropriate State insurance commission that the Medigap insurer is not complying with the payment provisions of §4081 of OBRA 1987. First, the FI/Carrier should contact the insurance department of the State in which the policyholder resides. If that State insurance department does not accept jurisdiction, the FI or carrier informs the appropriate RO. The RO contacts CMS Central Office for assistance in determining the department of jurisdiction. If, after contacting the insurance department recommended by CMS, the problem is unresolved, the FI or carrier treats it as a CMS debt under 42 CFR 401.601-401.625. *(NOTE: As of February 1, 2005, the COBC will assume the role of notifying the appropriate state insurance commission when a Medigap insurer fails to pay for the crossover service.)*

The requirements in §§20 - 30.1 do not supplant existing agreements which the intermediary or carrier may have with any other insurer to exchange complementary insurance information except for possible amendment to recognize the beneficiary's right to assign Medigap payment to participating physicians and suppliers on a claim-by-claim basis. The intermediary or carrier should modify these agreements to state that it is the beneficiary's right to designate a particular insurer to receive a notice for payment. If the FI/Carrier has transmitted an ANSI X12N 837 COB (Version 4010) Transaction to a designated Medigap insurer based on a properly executed assignment, that insurer should send claims information to other insurers under complementary arrangements.

80.3 - Medigap Electronic Claims Transfer Agreements

(Rev. 98, 2-06-04)

B3-4709, B4-2110.1

For electronic transfers occurring on a frequent basis, Medigap and other insurers must enter into agreements with the intermediary or carrier. These agreements may alter the procedures applying to existing agreements with complementary insurers, including Medigap assignment provisions.

At a minimum, all transfer agreements include:

- Functions of the carrier;
- Functions of the Medigap insurer;
- Fees and payment schedules;
- Confidentiality/Disclosure of information furnished;

- Office of Inspector General (OIG) review access;
- Contract periods and automatic renewal provisions;
- Contract termination provisions; and
- Dated signatures of authorized carrier/Medigap insurer representatives

FIs/carriers can negotiate other provisions that the Medigap insurer may want but are not required to by §§20 - 80. The standard formats as described by these sections must be used.

Effective February 1, 2005, all electronic transfer agreements [formally known as Coordination of Benefits Agreements (or COBAs)] will be negotiated and administered by the COBC, working on behalf of CMS. The COBAs will be executed between health insurers and health benefit programs that pay after Medicare and CMS rather than between intermediaries/carriers and these entities. Refer to §70.6 in this chapter for more details.

80.3.1 - Intermediary Crossover Claim Requirements

(Rev. 98, 2-06-04)

A-01-20, A-02-069, A-02-077, A-02-078, AB-02-20

Outbound COB

The outbound COB transaction is a post-adjudicative transaction. This transaction includes the incoming claim data as well as COB data. Intermediaries are required to receive all possible data on the incoming ANSI X12N 837 although they do not have to process non-Medicare data. However, the shared system must store that data in a SFR. This repository file will be designed and maintained by the shared system. This data must be re-associated with Medicare claim and payment data in order to create an IG compliant outbound COB transaction using the Medicare Part A Claim/COB flat file as input. The shared system is to use post-adjudicated Medicare data (data used from history and reference files to adjudicate the claim) instead of data received when building the outbound COB transaction. The shared system must retain the data in the SFR for a minimum of six months.

The Medicare Part A Claim/COB flat file is the format to be used to reassociate all data required to map to the COB transaction. The translator will build the outbound COB transaction from the Medicare Part A Claim/COB flat file.

Intermediaries are not required to process an incoming ANSI X12N 997. They may create and use their own proprietary report(s) for feedback purposes.

The shared system maintainer must accommodate the COB transaction.

The flat file creation process and responsibility for sending outbound COB files to crossover trading partners will change appreciably once CMS' COBA process is implemented. The implementation of COBA is scheduled to begin July 6, 2004, and conclude by January 31, 2005. See §70.6 for details about intermediary verses COBC responsibilities under the COBA process.

Summary of Process

The following summarizes all intermediary steps from receipt of the incoming claim to creation of the outbound COB:

- Intermediary's translator performs syntax edits, IG edits, and Medicare edits and maps incoming claim data to the Medicare Part A Claim/COB flat file;

- Medicare data on the Medicare Part A Claim/COB flat file is mapped to the core system by the shared system.

NOTE: No changes are being made to core system data fields or field sizes;

- Non-Medicare data (and Medicare data elements where field sizes are in excess of the core system) are written to the SFR by the intermediary's shared system; and

- Adjudicated data is combined with SFR data to create the outbound COB transaction.

For specifics on how the claims crossover process will change, as early as July 6, 2004, under the COBA initiative, refer to §70.6 in this chapter.

80.3.2 - Carrier/DMERC Crossover Claim Requirements

(Rev.)

B-01-32, B-01-06, OCR/ICR definition created through outside IS text

Outbound Coordination of Benefits (COB)

The outbound COB transaction is a post-adjudicative transaction. This transaction includes incoming claim data as well as COB data. Carriers are required to receive all possible data on the incoming ANSI X12N 837 although they do not have to process non-Medicare data. However, they must store that data in a store-and-forward repository (SFR). This repository will be

designed by the shared system. This data must be reassociated with Medicare claim and payment data in order to create an outbound ANSI X12N 837 COB transaction. The shared systems maintainer is to use post-adjudicated Medicare data (data used from history and reference files to adjudicate the claim) instead of data received when building the outbound COB transaction. Carriers must retain the data in the SFR for a minimum of six months.

The ANSI X12N-based flat file is the format to be used to reassociate all data required to map to the outbound ANSI X12N 837 (4010A1). The translator will build the outbound ANSI X12N 837 COB from the ANSI X12N-based flat file.

The shared system maintainer must create the outbound ANSI X12N 837.

The flat file creation process and responsibility for sending outbound COB files to crossover trading partners will change appreciably once CMS' COBA process is implemented. The implementation of COBA is scheduled to begin July 6, 2004, and conclude by January 31, 2005. See §70.6 of this chapter for details about carrier/DMERC versus COBC responsibilities under the COBA process.

Summary of Process

The following summarizes all the steps from receipt of the incoming claim to creation of the outbound COB:

- Carrier's translator performs syntax edits and maps incoming claim data to the ANSI X12N flat file;
- Standard system creates implementation guide and Medicare edits for the flat file data;
- Medicare data on ANSI X12N flat file is mapped to the core system;

  NOTE: No changes are being made to core system data fields or field sizes.
- Non-Medicare data (and Medicare data elements where field sizes are in excess of the core system) are written to the store-and-forward repository; and
- Adjudicated data is combined with repository data to create the outbound COB.

For specifics on how the claims crossover process will change, as early as July 6, 2004, under the COBA initiative, refer to §70.6 in this chapter.

Medicare Claims Processing Manual

Chapter 27 - Contractor Instructions for CWF

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80.14- Consolidated Claims Crossover Process

(Rev. 2, 2-6-04)

1. Beneficiary Other Insurance (BOI) Auxiliary Record

CMS has decided to streamline the claims crossover process to improve customer service to affected stakeholders. Under the consolidated claims crossover or Coordination of Benefits Agreement (COBA) process, trading partners will now execute one national COBA with the Medicare Coordination of Benefits Contractor (COBC) and will, in most cases, submit one eligibility file to identify their insureds. Under the COBA process, COBA trading partners will submit eligibility files to the COBC. The COBC will, in turn, post data from the eligibility file to the CWF Beneficiary Other Insurance (BOI) auxiliary record.

The table below contains all the data elements that will appear on the CWF BOI auxiliary file.

Data Elements Required for the BOI Auxiliary File

DATA ELEMENT	***REMARKS***
1. Record Type	*CWF BOI other insurer maintenance (Mandatory)*
2. Health Insurance Claim (HIC) Number	*Beneficiary's HIC/Railroad Board number (Mandatory)*
3. Beneficiary's Surname	*Beneficiary's surname (Mandatory)*
4. Beneficiary's First Initial	*Initial of first name of the beneficiary (Mandatory)*
5. Beneficiary's Date of Birth	*Beneficiary's date of birth (CCYYDDD)*
6. Beneficiary's Sex Code	*Beneficiary's sex code* *0 = Unknown* *1 = Male* *2 = Female*
7. Contractor Number	*Identifies COB contractor applying maintenance*
8. Creation Date	*Date record created (CCYYDDD)*
9. Deletion Date	*Date record deleted (CCYYDDD)*
10. Document control	*Document control number*
11. Action Type	*Identifies type of maintenance (Mandatory)* *0 = Add insurance data transaction* *1 = Change insurance data transaction*

	2 = Delete insurance data transaction
12. Update Indicator	*Date maintenance applied (CCYYDDD)*
13. Insurance Code	*Insurance coverage type (Mandatory)* *A = Supplemental* *B = TRICARE* *C = Medicaid*
14. Insurer's Name	*Insurer's name*
15. Insurer's Address - 1	*Insurer's address line 1*
16. Insurer's Address – 2	*Insurer's address line 2*
17. Insurer's City	*Insurer's city*
18. Insurer's State	*Insurer's State*
19. Insurer's Zip Code	*Insurer's zip code*
20. Policy Number	*Insurer's policy number of insured*
21. Insurance Effective Date	*Effective date of insurance coverage (CCYYDDD)* *One or more occurrences* *(Mandatory)*
22. Insurance Termination Date	*Termination date of insurance coverage (CCYYDDD)* *One or more occurrences* *(Mandatory, if applicable)*
23. Identifier Number Assigned by Supplemental Insurer	*Number assigned to insured by supplemental insurer*
24. Coordination of Benefits Agreement (COBA) number	*COBA number assigned to other insurer's agreement by COB contractor/numbers will be right justified and will fall into these ranges based on type of COBA trading partner:* *Supplemental 00001-29999* *Eligibility-Based Medigap 30000-54999* *TRICARE 60000-69999* *Eligibility-BasedMedicaid 70000-77999* *Others 80000-89999* *Unassigned 90000-99999* *(Mandatory)*
25. N Plan ID	*The CMS national plan identifier assigned to the insurer (Mandatory when available)*
26. Other Insurer Number	*Other number assigned to an insurer by an FI or carrier under a former trading partner agreement. (One or more occurrences.)*
27. Filler	*Filler (25 characters—reserved for future expansion.)*

2. The Mechanics of the CWF Claims Selection Process and BOI and Claim-based Reply Trailers

A. CWF Receipt and Processing of the Coordination of Benefits Agreement Insurance File (COIF)

Effective July 6, 2004, the COBC will begin to send copies of the Coordination of Benefits Agreement Insurance File (COIF) to the nine CWF host sites on a weekly basis. The COIF will contain specific information that will identify the COBA trading partner, including name, COBA ID, address, and tax identification number (TIN). It will also contain each trading partner's claims selection criteria exclusions (claim or bill types that the trading partner does not want to receive via the crossover process) along with an indication of whether the trading partner wishes its name to be printed on the Medicare Summary Notice (MSN).

The CWF shall load the initial COIF submission from COBC as well as all future weekly updates.

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

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

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

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

4) *Transmit a BOI reply trailer 29 to the Medicare intermediary or carrier only if the claim is to be sent, via 837 COB flat file or National Council for Prescription Drug Programs (NCPDP) file, to the COBC to be crossed over. (See Pub.100-4, Chap. 28, §70.6 for more information about the claim file transmission process involving the Medicare intermediary or carrier and the COBC.)*

B. BOI Reply Trailer 29 Processes

For purposes of eligibility file-based crossover, if CWF selects a claim for crossover, it shall return a BOI reply trailer 29 to the Medicare intermediary or carrier. The returned BOI reply trailer 29 shall include, in addition to COBA ID(s), the COBA trading partner name(s), an "A" crossover indicator that specifies that the claim has been selected to be crossed over, the insurer effective and termination dates, and a 1-digit indicator ["Y"=Yes; "N"=No] that specifies whether the COBA trading partner's name should be printed on the beneficiary MSN. If a Medicare intermediary or carrier receives an "N"

indicator from the BOI reply trailer designating that the trading partner's name is not to be printed on the MSN, it shall print its customary generic crossover message on the MSN rather than including the trading partner's name.

When a beneficiary's claim is associated with more than one COBA ID (i.e., the beneficiary has more than one health insurer/benefit plan that has signed a national COBA), CWF shall sort the COBA IDs and trading partner names in the following order: 1) Eligibility-based Medigap, 2) Supplemental, 3) TRICARE, 4) Others, and 5) Eligibility-based Medicaid. When two or more COBA IDs fall in the same range (see item 24 in the BOI Auxiliary File table above), CWF shall sort numerically within the same range.

When a Medicare intermediary or carrier receives a BOI reply trailer 29, which indicates that a particular claim is to be sent to the COBC for crossover, it shall use the returned BOI reply trailer information to take the following actions on the provider's 835 Electronic Remittance Advice:

1) *Record code 19 in CLP-02 (Claim Status Code) in the 2100 Loop (Claim Payment Information); and*

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

    - *NM101 [Entity Identifier Code]—Use "TT," as specified in the 835 Implementation Guide (IG);*
    - *NM102 [Entity Type Qualifier]—Use "2," as specified in the 835 IG;*
    - *NM103 [Name, Last or Organization Name]—Use the COBA trading partner name that accompanies the first sorted COBA ID returned to you on the BOI reply trailer;*
    - *NM108 [Identification Code Qualifier]—Use "PI" (Payer Identification; and*
    - *NM109 [Identification Code]—Use the first COBA ID returned to you on the BOI reply trailer.*

C. Claim-Based Medigap and Medicaid Crossover Processes

As described in §70.6 of Chapter 28 of the Medicare Claims Processing Manual (Pub. 100-4), for claim-based Medigap and/or Medicaid crossover, carriers and DMERCs shall validate that participating providers/suppliers have included valid claim-based COBA IDs on incoming claims. If the carrier or DMERC determines that a valid 5-digit Medigap claim-based COBA ID (range 55000-59999) or Medicaid claim-based COBA ID (range 78000-79999) was appropriately reported on the incoming claim, it shall report that ID in field 36 of the HUBC or HUDC query that is sent to CWF.

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

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

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

2) *Apply the Medigap claim-based trading partner's claims selection criteria;*

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

4) *Return an alert XXXX (4 position code) on the "01" response via a Claim-based alert trailer 21 to the carrier or DMERC, as specified in Requirement 23 above, if a claim-based COBA ID in the Medigap claim-based range (55000-59999) is not located on the COIF; and*

5) *Return nothing to the carrier or DMERC if a Medicaid claim-based COBA ID (78000-79999) is not found on the COIF.*

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

D. CWF Treatment of Non-assigned Medicaid Claims

If CWF receives a non-assigned Medicare claim for a beneficiary whose BOI auxiliary record contains a COBA ID in the Medicaid eligibility-based range (i.e. 70000-77999), it shall reject the claim. The CWF shall return an edit to the carrier or DMERC that specifies that non-assigned Medicare claims cannot be sent to Medicaid. At the same time, CWF shall also return a Medicaid reply trailer 36 to the carrier or DMERC that contains the trading partner's COBA ID and beneficiary's effective and termination dates under Medicaid. If the carrier or DMERC determines that the non-assigned claim's service dates fall during a period when the beneficiary is eligible for Medicaid, it shall convert the assignment indicator from "non-assigned" to "assigned" and retransmit the claim to CWF. After the claim has been retransmitted, the CWF will only

return a BOI reply trailer to the carrier or DMERC if the claim is to be sent to the COBC to be crossed over.

80.15 Claims Crossover Disposition Indicators

(Rev. 2, 2-6-04)

After CWF applies the COBA trading partner's claims selection criteria, it shall mark the processed claim with a claims crossover disposition indicator. (See table below for a listing of the indicators.) Once the claims crossover process is consolidated under the Coordination of Benefits Contractor (COBC), Medicare intermediary and carrier customer service staff will have access to a CWF auxiliary file that will display the crossover disposition of each beneficiary claim. The crossover disposition indicators that will appear on the HIMR detailed history screens (INPH, OUTH, HOSH, PTBH, DMEH, and HHAH) are summarized below.

Claims Crossover Disposition Indicator	***Definition/Description***
A	*This claim was selected to be crossed over.*
B	*This Type of Bill (TOB) excluded.*
C	*Non-assigned claim excluded.*
D	*Original Medicare claims paid at 100%.*
E	*Original Medicare claims paid at greater than 100% of the submitted charges excluded.*
F	*100% denied claims, with no additional beneficiary liability excluded.*
G	*100% denied claims, with additional beneficiary liability excluded.*
H	*Adjustment claims, monetary, excluded.*
I	*Adjustment claims, non-monetary/statistical, excluded.*
J	*MSP claims excluded.*
K	*This claim contains a provider identification number (ID) or provider state that is excluded by*

	the COBA trading partner.
L	*Claims from this Contractor ID excluded.*
M	*The beneficiary has other insurance that pays before Medicaid. Claim excluded by Medicaid.*
N	*NCPDP claims excluded.*

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