Coordination of Benefits Agreement

IMPLEMENTATION USER GUIDE

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Revision History

Date	Version	Reason for Change
November 2010	6.0	Previous publication date
February 3, 2014 (January Release B)	6.1	Branded for the Benefits Coordination & Recovery Center

Associated Documents Available for Download

- Claims Dispute File Layout
- COB Agreement (pdf 158KB)
  COBA Attachment (pdf 479KB)
- COBA Drug Coverage Eligibility (E02) Record Layout
- COBA Drug Coverage Eligibility (E02) Response Record Layout
- COBA Electronic Billing Introductory Package
- COBA Eligibility (E01) Record Layout
- COBA Eligibility File (E01) Acknowledgement Layout
- COBA Eligibility Response File (ERF) Layout
- COB COBA Problem Inquiry Request Form
- Connectivity-HTTPS User Guide (pdf, 1.5M)
  Connectivity-SFTP User Guide Section 1 (pdf, 2.3MB)
  Connectivity-SFTP User Guide Section 2 (pdf, 747KB)
  Connectivity-SFTP User Guide Section 3 (pdf, 5.5MB)
- Course Syllabus for COBA College
- Electronic Transmission Form
- HIPAA Closed Agree Issues Log (pdf 298KB)
- HIPAA Closed Disagree Issues Log (pdf 157KB)
- Medigap Claim-based COBA IDs for Billing Purpose [pdf, 60KB]
- SFTP/HTTPS Information Form
- Technical Readiness Survey (pdf 124KB)
- Termination Procedures (pdf 61KB)
- Test Sign Off Acceptance Form
- Trading Partner Customer Service Point of Contact List

INTRODUCTION

The purpose of the Coordination of Benefits Agreement Implementation User Guide is to communicate directly with staff affiliated with each trading partner about the administrative, technical, and financial requirements for implementing the Coordination of Benefits Agreement (COBA). Emphasis is given to preparing and testing data files to and from the Coordination of Benefits & Recovery Center (BCRC). This guide includes five sections. Referenced documents and forms are available for download at http://www.cms.gov/Medicare/Coordination-of-Benefits/COBAgreement/.

SECTION 1: COBA PROGRAM HIGHLIGHTS

This section introduces the Coordination of Benefits program—its goals and expected benefits. A checklist is provided to guide the trading partner through the steps required to implement the COB Agreement and its Attachment. A timeline for the COBA program and the trading partner displays the current schedule for the COBA program implementation.

SECTION 2: COBA – CONTENTS OF AGREEMENT AND ATTACHMENT

This section includes a description of the COBA, a glossary of 16 claims selection criteria, and a sample COBA Profile Report.

SECTION 3: COBA TECHNICAL REFERENCE

This section details the required process and formats for testing with current Eligibility and Claims File. Specifications for electronic transmissions, including Secure File Transfer Protocol (SFTP), Hypertext Transfer Protocol over Secure Socket Layer (HTTPS), and Connect Direct, provide the required file formats, and emphasize that all COBA participants must use HIPAA-standard transactions and code sets rules for claims. Also, contained in this section is the necessary procedure that the trading partner will follow to contact the BCRC in the event of a missing or indecipherable file. Other useful Web site addresses pertaining to HIPAA transaction and code sets are also provided.

SECTION 4: COBA FINANCIAL DETAILS

Trading partners under the COBA program must utilize an on-line payment remittance process to view and approve invoices and initiate payment, as applicable. This section introduces the BCRC's Electronic Invoice Presentment and Payment System (EIPP), and provides information on Crossover Fee Requirements.

SECTION 5: COBA CUSTOMER SERVICE

This section provides the appropriate addresses for submitting COBA correspondence and contact information for customer service representatives. Information on the Coordination of Benefits Trading Partner Problem Inquiry Request process, including problem/inquiry reporting, is provided in this section.

SECTION 1: COBA PROGRAM HIGHLIGHTS

1.0 Introduction to COBA

Overview

The Centers for Medicare & Medicaid Services (CMS) developed a model national contract, called the Coordination of Benefits Agreement (COBA), which standardizes the way that eligibility and Medicare claims payment information within a claims crossover context is exchanged. COBAs permit other insurers and benefit programs (also known as trading partners) to send eligibility information to CMS and receive Medicare paid claims data for processing supplemental insurance benefits for Medicare beneficiaries from CMS' national crossover contractor, the Coordination of Benefits & Recovery Center (BCRC). The BCRC transmits eligibility information that COBA trading partners send to the BCRC for purposes of initiating the crossing over of claims for their members to CMS' Common Working File (CWF), the central system through which all Medicare claims are sent for payment authorization. The CWF houses COBA trading partner's eligibility information for crossover purposes only in those instances where the information successfully matches with the in-file CMS entitlement information. As will be seen, COBA trading partners are apprised of situations where their eligibility information matches CMS eligibility data as well as when their submitted information does not result in a match.

The BCRC, under direction from CMS, also supports the COBA Medigap claim-based crossover process, which is addressed under "Purpose" directly below.

Purpose

The COBA program establishes a uniform national contract between CMS and other health insurers and benefit programs. The COBA program is a standard processing methodology used by the national Medicare community. The COBA allows greater efficiency and simplification via consolidation of the claims crossover process.

The COBA allows other insurers and benefit programs to send eligibility information to CMS and receive Medicare paid claims data, along with other coordination of benefits data, from one source, the BCRC.

Though not strongly encouraged, CMS also supports a "COBA Medigap claim-based crossover process," which is driven by a Medicare "participating" physician or supplier's entry of a 5-byte COBA ID (range 55000 to 59999) on incoming 837 professional claims or hard copy CMS-1500 claims. Under this process, the BCRC, on behalf of CMS, will **only** transfer Part B Medicare Administrative Contractor (MAC) and Durable Medical Equipment Medicare Administrative Contractor (DME MAC) 837 professional claims to a Medigap insurer with whom it has executed a crossover agreement (or COBA) when: 1) the physician or supplier is participating with the Medicare program (that is, by contract must **always** accept assignment on Medicare claims); 2) the beneficiary assigns his/her benefits (rights to payment) to the physician or supplier; and 3) the incoming claim contains a valid Medigap claim-based COBA ID within the range of 55000 to 59999.

1.1. Implementation Checklist

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

1.1.1. Enrollment

1.1.1.1. Contact the BCRC

The trading partner may contact the Electronic Data Interchange (EDI) Department to discuss the COBA service options, which will be customized to the trading partner's organization and specified in the COBA Attachment. The EDI Department's contact number is (646) 458-6740.

1.1.1.2. Execute the Base COBA(s)

Sign two original agreements. Upon receipt, the BCRC will sign both originals and return one original to the trading partner for its records.

1.1.1.3. Complete the COBA Attachment

This form provides specific information to establish the trading partner's COBA, such as the type of insurer or benefits program the trading partner represents, primary points of contact, and claims selection options. The COBA Attachment, although part of the formal agreement or contract, may be updated at the request of the trading partner or CMS as pertinent data or selections change without requiring an updating of the Base Agreement. **IMPORTANT**: If, however, the official authorized to bind the trading partner to an agreement involving the CMS Contractor changes, the COBA trading partner will be asked to execute both the Base Agreement and the COBA Attachment.

1.1.1.4. Complete Technical Readiness Survey

When new to the COBA program, the trading partner should initially use the Coordination of Benefits Agreement (COBA) Program Technical Readiness Assessment Survey to report its current technical ability in relation to the COBA technical requirements as outlined in this guide. The survey is available for download at http://www.cms.gov/Medicare/Coordination-of-Benefits/COBAgreement/

1.1.1.5. Mail Completed Documents

The trading partner forwards each signed COBA and Attachment to the BCRC at the mailing address specified in the COBA Attachment and the Customer Service section. The CMS and BCRC strongly prefer that the trading partner sends documents to the BCRC via an express mail option.

1.1.1.6. Obtain COBA Identification Number(s) from the BCRC

Upon receipt and successful processing of the trading partner's COBA and Attachment, the BCRC will generate a Profile Report assigning the trading partner's COBA ID(s), assigned according to the trading partner's line of business.

1.1.1.7. Complete and Return Profile Sheet

This action notifies the BCRC of the trading partner's approval of its Profile Report after reviewing it for accuracy. The trading partner must follow the notification instructions that accompany the Profile Report.

1.1.2. Testing

1.1.2.1. Set Up Connectivity Test

Trading partners must coordinate testing of two-way transmission capability with the BCRC, if applicable (i.e., electronic transmissions).

1.1.2.2. Obtain a Test Date from the BCRC

Upon receipt of each signed COBA and Attachment, the BCRC will provide the trading partner with the next available date to commence testing.

1.1.2.3. Provide Data Transfer Information

Complete the appropriate Electronic Transmission Form, which is available for download at http://www.cms.gov/Medicare/Coordination-of-Benefits/COBAgreement/. The completed information within the form enables the BCRC to route both 'test' and 'production' files to the appropriate destination for the trading partner. In addition, as applicable, completion of the form and Secure FTP Information Form results in the generation of a mailbox tied to the COBA trading partner's specific COBA identifier(s). Return the form to the BCRC as indicated in the Customer Service section of this guide.

1.1.2.4. Create Test Eligibility Files

Trading partners must generate Eligibility Files in the required COBA Eligibility File Format using their assigned COBA ID(s) as furnished by the BCRC. The initial eligibility test files should contain no more than 100 eligibility records. A syntax analysis will be performed on the initial mini test file. (**Note:** This does not apply to Medigap claim-based trading partners.) The first mini test file will be sent as all "add" transactions, followed by a second mini test file that contains "change" as well as "delete" records. COBA trading partners seeking to test claims should first furnish the BCRC with a full-size production Eligibility File.

1.1.2.5. Submit Test Eligibility Files to the BCRC

Please refer to Section 3, Electronic Transmission, for data transmission options.
(**Note:** Submission of eligibility files does not apply to Medigap claim-based trading partners.)

1.1.2.6. Review Test Eligibility Results

The BCRC will forward an Eligibility File Acknowledgement (EFA) that confirms receipt of an Eligibility File, followed by an Eligibility Response File (ERF) once the file has completed processing. The ERF provides a one-for-one disposition response for each record in the Eligibility File. Refer to Section 3, COBA Eligibility Files, for more details on the EFA and ERF. (**Note:** This does not apply to Medigap claim-based trading partners.)

1.1.2.7. Review Test Claims File(s) from the BCRC

The BCRC will create and forward Claims Files in the required formats for all claims matching eligibility information and the trading partner's claims selection criteria. For Medigap claim-based

trading partners, please refer to Section 3, COBA Technical Reference, for additional information on the testing procedures.

1.1.2.8. Sign off on the Test Process with the BCRC

Once the trading partner is satisfied with the test results, the trading partner's testing team needs to submit a Test Sign-off Acceptance Form, which is available for download at http://www.cms.gov/Medicare/Coordination-of-Benefits/COBAgreement/, and follow the instructions outlined on this form.

1.1.2.9. Perform Financial Testing for Billing and Payment

A summary of the BCRC online payment system initiative db-eBills, how it works, and how to get started is provided in the Coordination of Benefits Agreement Electronic Billing Introductory Package, which is available for download at http://www.cms.hhs.gov/COBAgreement/01_overview.asp. (Look for the option under Overview relating to COBA financial processes and dispute files and reference the Electronic Billing Introductory Package.)

1.1.3. Final Implementation

1.1.3.1. Obtain an Implementation Date from the BCRC

Upon receipt of the trading partner's Test Sign-off Form, the BCRC, in coordination with CMS, will provide the trading partner with the next available date to move its COBA (s) into production/implementation. **Note:** The trading partner must submit the eligibility file that it intends to use to generate crossover claims for production, including any needed updates, to the BCRC at least 14 days prior to the production date.

1.1.3.2. Review Invoices and Remit Payment to the BCRC

The trading partner should review and follow instructions as provided in Section 3: COBA Financial Details, for billing and payment remittance.

1.2. Implementation Timeline

1.2.1. COBA Trading Partner Timeline

Table 1-1 lists the major milestones and estimated durations in implementing the COBA program with the BCRC noted in business days:

Table 1-1: COBA Program Major Milestones

Task	Estimated Duration
Negotiate and execute COBA	20 days
Receive COBA ID(s), approve Profile Report, and begin data transfer setup.	10 days
Generate mini and full test Eligibility File(s) (Note: Does not apply to Medigap claim-based trading partner.)	20 days

Task	Estimated Duration
Review test claims files (maximum of 3 full claim files), complete financial testing, and provide test sign-off	25 - 40 days
Total Estimated Duration	75 - 90 days

Note: The above reflected timeframe represents the ideal testing period. The timeframe listed above does not include the time required to establish electronic transmission capabilities to the BCRC. The electronic set-up process may take 25 to 60 days depending on the option selected and the trading partner's organization's electronic capabilities. Therefore, connectivity should be addressed immediately while contract execution is in process.

Note to MEDIGAP claim-based insurers: While eligibility file testing is not required, the trading partner may require additional time to test claims, depending on the claim formats received previously from Medicare contractors (if applicable).

1.3. Termination of a COBA

Overview

Either the trading partner or the BCRC may terminate a COBA by giving at least sixty (60) calendar days advanced written notice to the other party-termination always occurs on a Monday. A trading partner may seek to terminate a COBA ID when:

1) The trading partner no longer wants to receive Medicare paid claims for supplemental payment due to liquidation or other related reasons; or

2) The trading partner is seeking to move from receiving crossover claims from a Clearinghouse to directly receiving crossover claims from the BCRC or vice versa. However, the trading partner may maintain its current COBA ID(s) in both situations. Please contact your EDI representative for further information.

Because the termination of a COBA requires the cessation of the identification of Medicare paid claims for supplemental payment (tagging) and claims transmission to the trading partner, adherence to the aforementioned notification timeframe is imperative. CMS approval is required if a shorter timeframe is requested.

1.3.1. Cessation of Crossover Activities in Their Entirety

Through the COBA process, claims are crossed over to supplemental payers/insurers (trading partner) only after the claims have left the Medicare claims payment floor. This process usually occurs within 14 calendar days after the claim is received by Medicare for electronic claims; the Medicare payment floor timeframe extends 15 additional calendar days for incoming hard-copy (paper) claims. To ensure that a significant percentage of crossover claims have been removed from the payment floor before the termination of the COBA ID, the Common Working File (CWF) will be advised to terminate the COBA 14 calendar days prior to the actual termination date. It is possible that a small percentage of claims will be tagged and transmitted to the BCRC for crossover to a supplemental insurer after the trading partner's connectivity to the BCRC has been terminated. If this occurs, notification will be sent to the Medicare contractor that processed the claim(s) advising it that claim(s) did not crossover to the supplemental insurer. The affected contractor then notifies any affected providers that the claim(s) did not cross to the supplemental insurer. The notification to CWF of the COBA termination date 14 calendar days prior to the actual termination date should minimize this occurrence.

A new COBA Attachment, including original signatures, must be prepared for each COBA ID that is affected by the termination request. The revised Attachment must include the effective date of the requested termination – always a Monday. The trading partner will be responsible for paying all outstanding unpaid invoices and any invoices generated for claims crossed between the notification and actual termination date.

Table 1-2 shows an example timeline of a COBA termination.

Table 1-2: Example COBA Termination Timeline

Date	Activities
Monday, 04/01/XX	BCRC receives notification to terminate COBA 99999. BCRC sets the CWF termination date to 5/15/XX to allow for payment floor clearance. The BCRC sets the COBA claim transmission termination date to 6/1/XX (actual 60 days). 04/01/XX - 05/15/XX Claims continue to be tagged at CWF and transmitted to the trading partner as normal.
05/15/XX	Invoice transmitted to COBA 99999 for April claim transmissions (04/01 - 04/30).
05/15/XX	COIF file transmitted to CWF terminating COBA 99999
05/16/XX	CWF applies COBA termination to cease tagging of claims to be crossed to COBA 99999.
05/16/XX - 06/01/XX	Pipeline/run out claims continue to be transmitted from contractors as they come off the Medicare payment floor to BCRC and crossed to COBA 99999.
06/01/XX	BCRC no longer accepts transmitted claims for COBA 99999. Claims received for COBA ID 99999 are returned to the submitting Medicare contractor.
06/15/XX	Invoice transmitted to COBA 99999 for May claim transmissions (05/01 - 05/31).

1.3.2. Transitions between the Trading Partner and a Clearinghouse

Neither CMS nor the BCRC solicits COBA trading partners with current clearinghouse contractual arrangements to have them change to direct receipt of crossover claims from the BCRC or receipt of crossover claims through another clearinghouse. However, CMS recognizes that all contractual situations are subject to change and is prepared to assist in the transition process when a trading partner decides upon an alternative contractual arrangement. Therefore, the trading partner must notify CMS, in writing, of its decision to transition to (1) receive claims directly from the BCRC or (2) receive claims from another clearinghouse. Notification may be forwarded to CMS via fax (410-786-7030) or by mail at:

CMS Central Office
COBA Crossover Team
Attn: Brian Pabst
7500 Security Blvd.
Mailstop: C3-14-16
Baltimore, MD 21244-1850

Notification must allow adequate time for connectivity to be established and Eligibility File and claim testing prior to the contract end date with the clearinghouse (approximately 60 calendar days).

In addition, the trading partner may make a decision to move to receiving crossover claims through a clearinghouse rather than receiving them directly from the BCRC. In this situation, formal notification to CMS, in writing, is not required. However, this type of transition must be closely coordinated with the trading partner's EDI and CMS representatives, which will identify the specific procedures to follow below.

The following outlines the transition procedures when the trading partner has decided to (1) receive claims directly from the BCRC or (2) transition its crossover claim business activities to a different clearinghouse.

1) The BCRC and CMS will schedule a brief teleconference with the requestor to discuss the details of the transition. An EDI representative and a CMS representative will be assigned to the transition. To avoid any interruption to claim receipt, the trading partner is expected to maintain its current COBA ID(s).

2) A revised Attachment, including original signatures, must be prepared for each COBA ID that is affected by the transition request. The revised Attachment must include the effective date of the requested transition – always a Monday. In addition, there may be a need to assign a separate effective date for the financial contact on the new attachment as discussed in number 9 below.

3) A copy of the Profile Report that was prepared by the BCRC based on data submitted on the original attachment should be used to determine if the claim selection criteria need to change prior to transition. As a rule, CMS finds it best that a COBA trading partner not change its claim selection criteria simultaneously with the transition date and/or revised attachment.

4) The trading partner will be responsible for notifying the clearinghouse(s) of the transition date and working out details on any claims that may be held for transmission to the trading partner as of the transition date (pipeline/run out claims) and any subsequent billing issues. The CMS and BCRC will be available to the trading partner and the clearinghouse(s), to advise on any timing issues.

5) Connectivity: If the trading partner has connectivity with the BCRC for the receipt of crossover claims associated to a COBA ID that is not associated to a clearinghouse business arrangement, that same connectivity can be used for the transitioning COBA ID. Connectivity includes Connect-Direct (NDM) or Secure File Transfer Process (SFTP). Both may take approximately two months to complete. If the trading partner has made a decision to change clearinghouses, the incoming clearinghouse may need to establish connectivity.

6) The trading partner or incoming clearinghouse will be expected to transmit an initial mini-Eligibility File (no more than 100 members as all "adds") for testing format (header/trailer) and syntax prior to the transition as well as a second "change" and "delete" mini-Eligibility File (again, no more than 100 members) for testing of format (header/trailer) and syntax validation prior to the transition. The current COBA ID will be maintained. A current Eligibility File must be submitted through the outgoing clearinghouse prior to the transition date that will be used to generate the first production claims directly to the trading partner or the incoming clearinghouse. All Eligibility Files submitted subsequently by the trading partner or incoming clearinghouse must be in the Add/Update (Change)/Delete format.

   While the trading partner or incoming clearinghouse is in test, the outgoing clearinghouse will continue to send a production eligibility file and receive the Eligibility Response File.

7) Claims Testing: If claims are currently received directly from the BCRC under another COBA ID, the trading partner or the incoming clearinghouse should be prepared to establish

a test data set name in addition to the production COBA data set name for testing receipt of the transitioning claims. As a reminder, the test claims are the same production claims received by the outgoing clearinghouse or the trading partner through a separate transmission.

8) The timeframe for claims testing will be dependent on whether or not the trading partner, which has decided to receive claims directly from the BCRC, is currently receiving the 837 COB claim format from the clearinghouse. This will not exceed 4 test files without CMS approval for an extension.

9) Invoices cannot be split in the middle of a month between claims received by the outgoing clearinghouse and the trading partner or incoming clearinghouse. Therefore, CMS and the BCRC require that the trading partner transition occurs as close to the end of a month as possible. Claim files sent on the last day of the month will be billed to the entity that is on file to receive invoices for all preceding days in that month. Therefore, in those instances where a clearinghouse is the entity on file to receive invoices, the COBA Attachment must be revised to reflect an effective date for the trading partner or the incoming clearinghouse to receive the invoice. It is the responsibility of the trading partner to coordinate with the outgoing clearinghouse where the invoice will be submitted and paid when transition occurs prior to a month end.

10) All invoices issued must be paid prior to the transition date.

11) The trading partner should attend COBA College in order to process dbe-Bills. The BCRC will provide a syllabus for all COBA College classes prior to the initial conversion meeting. The Course Syllabus for COBA College is available for download at http://www.cms.gov/Medicare/Coordination-of-Benefits/COBAgreement/

SECTION 2: COORDINATION OF BENEFITS AGREEMENT

2.0 COB Agreement and Attachment

The COB Agreement (COBA) is a contract between the Centers for Medicare & Medicaid Services (CMS) Contractor and other health insurers or benefit programs. The COBA specifies all of the essential functions to allow eligible insurers or benefit programs to receive Medicare paid claims automatically after Medicare releases claims from the payment floor. Only a "trading partner" can sign the COBA Base Agreement and Attachment. Refer to Article I of the COBA Base Agreement, which can be viewed at http://www.cms.hhs.gov/COBAgreement// for a definition of what constitutes as a "trading partner" in association with the national COBA crossover process. A third party administrator, related administrative services organization, or fiscal agent is permitted to sign the standard COBA directly, but only if that entity directly adjudicates claims on behalf of an insurer or State Medicaid Agency.

Trading partners may designate "Trading Partner Contractors" (e.g., healthcare clearinghouses or other vendors) to perform and support the COBA and associated processes. See Article I of the COBA Base Agreement for a definition of this term.

An electronic copy of this document may be downloaded from the COB Web site. Refer to the COBA Technical Reference in Section 3 of this guide for more information.

2.1. Understanding Your Claims Selection Options under the National COBA Crossover Program

The purpose of this chapter is to expound upon the various claims selection options found in Section IV of the COBA Attachment and within any existing COBA Addenda. A portion of this chapter includes a discussion of CMS' Common Working File (CWF) logic for including or excluding the various claim types, in accordance with the COBA trading partner's claims selections within its signed COBA.

Note: Institutional types of bills, as discussed below, are **not** available for receipt or individual exclusion to Medigap claim-based crossover trading partners. Medigap insurers that do not provide an eligibility file to identify their members for crossover purposes will receive only professional claims (and in the future the National Council for Prescription Drug Programs (NCPCP) claims) via the COBA Medigap claim based crossover process. Since Medigap claim-based trading partners will not receive institutional claims via their crossover process, they may not make elections in Section IV. Claims Selections Options of the COBA Attachment.

Part I. General Claims Selection Options

Section IV.A: Fiscal Intermediary (FI)/Medicare Administrative Contractor (MAC)/Regional Home Health Intermediary (RHHI) Types of Bills (TOBs)

- The non Medigap claim-based trading partner has the opportunity to globally include/receive all Part A types of bills <u>or</u> to exclude all types of bills. A trading partner may also exclude some types of bills while including others.
- Aside from IVA.1 and IVA.2, where the trading partner globally elects to include or exclude all Part A bills, the trading partner would otherwise place a mark next to those types of bills that it wishes to **exclude**.

IMPORTANT: CMS will assume in the absence of a mark beside a type of bill that the trading partner wishes to receive that bill type.

IMPORTANT NOTES:

1) Effective with April 2010, per direction from the National Uniform Billing Committee (NUBC), bill type 73X will be converted to bill type 77X in association with loop 2300 CLM05-1. This is reflected within the modified COBA Attached dated April 2010.

2) Effective with July 2010, per direction from the NUBC and through implementation of change request (CR) 6782, all Free-Standing End-Stage Renal Disease (ESRD) facilities are required to include new information within the 72x (ESRD Facility) type of bills that they submit to Medicare. A summary of the newly required elements is as follows:

   - KT/V [k=dialysis clearance of urea; t=dialysis time; and v=patient's total body water) data will be present and qualified by value code D5 within loop 2300;Modifier V8 or V9 will be reported in loop 2400 for infection information;
   - Modifier V5, V6, or V7 will be reported within the 2400 loop for vascular access type hemodialysis information.

Section IV.B: Fiscal Intermediary/MAC/RHHI Claims (Institutional) by Provider or State

- The trading partner has the opportunity to include **or** exclude Part A claims for up to 50 providers and provider states per COBA ID.

  IMPORTANT: This option is only applicable to 837 institutional claims.

- Trading partners have the option to include **or** exclude claims by 5-byte Medicare provider identification number (the Online Survey, Certification, and Reporting [OSCAR] legacy number) or national provider identifier [NPI]) or by provider state (2-digit state abbreviation code). **Note:** This option only applies to NPIs for facilities that are linked to OSCAR numbers. It is **not** possible to exclude NPIs for physicians or other ancillary providers within an 837 institutional claim context. Below are three (3) examples that illustrate how these options may be actualized within the COBA Attachment.

  Example 1: Gabriel Garcia, who represents insurer HIJ, wishes to receive 837 institutional claims for all states except for Maryland, Delaware, Virginia, and Pennsylvania. He additionally does **not** wish to receive 837 institutional claims tied to the District of Columbia. After indicating he wishes to receive Part A types of bills in Section IV.A.1, Gabriel will realize his objective by marking "excluded" under Section IV.B. 3 and listing MD, DE, VA, PA, and DC within Section IV.B.4.

  Example 2: George Williams representing insurer DEF wishes to receive 837 institutional claims for half of the states within the United States, but not for the second half. After completing Section IV.A.1, George may select either "included" or "excluded" under Section IV.B.3 (his choice, given there are 50 states) and list the states his company either wishes to include or exclude as part of Section IV.B.4.

  Example 3: Jane Smith represents insurer ABC, which insures retired public school employees within LMN county within state XX, and wishes to only receive 837 institutional claims for her company's employees when they have services within facilities in county LMN. Following selection of Section IV.A.1, the best way that Jane can ensure her company receives 837 institutional claims just for county LMN is by taking the following two-step

action: a) adding only retired public school employee in county LMN to the COBA eligibility file; and b) selecting "included" in Section IV.B.3 and then listing the NPI or OSCAR number of the facility provider within the box provided in Section IV.B.4. **Note:** The CMS is unable to furnish COBA trading partners with a listing of NPI or OSCAR facility numbers for this purpose.

- Exclusion by provider state means that CMS' CWF will internally exclude Part A claims based upon the first two (2) positions of the provider's internal OSCAR legacy number as associated to the NPI, which designates the state in which services were provided, and, prior to full MAC implementation, not necessarily in accordance with the state in which the provider's claim is processed.
- Once MACs are fully operational by fiscal year (FY) 2012 or thereabouts, providers will, with qualified exceptions specified by Medicare guidelines, no longer be given the option to nominate their Part A claims intermediary. Instead, they will be required to bill the designated MAC for their affiliated institutional services. This means that, from that point onward, the provider's state will always be linked to the assigned contractor for that jurisdiction across the board. Providers will no longer be able to select their processing Medicare intermediary, as had occurred in the past.

Section IV.C: Carrier/MAC Claims (Professional) by State

- The trading partner has the opportunity to globally include/receive all Part B (837 professional) claims[1] **or** to exclude such claims.
- The trading partner may include **or** exclude specific states for crossover purposes.

Impacts of Including or Excluding Part B (Carrier/MAC) Professional

- **Claims by State**
  - If a COBA trading partner checks the 'include' box and lists 10 specific states, CWF will include **only** those states for crossover purposes.
  - If a COBA trading partner checks the 'exclude' box and lists 25 specific states, CWF will exclude only those states. The trading partner will receive the remaining states for crossover purposes.
  - COBA trading partners that wish to exclude all Part B claims should include a check in §IV.C.2 in lieu of populating the table in §IV.C.3 in its entirety.
  - COBA trading partners that wish to include **or** exclude Part B Railroad Retirement Board (RRB) claims should denote 'RR' within the table provided. Part A RRB claims are **not** billed centrally to one contractor but rather are billed in accordance with normal Medicare jurisdictional rules concerning the filing of Medicare Part A claims.

[1] For COBA crossover purposes, 837 Professional claims encompass services provided by a non-institutional provider, such as a physician, practitioner, diagnostic specialist (e.g., radiologist or pathologist, other specialist (e.g., chiropractor, psychiatrist, surgeon, ophthalmologist, or anesthesiologist), clinical lab, ambulance company.
Note: Services billed to a Durable Medical Equipment Medicare Administrative Contractor (DMAC) are often billed on an 837 Professional claim. These kinds of services are not included under the category of "Carrier/MAC" (Professional) claims but rather are controlled for under the "DMERC/DME MAC Claims" section.

Section IV.D: Durable Medical Equipment Medicare Administrative Contractor (DMAC) Claims (Professional/National Council for Prescription Drug Programs (NCPDP) by Jurisdiction

- The trading partner has the opportunity to include all DMAC claims—which encompasses those submitted as 837 Professional, as well as Part B NCPDP batch drug claims—to exclude certain DMAC jurisdictions, **or** to exclude all DMAC claims by marking all jurisdictions for exclusion.
- The trading partner also has the opportunity to exclude certain DMAC jurisdictions and include others.
- The COBA trading partner may **not** uniquely include **or** exclude certain states within a DMAC jurisdiction. Rather, the trading partner has the option of including or excluding all jurisdictions, including all states therein, or subsets thereof.
- The trading partner may exclude receipt of NCPDP batch drug claims for Part B covered immunosuppressive or oral cancer drugs. (**Note:** Pharmacies now bill a high percentage of these Part B drugs to the CMS DME MACs using the 837 professional claim format, so very few Part B NCPDP batch claims actually flow through the COBA crossover process at present.)

Section IV.E: Common Claim Types (Institutional/Professional)

- The trading partner has the opportunity to receive all common claim types listed. Alternatively, the trading partner may exclude certain common claim types.
- The trading partner will receive all common claim types **not** otherwise excluded.

Part II. Common Claim Types and CWF Logic Used to Exclude Each Type

- **Non-assigned claims**
  - **Description:** Refers to Part B claims and claims for durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) where the physician or supplier does not accept assignment on Medicare claims. Under Medicare, non-assigned claims always carry “limiting charge” requirements, with the exception of claims for influenza (flu) shot and other injections, claims for ambulance suppliers, and DMEPOS claims. “Limiting charge” represents the maximum dollar amount above the Medicare approved amount that the physician may hold the beneficiary liable for; the limiting charge remains at 115 percent of the Medicare Physician Fee Schedule (MPFS) allowed amount.
  - **Reporting on 837 professional claims when these kinds of claims are included for crossover:** Loop 2300 CLM07 (value=C)
- **Original Medicare claims, fully paid, without deductible or co-insurance remaining (applies to Part A and B claims)**
  - **Description:** Refers to original Part A and B claims with no deductible or co-insurance amounts remaining.
  - **Reporting on 837 claims if these claims are included for crossover:** There will be no CAS segments that include deductible (PR1) or co-insurance (PR2) amounts due.

- The BCRC will generate to the COBA trading partner an 837 professional claim that is otherwise 100 percent reimbursable **only** if CWF determines that even one of the denied service lines features a CAS that designates beneficiary liability, expressed by CAS*PR, with accompanying claim adjustment reason code (CARC).

- **Adjustment claims, fully paid, without deductible or co-insurance remaining**
  - **Description:** Refers to Part A and B 'adjustment' claims with no deductible or co-insurance remaining.
  - **Reporting on 837 claims if these claims are included:** The value in 2300 CLM05-3 is indicative of adjustment (value= 7 for either institutional or professional claims or additional possible alpha codes for 837 institutional claims) and there are no CAS*PR segments indicative of beneficiary liability. **Note:** Prior to January 4, 2010, the BCRC will generate an 837 professional adjustment claim to the COBA trading partner that contains fully paid (100 percent reimbursable) service lines if CWF determines that the claim also contains even one denied service line, regardless of whether the beneficiary has liability for the denied line(s).
  - The BCRC will generate to the COBA trading partner an 837 professional adjustment claim that is otherwise 100 percent reimbursable **only** if CWF determines that even one of the denied service lines features a CAS that designates beneficiary liability, expressed by CAS*PR, with accompanying CARC.

- **Original Medicare claims paid at greater than 100% of the submitted charges without deductible or co-insurance remaining**
  - **Description:**
    - From a Part A context, this refers to situation where the amount paid on a Part A claim is within a range that is greater than 100% of the total submitted charges, as occurs under the Medicare prospective payment system (PPS), and the claim contains no deductible or co-insurance amounts.
    - From a Part B context, this refers **only** to ambulatory surgical center (ASC) claims for which the Medicare reimbursement is greater than the amount billed. These claims, which are always billed to Part B carriers/MACs and paid under a unique fee schedule, always carry deductible and co-insurance amounts.
  - **Reporting on 837 institutional claim if included for crossover:** If the claim is PPS and there are no deductible or co-insurance amounts, there would be no CAS segments that would contain beneficiary liability (PR). If the claim is included because it contained deductible or co-insurance amounts, these amounts would be reported either as a claim or service line level CAS segment with PR*1 or PR*2.
  - **Reporting of ASC services on 837 professional claims if included for crossover:** As noted above, despite the overarching label of this claim selection option, ASC claims are controlled by this exclusion. Therefore, amounts for beneficiary liability would be reflected as CAS*PR. The type of service "F" would not be reflected; however, place of service code 24 would be reported in the 2300

    IMPORTANT: <u>Impact of Excluding This Claim Type:</u>
  - The trading partner would not receive Part A PPS claims (situations where the Medicare diagnostic related groups (DRG) payment for the covered spell of illness or health care

episode often exceeds the total charges billed) **for which there are no deductible or co-insurance amounts on the claim.**

- Trading partners would still receive Part A PPS (DRG payment methodology) claims if they contain deductible or co-insurance amounts.
- The trading partner would **not** receive Part B ambulatory surgical center (ASC) claims that are billed to carriers/MACs (type of service=F; place of service=24), even though co-insurance amounts will be present on the claim, as well as Part B deductible amounts, as applicable.

- **100% denied original claims, with no additional beneficiary liability**
  - **Description:** Refers to fully denied claim situations where the beneficiary is determined to not have liability on any of the denied service lines (e.g., the beneficiary did not receive advanced notice that the service would not be covered or the provider is otherwise determined to be liable for all denied services/service lines).
  - **Reporting on the 837 institutional claim if claim is included for crossover: Claim would be fully denied as CAS*CO*(followed by CARC or reason code) at the 2320 (claim) or** 2430 (service line) level, depending upon whether the claim is inpatient or outpatient-oriented. **Reporting on 837 professional claim if claim is included for crossover:** Claim is fully denied **as CAS*CO* (followed by reason code) at the 2320 (claim) and 2430** (service line) levels.
- **100% denied adjustment claims, with no additional beneficiary liability**
  - **Description:** Refers to claims that are adjusted, possibly as the result of a post-payment claim review, to reflect fully denied where the beneficiary is determined to not have liability on any of the denied services or service lines.
  - **Reporting on 837 institutional claim if claim is included for crossover:** Value in the 2300 CLM05-3 indicates adjustment ("7" or possible other alpha code). The claim is fully denied at the 2320 (claim) or 2430 (service line) level, as appropriate to claim type (inpatient versus outpatient), with a CAS*CO* (followed by reason code).
  - **Reporting on 837 professional claim if claim is included for crossover:** Value in the 2300 CLM05-3 indicates adjustment claim (value= "7"). The claim is fully denied at the 2320 (claim) and 2430 (service line) level with a CAS*CO* (followed by reason code).
- **100% denied original claims, with additional beneficiary liability**
  - **Description:** Refers to claims that are fully denied and for which the beneficiary is determined to have liability on at least one of the fully denied services/service lines. **IMPORTANT: The beneficiary's liability in such cases is not a deductible or co-insurance amount. Instead, the liability relates to the full amount of the denied service or service line item.**
  - **Reporting on 837 institutional claim if claim is included for crossover:** The claim is fully denied at the 2320 (claim) or 2430 (service line) level, as appropriate, and there is a CAS*PR* (followed by denial reason).
  - **Reporting on 837 professional claim if claim is included for crossover:** The claim is fully denied at the 2320 and 2430 level, and there is a CAS*PR* (followed by reason code).

- **100% denied adjustment claims, with additional beneficiary liability**
  - **Description:** Refers to claims that are adjusted to reflect fully denied where the beneficiary is determined to have liability on at least one of the fully denied services or service lines. The beneficiary's liability in such cases is not a deductible or co-insurance amount.
  - **Reporting on 837 institutional claim if claim is included for crossover:** The value in the 2300 CLM05-3 indicates adjustment ("7" or possible other alpha code). The claim is fully denied at the 2320 (claim) or 2430 (service line) level, as appropriate, and there is a CAS*PR* (followed by denial reason).
  - **Reporting on 837 professional claim if claim is included for crossover:** Value in the 2300 CLM05-3 indicates "7." The claim is fully denied at the 2320 level, and there is a CAS*PR* (followed by reason code). Reporting will also be at the individual service line level.
- **Adjustment claims, monetary**
  - **Description:** Refers to claims on which the original financial decision was monetarily changed. Not classified as 'mass adjustment.'
  - **Reporting on 837 institutional claim if claim is included for crossover:** The value in the 2300 CLM05-3 indicates adjustment ("7" or possible other alpha code). Under 4010-A1, the claim features monetary changes in terms of total submitted charges (AMT segment, qualified by T3), allowed/approved amount (AMT segment, qualified by B6), paid amount (AMT segment, qualified by N1), and any CAS*PR or CAS*CO amounts.
  - Under 5010, the claim will feature monetary changes in all areas discussed for 4010-A1, except for the approved/allowed amount AMT segments, which are no longer reported.
  - **Reporting on 837 professional claim if claim is included for crossover:** Value in the 2300 CLM05-3 indicates "7." Under 4010-A1, the claim features monetary changes in terms of total billed amount, allowed/approved amount (AMT segment, qualified by B6), paid amount (AMT segment, qualified by D), and any CAS*PR or CAS*CO amounts.
  - Under 5010, the claim will feature monetary changes in all areas discussed for 4010-A1, except for the approved/allowed amount AMT segments, which are no longer reported.

  Special Notes:

  - Each COBA trading partner that wishes to receive adjustment claims, monetary will only receive these claims if CWF determines that the 'original' claim was crossed over to the COBA trading partner.
  - The CWF will exclude the Part A void/cancel claim (type of bill XX8 or other 3rd position alpha code) if the COBA trading partner wishes to exclude adjustment claims, monetary.
  - COBA trading partners that elect receipt of Part A adjustment claims, monetary will no longer receive both the debt and credit pairing. They will only receive the debt adjustment claim via the crossover process.
- **Adjustment claims, non-monetary/statistical**
  - **Description:** Refers to claims on which the original financial decision has **not** monetarily changed. This may include internal systematic rates that do not result in

visible monetary changes on outbound 837 claims. These adjustment claims are not classified as "mass adjustment."

Special Notes:

- Each COBA trading partner that wishes to receive adjustment claims, non-monetary/statistical will only receive these claims if CWF determines that the 'original' claim was crossed over to the COBA trading partner.
- The CWF will exclude the Part A void/cancel claim (type of bill XX8 or other 3RD position alpha code) if the COBA trading partner wishes to exclude adjustments, non-monetary/statistical.
- COBA trading partners that elect receipt of Part A adjustment claims, non-monetary/statistical will no longer receive both the debt and credit pairing. They will only receive the debt adjustment claim via the crossover process.

- **Mass Adjustment Claims Tied to the Medicare Physician Fee Schedule (MPFS) Updates**
  - **Description:** Refers to high volume adjustment actions taken to either increase or decrease the amounts allowed and reimbursed on services that are paid in accordance with the MPFS. Services excluded from payment under the MPFS include DMEPOS, ambulance, certain vaccinations (e.g., influenza/flu), and most Part A services that are reimbursed under PPS/DRG, with limited exceptions.
  - **Reporting on 837 institutional and professional claims if claims are included for crossover:** Value in the 2300 CLM05-3 indicates adjustment claim. In addition, the loop 2300 NTE02 will equal "MP," with NTE01=ADD. Under 4010-A1, the monetary amount tied to approved/allowed amount and payment within the 2320 loop will have changed. Under 5010, the monetary amount changed will chiefly be reflected in terms of the Medicare payment or claim billed amount.
- **Mass Adjustment Claims—Other**
  - **Description:** Refers to high volume adjustment actions taken independent of MPFS updates. These actions could be performed by CMS' Medicare contractors on all types of claims.
  - **Reporting on 837 institutional and professional claims if claims are included for crossover:** Value in the 2300 CLM05-3 indicates adjustment claim. In addition, the loop 2300 NTE02 will equal "MO," with NTE01=ADD. Under 4010-A1, the monetary amounts within the 2320 loop, or as applicable 2430 service line loop, not necessarily limited to claim allowance and payment will have changed. Under 5010, since the approved/allowed amount AMT segments are discontinued, monetary changes will be reflected in terms of the Medicare payment or claim billed amount.
  - **Impact of Excluding This Claim Type:**

    While mass adjustments related to the MPFS are high in volume, 'mass adjustments claims – other' are part of normal claims processing and the volume may be as few as 100 claims that are adjusted manually by Medicare contractors. By electing this exclusion, the trading partner may decrease the number of adjustment claims that it could easily handle in an electronic manner.

- **Medicare Secondary Payer (MSP) Claims**
  - **Description:** Globally refers to any claim, paid or denied, on which Medicare is the secondary payer.
  - **Impact of excluding:** By excluding MSP claims on which Medicare makes secondary payment, the supplemental payer is assuming that Medicare's payment includes all cost-sharing obligations that the beneficiary has on incurred claims. This is not always true. Therefore, exclusion of MSP claims outright allows for the possibility that the physician/provider/supplier may bill the supplemental payer on paper or via other means outside the crossover process.
- **MSP Cost-Avoided Claims**
  - **Description:** Refers to situations where Medicare fully denies a claim because it is aware that another payer/insurer should pay before Medicare. In such instances, Medicare is either not privy to the primary payer's payment decision **or** is privy to that information but determines that the primary payment exceeds what Medicare would have paid or allowed on the claim.
  - **Reporting on 837 institutional and professional claims if claims are included for crossover:** Unfortunately, in MSP cost-avoid situations, the provider attempts to bill Medicare as if Medicare was primary. Therefore, the claim would most likely deny in its entirety at the 2320 (claim) level, with appropriate reason code designating MSP. For Part B-oriented claims, there will likely be reporting of the denial reason at the service line level as well. No other indication of MSP will be present.
- **Claims if Other Insurance Exists for the Beneficiary (only available to State Medicaid Agencies)**
  - **Description:** Refers to situations where a beneficiary has other commercial insurance that may pay before his/her State medical assistance program (Title XIX Medicaid).
  - **Reporting on the 837 institutional and professional claims if this option is not excluded:** The 2320 SBR portion of the claim would reflect all payers, inclusive of Medicare, that have a part to play in payment of the claim.
- **National Council for Prescription Drug Programs (NCPDP) Claims**
  - **Description:** Refers to the NCPDP batch claim version that retail pharmacies transmit to DME MACs if they are billing national drug codes (NDCs) for certain Part B drugs (most commonly oral anti-cancer drugs and immunosuppressive drugs following organ transplantation surgeries). These claims are **always** assigned and carry co-insurance responsibilities for the beneficiary.
- **All Adjustment Claims**
  - **Description:** Through this option, all COBA trading partners may globally exclude **all** adjustment claims, except for recovery audit contractor (RAC)-initiated adjustment claims, from the national crossover process. Activation of this option has no impact upon COBA trading partners' receipt of "true" void/cancel claims amongst their 837 institutional crossover claim files.

Part III- Inclusion and Exclusion of Recovery Audit Contractor (RAC) Adjustment Claims; Inclusion of All Adjustment Claims and Mass Adjustment Claims

Recently, CMS made the following additional claims selection options available to commercial supplemental insurers:

- Recovery audit contractor (RAC) adjustment claims (available for inclusion or exclusion);
- All Adjustments claims (available for inclusion);
- Mass Adjustment Claims—Medicare fee-for-service updates (available for inclusion); and
- Mass Adjustment Claims—Other (available for inclusion).

Below are more descriptive overviews of each new option.

A. RAC-initiated adjustment claims (available at no cost to COBA trading partners)

- **Definition:** Claims arising from adjustment actions taken by CMS' Medicare Administrative Contractors (MACs) or Durable Medical Equipment Medicare Administrative Contractors (DME MACs) pursuant to recovery activities engaged in by any of the four RACs. The mission of the RACs is to identify mistaken overpayments on a post-payment basis, with the retroactive timeframes for recovery being limited to October 1, 2007. The scope of RAC adjustments does **not** include MSP, non-assigned claims, and claims tied to fraud and abuse investigations.
- **Important Note:** Unless COBA trading partners request COBA identifiers within the range 88000 to 88999 for receipt of their RAC adjustment claims, they will receive these claims under their pre-existing COBA IDs **at cost.**
- **Reporting on 837 institutional and professional claims:** Value in 2300 CLM05 indicates adjustment. The acronym "RA" will appear in the "ADD-qualified" 2300 NTE-02 segment, unless the incoming claim to Medicare already contained a 2300 NTE segment. Medicare will not attempt to over-ride a pre-existing ADD-qualified 2300 NTE segment.
- **Mechanics of "Including" RAC Adjustment Claims**
  1) Because RAC adjustment activities occur independent of physician or supplier claim submissions to Medicare, Medigap insurers that participate in the COBA Medigap claim-based crossover process are **not** eligible to receive RAC adjustment claims.
  2) Interested COBA trading partners need to a) download and complete page 1 of the COBA Attachment to request and obtain unique COBA IDs that fall within the range 88000 to 88999 to be eligible to receive RAC-initiated adjustment claims **at no cost**; and b) mark item d within Section IV.F ("Adjustment Claims Inclusion"), which is page 18 of the COBA Attachment (dated April 2010).
  3) As part of fulfilling number 2, above, COBA trading partners need to report all of their affected existing production COBA identifiers to the BCRC within the table provided in Section IV.G ("Recovery Audit Contractor [RAC] Claims") on page 18 of the COBA Attachment (dated April 2010).
  4) COBA trading partners should **not** exclude adjustment claims/monetary (item 9 within Section IV.E of the COBA Attachment) or adjustment claims/fully denied, with beneficiary liability remaining (item 10 within Section IV.E of the COBA

Attachment). Doing so will result in their **not** receiving RAC-initiated adjustment claims.

5) COBA trading partners will never receive MSP claims or MSP cost-avoided claims via the RAC adjustment process. This is because MSP is **not** in scope with respect to RAC overpayment recovery activities. Therefore, COBA trading partners should exclude MSP claims and MSP cost-avoided claims as part of Section IV.E of the COBA Attachment as a matter of practice.

6) COBA trading partners should additionally exclude the following claim types from Section IV.E by number in conjunction with their requested RAC COBA identifiers to receive RAC adjustment claims independently: 2, 4, 5, 7, 11, and 12.

7) The COBA trading partner does **not** need to complete Section IV.E of the COBA Attachment if it wishes to duplicate its pre-existing claims selection criteria in conjunction with its receipt of RAC-initiated adjustment claims.

8) The COBA trading partner must ensure that it excludes receipt of RAC-initiated adjustment claims under its pre-existing COBA IDs, as applicable. Otherwise, it will receive duplicate claims—one claim at cost under its original COBA IDs, and the other at no cost under its RAC COBA IDs.

9) All interested COBA trading partners must send a separate eligibility file to identify beneficiaries for whom they wish to receive RAC-initiated adjustment claims.

- **Important Note About "Excluding" RAC Adjustment Claims**

  All COBA trading partners have the opportunity to uniquely exclude RAC-initiated adjustment claims—i.e., not receive such claims at all—under the COBA crossover process. COBA trading partners should only exercise this option if they do not wish to obtain any RAC-initiated adjustment crossover claims, either at cost or not at cost.

B. All Adjustment Claims

- **Definition:** All adjustment claims" literally refers to all adjustment claims, including monetary and non-monetary, as well as mass adjustment claims. Due to internal logic programming, the inclusion of "all adjustment claims" **will not result** in the COBA trading partner's receipt of "RAC-initiated adjustment claims."

- **Mechanics of "Including" All Adjustment Claims**

  1) Download the COBA Attachment from the COB website and request (a) new COBA ID(s) through completion of page 1.

  2) Select the option to **include** All Adjustment Claims under item 1(a) within Section IV.F of the COBA Attachment (dated April 2010).

  3) Ensure that "all adjustment claims" are **excluded** under your current COBA IDs for receipt of "original" Medicare crossover claims (see COBA Attachment IV.E, item 17).

  4) At a minimum, **exclude** the following claim types from Section IV.E by number in conjunction with the newly requested COBA identifiers: 2, 4, 5, and 7.

  5) Within section IV.E, do **not** make the mistake of excluding adjustment claims, monetary.

6) You may apply additional exclusions (e.g., adjustment claims, fully paid, with no deductible or co-insurance remaining; exclude Part A claims; exclude claims by state) just as you do for your original Medicare claims

C. Adjustment Claims—Medicare Physician Fee Schedule (MPFS) Update and Other

- **Definition:** See these terms as defined in Section II above.

Mechanics of "Including" Mass Adjustment Claims

1) Download the COBA Attachment from the COB website and request (a) new COBA ID(s) through completion of page 1.

2) Select the option to **include** mass adjustments/MPFS (item 1(b) under Section IV.F) **or include** mass adjustment claims/other (item 1(c) under Section IV.F) of the COBA Attachment as desired. BCRC will assign you a separate BCRC ID for each brand of mass adjustment if both are requested.

3) <u>At a minimum, exclude the following Section IV.E options under the newly requested</u> COBA IDs: 2, 4, and 7.

4) Exclude the following Section IV.E options under your pre-existing COBA IDs: 2, 4, 7, 11 or 12 (as appropriate).

5) Within section IV.E, do **not** make the mistake of excluding adjustment claims, monetary.

D. Example Scenarios

- **Example 1:** FGH of America wants to receive mass adjustment claims-MPFS and RAC-initiated adjustment claims unto themselves under the COBA process. The insurer is not interested in receiving all other types of mass adjustment claims. What steps should it take?
  - Download 3 copies of the COBA Attachment—two to apply for new COBA IDs for mass adjustments/MPFS and RAC-initiated adjustment claims; and a third to address changes to its pre-existing COBA IDs.
  - Under Section IV. F, item 1(b), mark "All Mass Adjustment Claims tied to the Medicare Physician Fee Schedule (MPFS) Update. Also, under Section F, item 1(d), mark "All Recovery Audit Contractor (RAC)-Initiated Adjustment Claims.
  - Importantly, to realize the unique inclusion of mass adjustment claims/MPFS, FGH of America needs to **exclude** item 11 in Section IV.E of the COBA attachment under its pre-existing COBA ID(s). Otherwise, it will receive duplicate copies of the same claim.
  - FGH of America needs to **exclude** item 12 in Section IV.E of the COBA Attachment in conjunction with its request for new COBA IDs for mass adjustment claims/MPFS.
  - The trading partner needs to ensure that it **excludes** RAC-initiated adjustment claims in conjunction with its pre-existing COBA IDs by marking item 18 [Recovery Audit Contractor (RAC) within the box in Section IV.E and concurrently **includes** such claims under its newly requested COBA IDs.
- **Example 2:** Insurance Company A wants to **include** all adjustment claims, except for adjustment claims that are fully paid, without deductible and co-insurance remaining.

The company also wants to exclude receipt of any 837 institutional claims as adjustments. How would it realize this objective?

- Download page 1 of the the COBA Attachment document (April 2010 version) to apply for a new COBA ID.
- Download the COBA Attachment and place a check in the box of Section IV.A.2 of the COBA Attachment to exclude Part A claims under the newly requested COBA ID.
- Download the COBA Attachment and mark the option to exclude item 3 (adjustment claims, fully paid, without deductible and co-insurance remaining) of Section IV.E.
- Place a mark besides item 1(a) within Section IV.F ("Adjustment Claims Inclusion") of the COBA Attachment.

IMPORTANT: To ensure that the COBA trading partner will not receive duplicate sets of adjustment claims, it will also need to complete a COBA Attachment set to **exclude** receipt of adjustment claims under pre-existing in-use COBA IDs. This is accomplished by marking the appropriate designated item within the table in Section IV.E of the COBA Attachment (April 2010 version).

Part IV. Other Information Regarding COBA Claims Selection Options

- Adjustment claims will only be selected for crossover if the associated 'original' claims were crossed over, with the exception of instances where the 'original' claim has been archived (not on CWF's online history) but the trading partner has elected to receive adjustment claims, monetary or adjustment claims, non-monetary, or both.
- COBA trading partners do not have the option to exclude 'true' voided/cancelled claims, which represent actions taken to wipe-out the original claim <u>without</u> also performing a replacement/adjustment action on the original claim.
- CMS has the systematic capability to exclude 'original' claims that are initially rejected by CWF and subsequently adjudicated as 'adjustment' claims if the COBA trading partner wishes to exclude either adjustment claims, monetary or adjustment claims, non-monetary or both.
- Home health care requests for anticipated payment (RAPs) are auto-excluded under COBA, since these do not represent claims but rather forecasts for resources to be expended.
- Final home health prospective payment (HHPPS) claims (type of bill 339 and 329) that contain no co-insurance responsibilities will not be automatically -excluded (i.e., blocked without COBA trading partners needing to make this specification) from the national crossover process.

  IMPORTANT: Since most home health agencies clearly prefer to not receive denial statements from supplemental payers, CMS strongly recommends that COBA trading partners consider excluding receipt of these claim types.
- COBA trading partners may ensure they only receive types of bills 329 and 339 if these claims carry co-insurance by excluding "adjustment claims, fully paid, without deductible and co-insurance remaining." **Note:** CWF internally regards HHPPS claims ending with bill type XX9 as adjustments. This is why this option needs to be marked to ensure exclusion of these claims when they carry no deductible or co-insurance responsibilities.)

- COBA trading partners do not have the option to exclude claims that are partially denied in those instances where the remaining portion of the claim carries beneficiary deductible or co-insurance amounts.
- Beneficiary liability on fully denied claims does not refer to any remaining co-insurance or deductible cost-sharing responsibilities. Rather, it refers to the full amount of the denied service/service line for which the supplemental payer may, depending upon its policy guidelines, make payment.

  For example, an 837 professional claim contains four (4) service detail lines, all of which are denied. The beneficiary is determined to be responsible for 3 of the detail lines, while the provider is obligated to write-off the remaining denied line. This would be expressed as 3 detail lines that each contain a CAS*PR with an accompanying reason code, since the beneficiary is liable for each of the denied lines. The remaining line will contain a CAS*CO with an accompanying reason code, since the provider is liable for that denied line.

2.2. Profile Report

Upon receipt and successful processing of the COBA Base Agreement and COBA Attachment, the BCRC will generate a Profile Report to the COBA trading partner. The Profile Report will also be sent anytime there is an Attachment change. The COBA Profile Report displays COBA information as provided by the trading partner in the COBA Attachment and lists the trading partner's assigned COBA ID (s). The trading partner will use the COBA ID when generating test and production Eligibility Files.

The trading partner must review the Profile Report for accuracy and notify the BCRC of its approval. To provide approval, the trading partner signs the Signatory letter and faxes the signed report to its EDI representative.

2.2.1. COBA ID Assignment

A trading partner may be assigned one or more COBA IDs. At a minimum, the BCRC will assign separate COBA IDs to those insurers having Medigap and other lines of business for use in generating Eligibility Files. Trading partners will also receive separate COBA IDs if:

1) The trading partner submits separate Eligibility Files, as in the case of two distinct lines of business;
2) The trading partner elects separate claims selection options within the same line of business or separate claims selection options per each line of business or other differences with respect to the COBA Attachment; or
3) The trading partner requests test COBA IDs for the purpose of testing additional claims selection options that are not included in its current agreement. These COBA IDs will remain in effect for 90 days, beginning from the activation date. Any extensions beyond 90 days are non-standard and must be evaluated and approved by CMS.

Figure 2-1: Example Trading Partner Profile Report (1)

Trading Partner Profile Report

TP Contact ID:	TIN:	Company Name:	Part A Rate/Code Rate:
COBA ID:	Authorizing Name:	Line of Business:	Part B Rate/Code Rate:
Contract Date:	Production Date:	Status:	Status Date:

Trading Partner Contact Information

	Administrative Contact	Technical Contact	Invoice Contact	Customer Service Contact
Contact ID:				
Name:				
Title/Position:				
Company/Organization:				
Address 1:				
Address 2:				
City/State/Zip				
Telephone Number:				
Fax Number				
E-Mail Address:				

Data Transfer Information

	Eligibility File	COBA Claims File	
COBA Eligibility Record – Medicare Parts A and B Claims Crossover	Frequency of Eligibility File: _____ Eligibility File Type: _____ Media Type: _____	*ISA-07 Receiver: _____ ISA-08 Receiver: _____ NCDPD Receiver: _____	Frequency of Claims File: _____ Transmission Day: _____ Media Type: _____
Drug Eligibility Record – Prescription Drug Coverage	Frequency of Eligibility File: _____ Eligibility File Type: _____ Media Type: _____	Print Trading Partner's Name on the Medicare Summary Notice (MSN)? _____ (Y/N) *"ZZ" will be used unless agreed upon by the receiver/sender. Claim Version: 4010: ____ → 5010: _____ → NCDPD: _____ → D.0: _____	

Figure 2-2: Example Trading Partner Profile Report (2)

Trading Partner Profile Report

TP Contact ID:	TIN:	Company Name:	Part A Rate/Code Rate:
COBA ID:	Authorizing Name:	Line of Business:	Part B Rate/Code Rate:
Contract Date:	Production Date:	Status:	Status Date:

Claims Selection Options

A. → Fiscal Intermediary/Medicare Administrative Contractor (MAC)/Regional Home Health Intermediary (RHHI) Types of Bills

_____ → Check here if you would like to receive all types of bills.

_____ → Check here if you do not want to receive all types of bills.

B. → Fiscal Intermediary/MAC/RHHI Claims (Institutional) by Provider/State

_____ → Check here if you wish to receive all Fiscal Intermediary/MAC/RHHI claims for all providers and all states (will receive all institutional claims).

_____ → Check here if you wish to EXCLUDE ALL Part A claims.

_____ → "I" Include or "E" Exclude.

List provider identification numbers or provider states to be included or excluded as indicated above

Exclusion Section:

Check all types of bills you wish to exclude:

Fiscal Intermediary/MAC TOBs:

Institutional	*TOB*	*Description*
_____ → Part A	11	Hospital: Inpatient Part A
_____ → Part A	12	Hospital: Inpatient Part B
_____ → Part A	13	Hospital: Outpatient
_____ → Part A	14	Hospital: Other Part B (Non-patient)
_____ → Part A	18	Hospital: Swing Bed
_____ → Part A	21	Skilled Nursing Facility: Inpatient Part A
_____ → Part A	22	Skilled Nursing Facility: Inpatient Part B
_____ → Part A	23	Skilled Nursing Facility: Outpatient
_____ → Part A	71	Clinic: Rural Health
_____ → Part A	72	Clinic: Freestanding Dialysis
_____ → Part A	74	Clinic: Outpatient Rehabilitation Facility

Figure 2-3: Example Trading Partner Profile Report (3)

Trading Partner Profile Report

TP Contact ID:	**TIN:**	**Company Name:**	**Part A Rate/Code Rate:**
COBA ID:	**Authorizing Name:**	**Line of Business:**	**Part B Rate/Code Rate:**
Contract Date:	**Production Date:**	**Status:**	**Status Date:**

Exclusion Section:

Check all types of bills you wish to exclude:

Fiscal Intermediary/MAC TOBs:			
_____ → Part A	75	Clinic: Comprehensive Outpatient Rehabilitation Facility (CORF)	
_____ → Part A	76	Clinic: Comprehensive Mental Health Clinic	
_____ → Part A	83	Special Facility: Ambulatory Surgical Center	
_____ → Part A	85	Primary Care Hospital	
Specialty Fiscal Intermediary TOBs:			
_____ → Part A	24	Skilled Nursing Facility: Other Part B (Non-patient)	
_____ → Part A	28	Skilled Nursing Facility: Swing Bed	
_____ → Part A	41	Christian Science/Religious Non-Medical Services (Hospital)	
_____ → FQHC	77	Clinic: Federally Qualified Health Center (formerly TOB 73)	
_____ → Part A	79	Clinic: Other	
Fiscal Intermediary/RHHI TOBs:			
_____ → RHHI	32	Home Health: Part B Trust Fund	
_____ → RHHI	33	Home Health: Part A Trust Fund	
_____ → RHHI	34	Home Health: Outpatient	
_____ → RHHI	81	Special Facility: Hospice Non-Hospital	
_____ → RHHI	82	Special Facility: Hospice Hospital	

Figure 2-4: Example Trading Partner Profile Report (4)

Trading Partner Profile Report

TP Contact ID:	TIN:	Company Name:	Part A Rate/Code Rate:
COBA ID:	Authorizing Name:	Line of Business:	Part B Rate/Code Rate:
Contract Date:	Production Date:	Status:	Status Date:

Claims Selection Options (Professional & DMAC)

C. Carrier/MAC Claims (Professional) by State

_____ → Check here if you to receive claims for all states.
→ → (Will receive all professional claims).
_____ → Check here if you wish to EXCLUDE ALL Part B Claims.
_____ → "I" Include or "E" Exclude.
List all states to be included or excluded as indicated above.

D. Durable Medical Equipment Medicare Administrative Contractor (DMAC) Claims (Professional/NCPDP) by Jurisdiction

_____ → Check here if you wish to receive all DMAC claims.
_____ → Check here if you wish to EXCLUDE ALL DMAC claims.
_____ → Jurisdiction A
_____ → Jurisdiction B
_____ → Jurisdiction C
_____ → Jurisdiction D
_____ → Check here if you wish to EXCLUDE NCPDP claims.

Claims Selection Options

E. Common Claim Types (Institutional/Professional)

Check here if you wish to receive all claim types listed below: _____
Otherwise, place a mark next to the claim types you wish to exclude:

1. Non-Assigned. → _____
2. Original Medicare claims fully paid without deductible or co-insurance remaining. → _____
3. Adjustment claims fully paid without deductible or co-insurance. → _____
4. Original Medicare claims paid at greater than 100% of submitted charges without deductible or co-insurance remaining. → _____
5. 100% denied original claims, with no additional beneficiary liability. → _____

F. Adjustment Claims Inclusion

_____ → Include Adjustment Only
_____ → Include MPFS Adjustment Only
_____ → Include Mass Adjustment Other Only
_____ → Include RAC Adjustment Only

G. Recovery Audit Contractor (RAC) Claims - Associated production COBA identifier(s)

Figure 2-5: Example Trading Partner Profile Report (5)

Trading Partner Profile Report

TP Contact ID:	TIN:	Company Name:	Part A Rate/Code Rate:
COBA ID:	Authorizing Name:	Line of Business:	Part B Rate/Code Rate:
Contract Date:	Production Date:	Status:	Status Date:

Claims Selection Options

6. → 100% denied adjustment claims, with no additional beneficiary liability. → _____
7. → 100% denied original claims, with additional beneficiary liability. → _____
8. → 100% denied adjustment claims with additional beneficiary liability. → _____
9. → Adjustment claims, monetary (see 11 below to also exclude only Medicare (Physician Fee Schedule [MPFS] updates). → _____
10. → Adjustment claims, non-monetary/statistical (see #12 below to also exclude non-monetary mass adjustments). → _____
11. → Mass adjustment claims tied to MPFS updates (monetary in nature). → _____
12. → Mass adjustment claims - other (could be monetary or non-monetary in nature). → _____
13. → Medicare Secondary Payer (MSP) claims (to globally exclude MSP paid or denied claims. → _____
14. → MSP cost-avoided (fully denied) claims. → _____
15. → Claims if other insurance exists for beneficiary. → _____
16. → Reserved for future use. → _____
17. → All Adjustment Claims. → _____
18. → Recovery Audit Contractor (RAC) Claims. →

Name of Trading Partner Contractor(s):

SECTION 3: COBA TECHNICAL REFERENCE

3.0 Test Procedures

Trading partners should not proceed with any coding/programming based on documents posted on this web site unless confirmed with your EDI representative or CMS representative that recent updates have not been made or are in process.

This section outlines the necessary steps for eligibility and claims file testing with the BCRC. The trading partner is required to complete all enrollment steps as defined under COBA in the Implementation Checklist section of this guide prior to initiating testing with the BCRC. Refer to the Implementation Checklist section within this guide for more information regarding implementation requirements.

3.1. Requirements

3.1.1. Provide Data Transfer Information

The trading partners will complete the appropriate Electronic Transmission Form (ETF), which is available for download at http://www.cms.gov/Medicare/Coordination-of-Benefits/COBAgreement/.

3.1.2. Set up Connectivity Test

The trading partner will coordinate testing two-way transmission capability with the BCRC, if applicable (i.e., electronic transmissions).

3.1.3. Obtain a Test Date from the BCRC

Upon receipt of the COBA and Attachments, the BCRC will provide the trading partner with the next available date to commence testing.

3.1.4. Create Test Eligibility File(s)

The trading partner must generate Eligibility Files in the required COBA Eligibility File Format using its assigned COBA ID(s) as furnished by the BCRC. (Note: Does not apply to Medigap claim-based trading partners.)

3.1.5. Submit Test Eligibility File(s) to the BCRC

The trading partner must complete a mini eligibility test before submitting the full Eligibility File. The first mini test file should contain no more than 100 “add“ records. The file will be reviewed for structure and syntax. The second mini test file will contain “adds,” “changes,” and “deletes.” (Note 1: The full eligibility test file will be loaded to the Beneficiary Other Insurance [BOI] file in CWF.)

With Medigap claim-based crossovers, no eligibility files are utilized and notification to the contractors of a claim-based crossover is based upon the provider entering the appropriate COBA ID on the claim. Consequently, to test claim-based crossover, the BCRC will need to replicate a transmission of these types of claims without corresponding eligibility claims.

The following is a summary of the Medigap claim-based COBA testing process:

The BCRC will build 4 test decks of claims (100 Part B and 10 NCPDP claims). When a Medigap claim-based trading partner requests a test cycle, a copy of these test decks will be created with the appropriate COBA ID. Each week a test cycle will be executed inputting 1 of the test decks for each claim-based COBA that is testing. As a result, each COBA will receive a new file of claims over a 4-week period. If the Medigap claim-based trading partner continues to test for more than a 4-week period, the test bed of claims will be recycled.

It should be noted that each Medigap claim-based COBA ID will receive the same series of HICNs. It will not be possible for BCRC to build claim files for each COBA with individual HICNs that it is accustomed to receiving (i.e., beneficiaries it insures).

The following provides an overview of the cycling of test decks:

1) Medigap COBA 65001 requests a test.
2) A copy of each test bed is created and the COBA ID is replaced with 65001.
3) Test cycle 1 is executed on the first week and uses test bed A
4) Test cycle 2 is executed on the second week and uses test bed B
5) Test cycle 3 is executed on the third week and uses test bed C
6) Test cycle 4 is executed on the fourth week and uses test bed D
7) Test cycle 1 is executed on the fifth week and uses test bed A
8) Test cycles continue rotating the test beds.
9) COBA 65001 terminates testing.
10) Replicated test decks A/B/C/D are pulled from the input cycle.

3.1.6. Review Test Eligibility Results

The BCRC will forward an Eligibility File Acknowledgement (EFA) that confirms receipt of an Eligibility File, followed by an Eligibility Response File (ERF), after the file has completed processing at the Medicare Common Working File (CWF). The ERF provides a one-for-one disposition response for each record in the Eligibility File. Refer to the COBA Eligibility Files section of this guide for more details on the EFA and ERF. (**Note:** Does not apply to Medigap claim-based trading partners.)

3.1.7. Review Test Claims File(s) from the BCRC

The BCRC will create and forward Claims Files in the required formats for all claims matching eligibility information and claims selection criteria.

COBA trading partners should note that, due to the Medicare claims payment floor, they will not receive normal claim volumes until 11-14 calendar days from the date that CWF accepts and applies their eligibility files (i.e., typically no more than 8 calendar days from trading partner submission of the eligibility files to the BCRC). COBA trading partners will receive adjustment claims, fully denied claims, and claims applied fully to the deductible much earlier than all other claim scenarios, since Medicare does not subject these claims to its claim payment floor. See Section 3.6, “Claims File Process,” for a fuller explanation of the Medicare claims payment floor and its impact upon the COBA claims crossover process.

3.1.8. Sign-off on the Test Process with the BCRC

Once the trading partner is satisfied with the test results, complete the Test Sign off Acceptance Form, which is available for download at http://www.cms.hhs.gov/COBAgreement/30_New_COBA_Partner.asp and fax it to the EDI Department. Follow the instructions as outlined on the form.

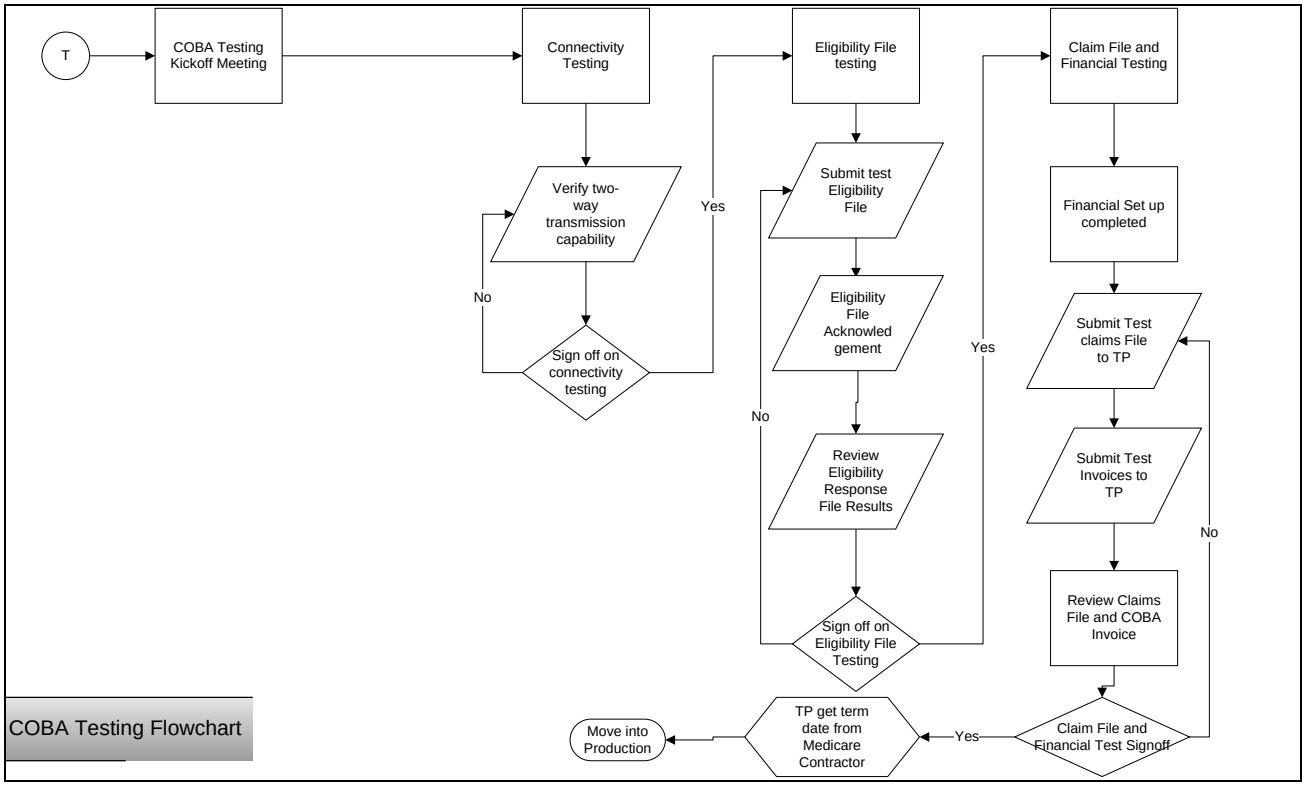
3.1.9. Perform Financial Testing for Billing and Payment

A summary of the BCRC online payment system initiative db-eBills, how it works, and how to get started is provided in the Financial section of this guide.

3.2. Test Process Flowchart

The following page displays the flowchart for the COBA test process. (**Note:** Eligibility file process does not apply to Medigap claim-based trading partners.)

Figure 3-1: Test Process Flowchart



3.3. Electronic Transmission

3.3.1. Transmission Types

3.3.1.1. Secure File Transfer Protocol (SFTP)

Files sent via SFTP are actually sent to CMS. Then, CMS, in turn, sends the file to GHI via Connect Direct. The trading partner's SFTP mailbox is located on a CMS server. Trading partners must complete the SFTP/HTTPS Information Form and the Electronic Transmission Form and return both forms to the BCRC. Both forms are available for download at

http://www.cms.gov/Medicare/Coordination-of-Benefits/COBAgreement/. For further information on SFTP/HTTPS, refer to the appropriate connectivity guide also available for download at this same web site.

3.3.1.2. Hypertext Transfer Protocol over Secure Socket Layer (HTTPS)

Files sent to the BCRC via HTTPS are sent to CMS. Then, CMS sends the file to GHI via Connect:Direct (NDM). The trading partner's HTTPS mailbox is located on a CMS server. Trading partners must complete the SFTP/HTTPS Information Form and Electronic Transmission Form and return both forms to the BCRC. Both forms are available for download at http://www.cms.gov/Medicare/Coordination-of-Benefits/COBAgreement/. For further information on SFTP/HTTPS, refer to the appropriate connectivity guide also available for download at this same site.

3.3.1.3. Connect Direct (NDM via the AT&T Global Network System (AGNS))

This process is similar to a private Internet. Files are sent via AGNS using Connect Direct. Subscribers to that network can participate in sessions with other subscribers' entities. The network uses an encryption scheme of triple DES as a default to keep the physical transport of the data source. Trading partners must complete the Connect Direct Information Form and the Electronic Transmission Form and return both forms to the BCRC. Both forms are available for download at http://www.cms.gov/Medicare/Coordination-of-Benefits/COBAgreement/.

3.3.1.4. Specifications for Secure File Transfer Protocol and Hypertext Transfer Protocol over Secure Socket Layer (HTTPS)

The specifications for SFTP and HTTPS are very similar in nature. When choosing to send files to the BCRC via SFTP or HTTPS, the trading partner is actually sending the file via SFTP/HTTPS to CMS. Then, CMS sends the file to BCRC via a Connect Direct connection. The trading partner's mailbox is located on a CMS server. All files will be sent and received through the Enterprise File Transfer (EFT) Facility GENTRAN. The trading partner will have one mailbox per customer account and all of its COBA IDs will be configured to that single mailbox. SFTP/HTTPS Information Form contains instructions for registering for a SFTP or HTTPS mailbox. Trading partners that elect to send/receive files via one of these methods must complete and return the SFTP/HTTPS Information Form.

3.3.1.5. GENTRAN and SFTP/HTTPS GENTRAN Mailbox Access and System Requirements

To access GENTRAN, please use your GENTRAN User ID (GUID) that was provided by the Individuals Authorized Access to CMS (IACS) system. This should be your 7-character user ID. Plans may only have 4 submitters. Accounts are given to an individual and their SSN is a required field on the online application. Designated submitters are identified within the Plan organization and approved by the local external point of contact (EPOC). **Access will not be provided to unapproved individuals.**

Trading partners and/or those specifically identified will be using either HTTPS or the Sterling SFTP Client for file submission or file retrieval. SFTP Installation and Configuration user guides for additional information, please contact the EDI Department at 646-458-6740. Details for procuring the Sterling FTP Client are available through the Sterling Commerce web site: http://www.sterlingcommerce.com. (See Table 3-2)

If you have any technical questions or need assistance with establishing this transmission link, please contact your assigned EDI representative. The contact number for the main EDI line is 646-458-6740.

The current CMS mailbox retention periods for all outgoing files are listed in Table 3-1.

Table 3-1: CMS Mailbox Retention Periods

Application	Retentions
MARx	Monthly reports 30 days total, all other reports 6 days (including weekends)
MBD	All files 6 days (including weekends)
DDPS PDE/RAPS	All files 14 days (including weekends)
COB	All files 6 days (including weekends)
HPMS	All files 6 days (including weekends)

3.3.1.6. HTTPS GENTRAN Mailbox Access and System Requirements

To configure your client, you will need the following information:

- Internet URL: https://gis.cms.hhs.gov:3443/mailbox
- Extranet URL: https://gis.cmsnet:3443/mailbox

  Note: Remember to configure your network or node to use the CMS MDCN Domain Name Server (DNS) for name resolution
- Port Number: 3443

  Note: Do not use the typical Port 80 for HTTP or Port 443 for HTTPS.
- Browser Requirements: Internet Explorer 5.x or later

  Note: CMS recommends that EFT users use a Microsoft Operating Systems that is currently supported by Microsoft and at the appropriate Service Pack Levels.

To eliminate the HTTPS Security Pop-up after you have downloaded the GENTRAN Certificate, the end user may need to update his/her VeriSign Class 3 Certificate. Instructions are available from the CSMM Helpdesk. Also, HTTP Screen Shot user guides are available under the download section at http://www.cms.gov/Medicare/Coordination-of-Benefits/COBAgreement/.

SFTP (SSH Client) GENTRAN Mailbox Access and System Requirements

CMS has experience with the Sterling FTP client. If you have another client that you would like to use, it must have SSH version 2.

To configure your client you will need the following information:

- Host Name/IP Address: GIS.CMS.HHS.GOV
- Port Number: 10022

  TCP Port 10022 for SFTP with SSH is used for the SFTP sessions

Table 3-2: Sterling FTP Client Minimum Requirements (Sterling Commerce)

Operating System	Requirement
UNIX	RAM: 512 MB
-	OS: AIX 5.3
-	Solaris 9
-	HPUX 11i
-	Suse Linux 8.2
-	Red Hat Linux 9
Microsoft Windows	RAM: 512 MB
-	Windows NT 4 SP6
-	Windows 2000 Pro
-	Windows XP SP1

GENTRAN Incoming File Naming Conventions (Trading Partner to GENTRAN)

Trading partners may submit their Eligibility File, both test and production, to the BCRC through the use of SFTP or HTTPS. Files sent to the Enterprise File Transfer Facility GENTRAN mail boxes should follow the naming convention below and be formatted in ALL CAPITAL LETTERS, e.g., GUID.RACFID.APPID.X.UNIQUEID.FUTURE.W.ZIP. Refer to COBA Eligibility (E01) Record Layout, which is available for download at http://www.cms.gov/Medicare/Coordination-of-Benefits/COBAgreement/, for the format and content details for the COBA Eligibility File. (This does not apply to claim-based Medigap trading partners.)

Table 3-3: SFTP or HTTPS Filename Convention Table

File Name Convention	Description
GUID	7 character Alphanumeric user ID generated by the Individuals Authorized Access to CMS Computer Services (IACS).
RACFID	4 character RACF user ID. **Note:** If no RACF ID, insert NONE.
APPID	COB **Note:** System that will process the inbound file.
X	D – DAILY W – WEEKLY M – MONTHLY Q – QUARTERLY Y – YEARLY A – AD HOC **Note:** This field indicates type of data (e.g., Daily, Monthly). However, multiple file types may be transmitted on the same day, (e.g., 2 Daily submissions).
UNIQUEID	**COBA ID w/ CB prefix (i.e. CB00000)**

File Name Convention	Description
FUTURE	Code exactly as shown for the applications listed below or code FUTURE. This field is reserved for future use. DISPUTE – When sending a dispute file, replace FUTURE with DISPUTE. HEW – When sending a HEW Query file only file, replace FUTURE with HEW.
W	Code T for Test Data Code P for Production Data
ZIP	Only used when file compression is used and automatically added to the file name by the ZIP application, e.g., WINZIP or PKZIP. **Note:** WINZIP version 9 or higher is required to support long file names.
. (Periods)	Delineators

GENTRAN Outgoing File Naming Conventions (GENTRAN Back to Trading Partner)

There are eight (8) files that the trading partner can choose to receive from the BCRC. The filenames created by the application will be sent unchanged to the mailbox. GENTRAN will then append a unique identifier to the end of each file. When downloading the file(s) from your organizational mailbox, you may change the filename(s) in accordance with your organizational naming requirements.

Gentran filenames are listed below. Please note the fourth node in the filename, which is represented as “rrrrrrrr,” is unique for each business partner. The last node in the file name, which is represented as “ssssss,” is issued by CMS after the file has successfully processed.

Refer to the COBA Eligibility (E01) File Acknowledgement Layout and the COBA Eligibility Response File (ERF) Layout for further information. Both layouts are available for download at http://www.cms.gov/Medicare/Coordination-of-Benefits/COBAgreement/.

Table 3-4: Test Filenames

Description	Mailbox Filename
Eligibility File Acknowledgement Report	TCOB.BA.COBA.rrrrrrrr.EACK.REPORT.ssssss
Eligibility Response File	TCOB.BA.COBA.rrrrrrrr.BODET.REPORT.ssssss
Part A Claims	TCOB.BA.rrrrrrrr.PARTA.CLAIMS.ssssss
Part B Claims	TCOB.BA.rrrrrrrr.PARTB.CLAIMS.ssssss
NCPDP Claims	TCOB.BA.rrrrrrrr.NCPDP.CLAIMS.ssssss
E02 Eligibility File Acknowledgement	TCOB.BA.COBA.rrrrrrrr.RXEACK.REPORT.ssssss
E02 Response file	TCOB.BA.PARTD.rrrrrrrr.RXRESP.ssssss
HEW Query Response file	TCOB.BA.COBA.rrrrrrrr.HEWRESP.ssssss

Table 3-5: Production Filenames

Description	Mailbox Filename
Eligibility File Acknowledgement Report.	PCOB.BA.COBA.rrrrrrrr.EACK.REPORT.ssssss
Eligibility Response File	PCOB.BA.COBA.rrrrrrrr.BODET.REPORT.ssssss
Part A Claims	PCOB.BA.rrrrrrrr.PARTA.CLAIMS.ssssss
Part B Claims	PCOB.BA.rrrrrrrr.PARTB.CLAIMS.ssssss
NCPDP Claims	PCOB.BA.rrrrrrrr.NCPDP.CLAIMS.ssssss
E02 Eligibility File Acknowledgement	PCOB.BA.COBA.rrrrrrrr.RXEACK.REPORT.ssssss
E02 Response file	PCOB.BA.PARTD.rrrrrrrr.RXRESP.ssssss
HEW Query Response file	PCOB.BA.COBA.rrrrrrrr.HEWRESP.ssssss

Notes:

File Size Limitation:
There is a file size limit of 1.0 GB, with or without compression.

CRLF Considerations:
Gentran will handle the CRLF (carriage return line feed) characters.

ZIP Utility Software:
At the present time GENTRAN cannot support multiple files within a single compressed filename.

3.3.2. AT&T Global Network System (AGNS)

The AT&T Global Network Service, better known as AGNS or Advantis, is like a private Internet. Only subscribers to that network can participate in sessions with other subscribers' entities. The network uses an encryption scheme of triple DES as a default to keep the physical transport of the data source.

The following provides an overview of how BCRC routes users to either the FTP or Connect:Direct (NDM) applications via the AGNS network:

- When a trading partner comes in to BCRC via the AT&T Global Network, that partner will be using a registered Internet address that belongs to AT&T to ensure customer routing via the AGNS network.
- The AT&T Global account ID for COBA will be BXGH that has a frame-relay connection via an AGNS managed router to the AT&T Cloud. The AT&T managed router at the BCRC is called "BXGHNEWY."
- A trading partner will need a PVC for a private line to the AT&T network or a modem dial line to the AT&T network using appropriate AT&T software.
- If the trading partner will use a dial line, the AT&T software will assign to the user from a pool of 32 block addresses a specific 32.xxx.yyy.zzz address to use as its Source IP address.
- The user will need to have an AT&T account, Userid and Password to connect.
- The destination IP that the user will specify for BCRC will depend on whether the user is using NDM/IP or FTP. It will probably be a 32.xxx.yyy.zzz address that will be passed from the BCRC's AGNS router to the BCRC's firewall.

- The BCRC has a 32.xxx.yyy.zzz setup in its AGNS router currently for CMS' use of NDM/IP and probably can expand this for other users of this product.
- The BCRC has a firewall that translates the user destination address (32.xxx.yyy.zzz) to a GHI network address that will route to the desired host and application.
- The BCRC has also had to provide static routing in its core router to send the data back to the AGNS network so the user Source IP is also important. This will also apply to BCRC's Firewall configuration. (Source IP addressing for dial will be assigned by the AT&T software via DHCP)
- For private line users connected to the AGNS network, the trading partner will have a site Source IP either directly out of AGNS or defined as a translated address in their Firewall (if any).
- Firewall and router modifications may be set up on an individual basis.

3.3.2.1. AT&T Global Network Service (AGNS) Transmission Resellers

AGNS is a private network that is capable of transporting multiple protocol data streams to its members at any point in the world. Because the BCRC is a member of the AGNS VAN it can talk to other trading partners who are connected to this network. This network service precludes the need to support a separate link to each trading partner, which would be more expensive and difficult to implement and maintain. It is the mandated network to use for COBA related business as directed by the Centers for Medicare & Medicaid Services (CMS). Moreover, AGNS uses an encryption scheme of triple DES as a default to secure the physical transport of transferred data.

Trading partners that do not currently have an existing AGNS account and plan to send and receive crossover information via telecommunications, should contact one or more of the well-established resellers to obtain a dedicated or a dial-up access line to the managed AGNS VAN. The BCRC strongly encourages trading partners to activate new accounts as early as possible to comply with the current technical requirements of the COBA Program.

3.4. COBA Eligibility Files

Note: Sections 3.4 and 3.5 do not apply to Medigap claim-based trading partners.

The trading partner or the trading partner's contractor will transfer Eligibility Files to the BCRC based on the terms defined within its COBA for all Medicare beneficiaries for whom it provides supplemental insurance coverage. The COBA Eligibility File is used by trading partners to identify their eligible beneficiaries to receive Medicare paid claims information for their supplemental payment processing and to submit drug coverage eligibility data. The BCRC will process the Eligibility File, apply syntactical and data consistency edits, and transmit valid eligibility records daily to the Medicare Common Working File (CWF). The BCRC will transmit E-02 data to CMS' Medicare Beneficiary Database to ensure that pharmacies will have awareness at point of sale regarding payers that supplement Medicare Part D drug plan payments.

3.4.1. E01 Eligibility File Submission Process

The Coordination of Benefits Agreement (COBA) process only allows for one type of Eligibility File submission methodology: Adds, Changes (Updates), and Deletes. Through this method, only beneficiary other insurance (BOI) eligibility records to be added, changed (updated), or deleted are submitted to the BCRC for application to the CWF. Records that remain unchanged should not be included. Also, note that a separate COBA Eligibility E01 Record must be submitted for each

coverage period reported for one Health Insurance Claim Number (HICN). BOI records are transmitted nightly to the CWF based on the Eligibility Files sent by the trading partner. If multiple BOI records exist, all payers will receive the claim. CWF maintains a history of up to 40 insurance periods. After 40 BOI records are received, the earliest record is deleted.

COBA uses a 200-byte standard COB Eligibility File Format as provided in the COBA Eligibility (E01) Record Layout. CMS does not have any plans to change this proprietary format.

3.4.1.1. Description of Eligibility Records - Add, Change (Update), Delete

The trading partner or the trading partner's contractor will transfer Eligibility Files to the BCRC based on the terms defined within its COBA for all Medicare beneficiaries for whom it provides supplemental insurance coverage. The following defines **Adds, Changes (Updates),** and **Deletes** and provides an example of each:

Adds: New information the trading partner provides through the COBA process on a covered individual for whom the trading partner provides supplemental coverage. This information was never provided through the COBA process previously.

Example (Add): John Smith is a newly covered individual under one of the trading partner's plans. The trading partner wants to receive Medicare paid claims information for John Smith. Insurance plan X provides individual information for the first time to the BCRC to identify John Smith as a covered individual.

Changes/Updates: Updates to covered individual records that were previously provided as "adds" through the COBA process.

Example (Change): Insurer Y via an "Add" action previously posted Jane Doe to the COBA eligibility database as a covered individual. Three months later, Jane Doe ceased coverage with that insurer. Insurer Y sends this change through the COBA process in the next "Update" Eligibility File.

Note: Effective January 2, 2007, the CWF consistency logic was modified to consider an Add and Change (Update) transaction equally. That is, when CWF receives an incoming BOI record, it will check for the presence of an existing BOI that matches the COBA ID, beneficiary Health Insurance Claim Number (HICN), and Effective Date contained on the incoming BOI transaction. If the incoming BOI matches the existing record, and the incoming transaction is an update, CWF will apply the change to the existing record.

Example (Add and Change): Insurer Z via an "Add" action type previously posted Jane Doe to the COBA eligibility database as a covered individual with a coverage period of 01012006 through 00000000 (open-ended). Three months later, Insurer Z sends an "Add" action type for Jane Doe with a coverage period of 01012006 through 00000000. Since the COBA ID and beneficiary HICN contained on the incoming BOI record matches the previously applied record, CWF will update the existing record. Prior to January 2, 2007, this record would be rejected as a duplicate. However, since the two records matching criteria are equal, CWF will now update the previously established BOIA record.

Note: COBA trading partners should **not** report records to the BCRC where the effective date is equal to the coverage termination date. If the intent of this record is to communicate that the coverage period is invalid or incorrect, the COBA trading partner needs to send a delete action request via the Eligibility File.

Also, when a policy number changes and this is communicated on the Eligibility File, the BCRC will communicate this to CWF as an update.

Deletes: A delete means the removal of a record that was previously posted to the COBA eligibility database in error.

Example 1 (Delete): Insurer Z previously added John Doe to the COBA eligibility database as a covered individual. However, insurer Z determined that it had erroneously identified John Doe as a covered individual through its employer retiree plan. In reality, John Doe was actively employed. Insurer Z submits a "Delete" action type for John Doe for the previously submitted period of coverage.

Example 2 (Delete): Insurer Z via an "Add" action type previously posted Jane Doe to the COBA eligibility database as a covered individual with a coverage period of 01012006 through 00000000 (open-ended). However, Jane Doe's coverage effective (start) date should have been 10012006. In order to apply the correct coverage period to the eligibility database, the COBA trading partner must first request a delete action for the initial record (01012006 through 00000000) and then apply an "Add" action type to apprise CMS of the correct coverage period (10012006 through 00000000).

3.4.1.2. Information Concerning Concurrent Crossovers to Multiple Insurers

If the beneficiary has more than one insurance plan and the beneficiary's record is attached to unique COBA IDs, then the BCRC will create multiple crossover claims for each COBA ID, per the claims selection criteria specifications in the signed COBA.

If a beneficiary has two or more policies with a single insurance company, and the insurance company has requested that its name be placed on the Medicare Summary Notices (MSNs) and if the beneficiary's eligibility records are attached to two unique COBA IDs, the MSN would list multiple times that the claim had been crossed over to that particular trading partner. On the provider hard copy remittance advice or the PC Print of the 835 Electronic Remittance Advice (ERA), Medicare will include one instance of MA18 to indicate that the claim was crossed over to one named payer. Under the HIPAA 835 requirements, Medicare cannot list more than one crossover payer. The pecking order is determined in association with the following COBA ID sort routine: 1) Eligibility-based Medigap (30000-54999); 2) Claim-based Medigap (55000-59999); 3) Supplemental (00001-29999); 4) TRICARE (60000-69999); 5) Other Insurer (80000-88999); 6) Medicaid (70000-79999)l and 7) Healthcare Pre-Payment Plans (HCPPs). Transfers to health care pre-payment plans (HCPPs) [COBA ID 89000-89999] are not reflected on the 835 ERA or hard copy remittance advice or on the beneficiary's Medicare Summary Notice (MSN).

Medicare does, as a rule, indicate code N89 on the ERA when a claim is transferred to multiple payers.

Note: If desired, the trading partner's Federal Employee Health Benefits Plan (FEHBP) population can be isolated on a separate Eligibility File, and can be subject to its own selection criteria.

3.4.1.3. Eligibility File Submission

The trading partner or the trading partner's contractor will transfer Eligibility Files to the BCRC based on the terms defined within its COBA for all Medicare beneficiaries for whom it provides supplemental insurance coverage. There is no limit to the number of COBA IDs that can be contained in one Eligibility File; however, multiple Eligibility Files per COBA ID are not acceptable. Trading partners with multiple COBA IDs have the option of submitting a separate Eligibility File for each COBA ID or combining all their eligibility records into a single file. In the combined file scenario, all beneficiary records must be sorted by COBA IDs and separated by a

header and trailer. Note that a separate COBA Eligibility E01 Record must be submitted for each coverage period reported for one HICN. Trading partners will complete an Electronic Transmission Form (ETF) on which they designate their transmission method.

Trading partners may submit an Eligibility File from a different location and/or using a different communication method than used for the claim file receipt (i.e., claims are received via NDM, but the eligibility file is sent via SFTP.)

3.4.1.4. Transmitting A Single Eligibility File For Use Of Multiple COBA IDs

The COBA process requires that a new header and trailer within the file be present to separate all beneficiary records. The header record includes the record type, COBA ID, creation date, and beneficiary state code. (**Note:** this code is optional and is not used by the COBA process.) Trading partners should sort the Eligibility File by COBA ID. Here is an example for a trading partner or trading partner's contractor with multiple COBA IDs:

Header record contains COBA ID 000012345

Detail record contains COBA ID 000012345

Detail record contains COBA ID 000012345

Detail record contains COBA ID 000012345

Detail record contains COBA ID 000012345

Detail record contains COBA ID 000012345

Trailer record

Header record contains COBA ID 000067890

Detail record contains COBA ID 000067890

Detail record contains COBA ID 000067890

Detail record contains COBA ID 000067890

Detail record contains COBA ID 000067890

Detail record contains COBA ID 000067890

Trailer record

3.4.2. Frequency

The trading partner may provide Eligibility Files on a bi-weekly or monthly basis. The trading partner will need to indicate its frequency of Eligibility File submission to the BCRC via the COBA Attachment. The Eligibility File frequency may be modified or changed by the trading partner. To communicate any changes to its selected options, the trading partner may complete and submit another COBA Attachment, indicating on page 1 that this is a change.

Transmissions are limited to bi-weekly to ensure as many records are applied at the CWF as possible. The following example demonstrates the processing that may transpire with a normally transmitted file. This example does not take into account any system delays or delays due to file limitations.

Week 1

Monday	Trading partner submits Eligibility File.
Tuesday	Eligibility File is initially edited and Eligibility File Acknowledgement (EFA) is transmitted to the trading partner.
Wednesday	Eligibility File transmitted to CWF.
Thursday	Response received from CWF and applied to the BCRC eligibility database.
Friday	Immediate recycles transmitted to CWF and additional responses applied to the BCRC eligibility database.

Note: The CWF requires that the BCRC hold response records received with corrected HICNs (Disposition Code 51) and out of service area (OSA) beneficiary master records (Disposition Code 50) for three (3) days before retransmitting records to the CWF. This process is called "recycling."

Week 2

Monday	Additional responses applied.
Tuesday	Retransmit records held during Week 1 (recycles), if no CWF response received to date.
Wednesday	Response received from CWF and applied to the BCRC eligibility database.
Thursday	Eligibility Response File (ERF) created for transmission to trading partner.
Friday	Transmit ERF to trading partner.

There is no cut-off time for Eligibility File submission. If the trading partner does not submit files, the eligibility remains unaltered on CWF. The BCRC processes Eligibility Files on a daily basis. The Eligibility File data are transmitted to the CWF within five business days of receipt as demonstrated in the example above.

In accordance with its contractual obligations, as per the executed COBA, and realizing effective customer relations, CMS expects each COBA trading partner to take seriously the task of identifying new members or policyholders within and terminating former members or policyholders from its E-01 eligibility records. Trading partners that are having difficulties with eligibility file maintenance need to alert their designated EDI representative so that they can deploy possible strategies (e.g., exchange of BCRC extract file) to alleviate these issues.

3.4.3. Eligibility File Acknowledgment (EFA)

Syntactical data validation routines will be applied to all Eligibility Files. The BCRC will initially edit the Eligibility File and transmit an EFA back to the trading partner containing a matching header record from the submitted file, a count of E01 records submitted, whether the Eligibility File was accepted (Status code = "A") or had a fatal (severe) error (Status code = "S"), and an error description. If a severe error occurs, it is the trading partner's responsibility to correct the error and retransmit the file to the BCRC. Table 2-6 provides the error type and definition of Eligibility File fatal errors. The COBA Eligibility File (E01) Acknowledgement Layout is available for download at http://www.cms.gov/Medicare/Coordination-of-Benefits/COBAgreement/.

Table 3-6: Eligibility File Acknowledgment Severe Error Types

Error Type	Description
INVALID COBA ID	The COBA ID on the file does not conform to the required specifications, i.e., 9 position, alphanumeric (no special characters), left justified, last four positions are spaces.
RECORD COUNT IN TRAILER DOES NOT MATCH ACTUAL RECORD COUNT	The record count denoted in the trailer record does not match the actual record count.
FILE SENT OFF SCHEDULE	The file was submitted prior to the scheduled timeframe denoted in the COBA Attachment or less than 2 weeks after previous submission.
NO HEADER RECORD FOUND	File does not contain the required header record.
NO E01 RECORDS SUBMITTED	File received with header and/or trailer record with no detailed E01 records.
MISSING TRAILER RECORD	File does not contain the required header and/or trailer record
PREVIOUS ELIGIBILITY FILE IN SEVERE ERROR STATUS	Incoming Eligibility File cannot be processed because previously submitted file is in severe error status.
DELETE COUNT IS GREATER THAN 15% OF 999999	Delete record count is greater than 15% of the total in the COBA Eligibility database.
FULL FILE REPLACEMENT NOT ALLOWED	Full File replacement no longer allowed, only A/U/D eligibility files accepted.
INVALID HEADER FORMAT	E00 record does not conform to format stated in the file format.
MULTIPLE FILES ENCOUNTERED WITH THE SAME COBA ID	More than one file has been submitted at the same time for a single COBA ID.
TRAILER TOTAL DOES NOT MATCH RECORD TOTAL	E01 count plus E02 count within trailer does not match the overall total.

If an entire Eligibility File rejects, the COBA process will continue to crossover claims based on the trading partner's most recently "accepted" Eligibility File. For those Eligibility Files that do not contain a fatal error, the BCRC will attempt to process each eligibility record on the file. Edited eligibility records will continue to be loaded to the COBA database, which resides at the BCRC, where initial errors will be recorded. The A/U/D records that pass edits will be transmitted to the CWF. The CWF responses, including those that are not applied due to an error, are loaded to the COBA database. When CWF generates all responses, or eight (8) business days after the date of receipt of the Eligibility File have elapsed, whichever comes first, the BCRC will create an Eligibility Response File (ERF) that includes errors from both the COBA database and the CWF, along with all other record dispositions.

3.4.4. Eligibility Response File (ERF)

The BCRC will also provide a detail-level report, ERF, back to the trading partner identifying eligibility records received, accepted, and denied when all CWF responses have been received or eight (8) business days after the initial Eligibility File is received, whichever comes first. Transmission of the ERF, at the time, will confirm that all records are applied to the CWF, or if not applied, the current status of each record will be known. The BCRC will not be processing an incoming Eligibility File until the previous file has completed processing through the CWF and an ERF is returned to the trading partner. The COBA Eligibility Response File (ERF) Layout is

available for download at http://www.cms.gov/Medicare/Coordination-of-Benefits/COBAgreement/.

Each record submitted will be returned to the trading partner with a one-for-one beneficiary other (BO) insurance error or disposition code. The ERF will contain, along with the CWF disposition code, error codes that prevented the record from being submitted to the CWF (COBA database pre-edits) and errors detected at the CWF. CWF responses that are received after the E01 response file (ERF) has been transmitted to the trading partner will only be applied to the COBA database. It will be the trading partner's responsibility to resubmit recycling BOI transactions.

The following chart provides a list of the BO errors, disposition codes, and their accompanying definition and descriptions. Keep in mind that not all of these codes will apply to all response files you may receive from the BCRC. Please contact the BCRC if you have questions about any of the Disposition or SP Edit codes.

3.4.4.1. Eligibility Response Files Disposition Codes and Descriptions

Table 3-7: Eligibility Response File Disposition Codes

Disposition Code	Description
01	Record accepted by Common Working File (CWF) as a "Delete,""Add," or a "Change" record. No trading partner action required.
BO	Transactions edit; record returned with at least one BO edit (specific BO edits are described below). Trading partner action may be required to correct error.
50	Record still being processed by CWF. Beneficiary host site search being performed. Trading partner should resubmit record in next Eligibility File for a final disposition.
51	Beneficiary is not in file on CWF. If the BCRC receives a corrected HICN, the record will be recycled by the BCRC. If this deposition is received in ERF, the beneficiary most likely not entitled to Medicare. Trading partner needs to reverify name, HICN, date of birth and sex based on information in its files; then, resubmit on next Eligibility File.
52	Record still being processed by CWF. Trading partner should resubmit record in next Eligibility File for a final disposition.
55	Name/Personal Characteristic Mismatch. Name or personal characteristic of beneficiary does not match the HICN on Medicare's files. Trading partner needs to reverify name, HICN, date of birth, and sex based on information in its files; then, resubmit on next exchange file.
*60	CWF Cross-Reference Data Base Problem. Trading partner should resubmit record in next Eligibility File for a final disposition.
*AB	CWF problem that can only be resolved by CWF Technician. Trading partner should resubmit record in next Eligibility File for a final disposition.
*CI	CWF Processing Error. Trading partner should resubmit record in next Eligibility File for a final disposition.

*The trading partner should normally not receive these errors in the ERF. However, if received, the records should be resubmitted in next Eligibility File for a final disposition.

3.4.4.2. Beneficiary Other (BO) Insurance Error Codes, Description and Definition

Table 3-8: Beneficiary Other Insurance Error Codes

Error Code	Description	Definition
BO01	INVALID HICN	Invalid HICN (Mandatory). Field must contain alpha and numeric characters. You received this error because: 1) either an invalid character was provided in this field, or 2) we were unable to match the HICN you supplied.
BO02	INVALID SURNAME	Invalid Beneficiary Surname (Mandatory). Field must contain alpha characters. Field cannot be blank or contain spaces or numeric characters. Note: Currently, if the first initial **and** the surname do not match, one BO02 error is returned and the record will not post to CWF. If only the first initial **or** the surname do not match and the HICN and all other matching criteria are accurate, one BO02 error is returned and the record will post to CWF (Disposition Code 01).
BO03	INVALID DATE OF BIRTH	Invalid Beneficiary Date of Birth (Mandatory). Field must contain numeric characters. Field cannot be blank or contain spaces or alpha characters. Format of this field must be CCYYMMDD. Day of the month must be correct. For example, if month = 02 and date = 30, the record will reject.
BO04	INVALID SEX CODE	Invalid Beneficiary Sex Code (Mandatory). Field must contain numeric characters. Field cannot be blank or contain spaces or alpha characters. Acceptable numeric characters include the following: M = Male F = Female If sex is unknown, default to M for male.
*BO05	INVALID CONTRACTOR NUMBER	Invalid Contractor Number (Mandatory). Non-blank, numeric. Must be a valid CMS-assigned Contractor Number. Internal CMS use only. Partner should not receive this error.
*BO08	INVALID DOCUMENT CONTROL NUMBER	Invalid Document Control Number (DCN). CMS replaces the Agreeing Partner's original DCN with CMS' DCN. CMS Automatically provides a DCN, so the partner should not receive this error. Blank for all others. (Valid Values: Alphabetic, Numeric, Space, Comma, & - '. @ # /; :)

Error Code	Description	Definition
BO09	INVALID ACTION TYPE	Invalid File Update Indicator (Mandatory). This error results from what is provided in the type of record transaction field. Field must contain alpha characters. Field cannot be blank or contain spaces. Acceptable alpha characters include the following: 'A' = Add 'C' = Change/Update 'D' = Delete Required as of March 1, 2007
*BO11	INVALID INSURANCE TYPE	Invalid Insurance Type. Field may contain alpha or numeric characters. Field cannot be blank. Valid values are: 'A' – Supplemental 'B' – Tricare 'C' – Medicaid
BO12	INVALID INSURANCE NAME OR ADDRESS	Invalid Insurer Name. Place the name of the insurer in this field. Spaces are allowed between words in an insurer plan name. Field may contain alpha and/or numeric characters, commas, & - ' . @ # / : ;. Field cannot be blank or contain numeric characters.
BO13	INVALID POLICY NUMBER	Invalid Policy Number. If field is not used, field must contain spaces. Field may contain alpha and/or numeric characters, commas, & - ' . @ # / : ;
BO14	INVALID EFFECTIVE DATE	Invalid Effective Date. Field must contain numeric characters. Field cannot be blank, or contain spaces, alpha characters, or all zeros. Number of days must correspond with the particular month. Valid format is CCYYMMDD.
BO15	INVALID TERMINATION DATE	Invalid Termination Date. Field must contain numeric characters. Date must correspond with the particular month – CCYYMMDD. For example, 19970228 is acceptable, but not 19970230. If there is no termination date (coverage is still active), must use zeros (not spaces) in this field. Termination date cannot be less than the effective date.
BO16	INVALID SUPPLEMENTAL ID (Format)	Field may contain alpha and/or numeric characters, spaces, commas, & - ' . @ # / : ; If field is not used, field must contain spaces.
BO17	INVALID COBA NUMBER	Field may contain numeric characters only. Spaces, commas, & - ' . @ # / : ; are invalid. Field is 9 position, alphanumeric (no special characters), left justified, last four positions are spaces. Mandatory.
BO18	INVALID PLAN ID NUMBER	Field may contain alpha and/or numeric characters, spaces, commas, & - ' . @ # / : ; If field is not used, field must contain spaces.
BO19	INVALID OTHER INS NUMBER	Field may contain alpha and/or numeric characters, spaces, commas, & - ' . @ # / : ; If field is not used, field must contain spaces.

Error Code	Description	Definition
BO20	NO MATCH FOUND FOR DELETE	Beneficiary other insurance (BOI) occurrences not found for delete transaction. Where there is an existing period of coverage, the incoming record must match on certain criteria so the system can differentiate among various periods of coverage on the beneficiary's Medicare file. These criteria are: COBA ID/ HICN/ Effective Date
BO22	RECORD ALREADY DELETED	Beneficiary other insurance (BOI) record not found for delete data transaction. This edit occurs when an attempt is made to delete a non-existent BOI record.
BO23	TERM DATE IS LESS THAN THE EFFECTIVE DATE.	Trading partner attempted to apply a through date that is less than the start date (e.g., start date=09/01/2010 and through date=08/31/2010). **Effective May 1, 2010**.
BO90	OVERLAPPING COVERAGE	Trading partner submitted an overlapping eligibility period for their member. The edit occurs when a BOI record already exist within that coverage period.
BO91	SURNAME MISMATCH	Based upon its assessment of the 1st six positions of the surname, the BCRC has determined that the reported surname does not match the information that CMS has on file, as derived from its source entitlement system.
BO92	FIRST INITIAL MISMATCH	The first initial of the beneficiary's first name does not match the information that CMS has on file.
BO93	DATE OF BIRTH MISMATCH	The beneficiary's date of birth, as reported in the format CCYYMMDD, does not match the information that CMS has on file.
BO94	SEX CODE MISMATCH	The reported gender code does not match the gender code that CMS has on file for the indicated individual.
B095	DUPLICATE ELIGIBILITY RECORD	The COBA trading partner has submitted a duplicate eligibility record with the only element being changed being the effective date. Previously submitted record not terminated.
BO98	SUPPLEMENTAL ID MUST BE AT LEAST 2 CHARACTERS IN LENGTH	The first 2 Characters of the supplemental ID must be alphanumeric and the second position cannot contain a space.
BO99	DUPLICATE RECORD	This record is a duplicate of a record in the incoming Eligibility File. A match is performed on COBA, HICN, and Effective Date to determine duplicates. **Note:** This is a BCRC generated error. Record will not be sent to the CWF.

*The trading partner should normally not receive these errors in the ERF. However, if received, the records should be resubmitted in next Eligibility File for a final disposition.

3.4.5. E01 Flowchart

The flowchart displays how the BCRC's COBA Eligibility File Process will edit, validate, and process trading partners' Eligibility File. (**Note:** Does not apply to Medigap claim-based trading partners.)

Figure 3-2: EO1 Flowchart (Part 1)

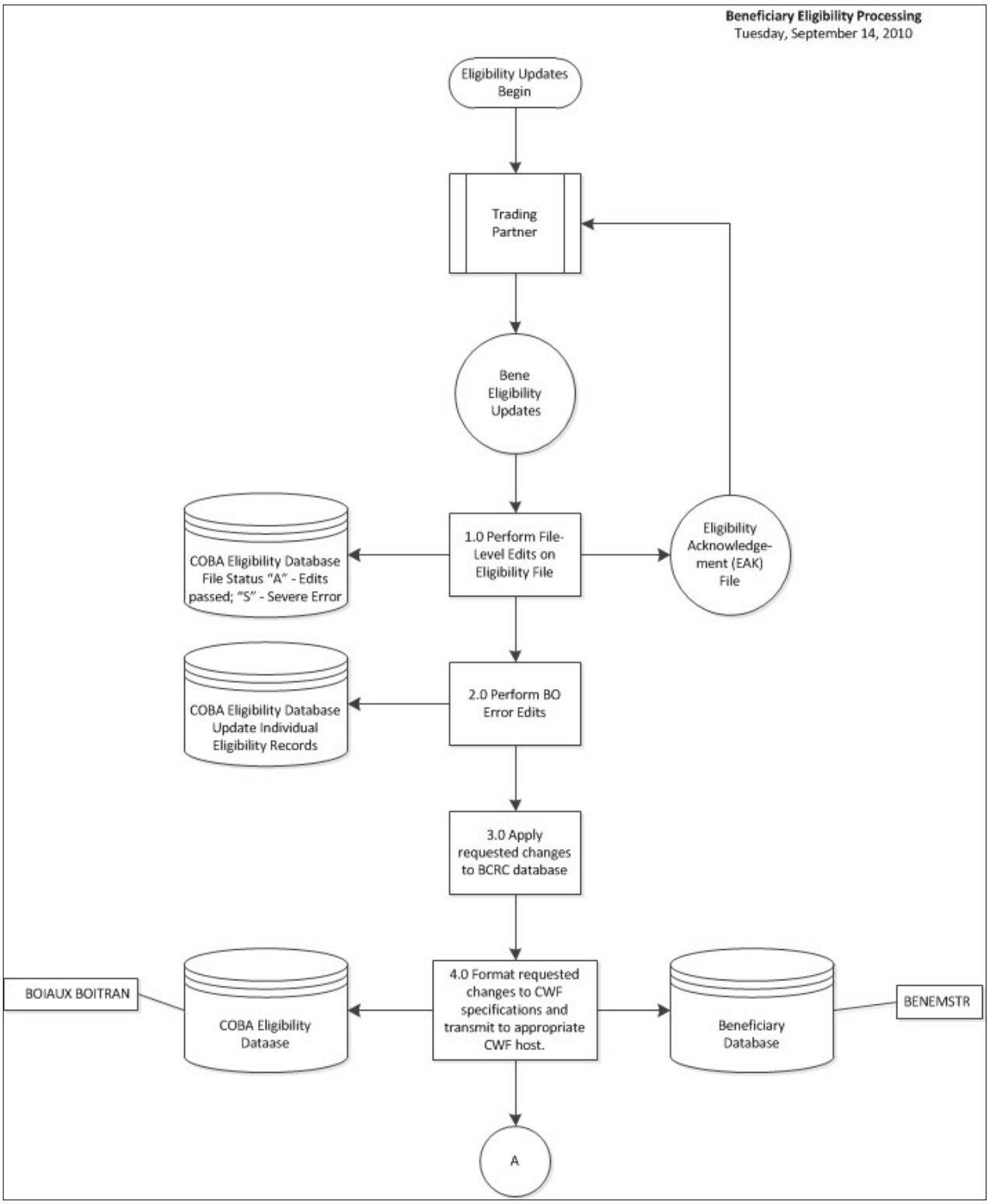
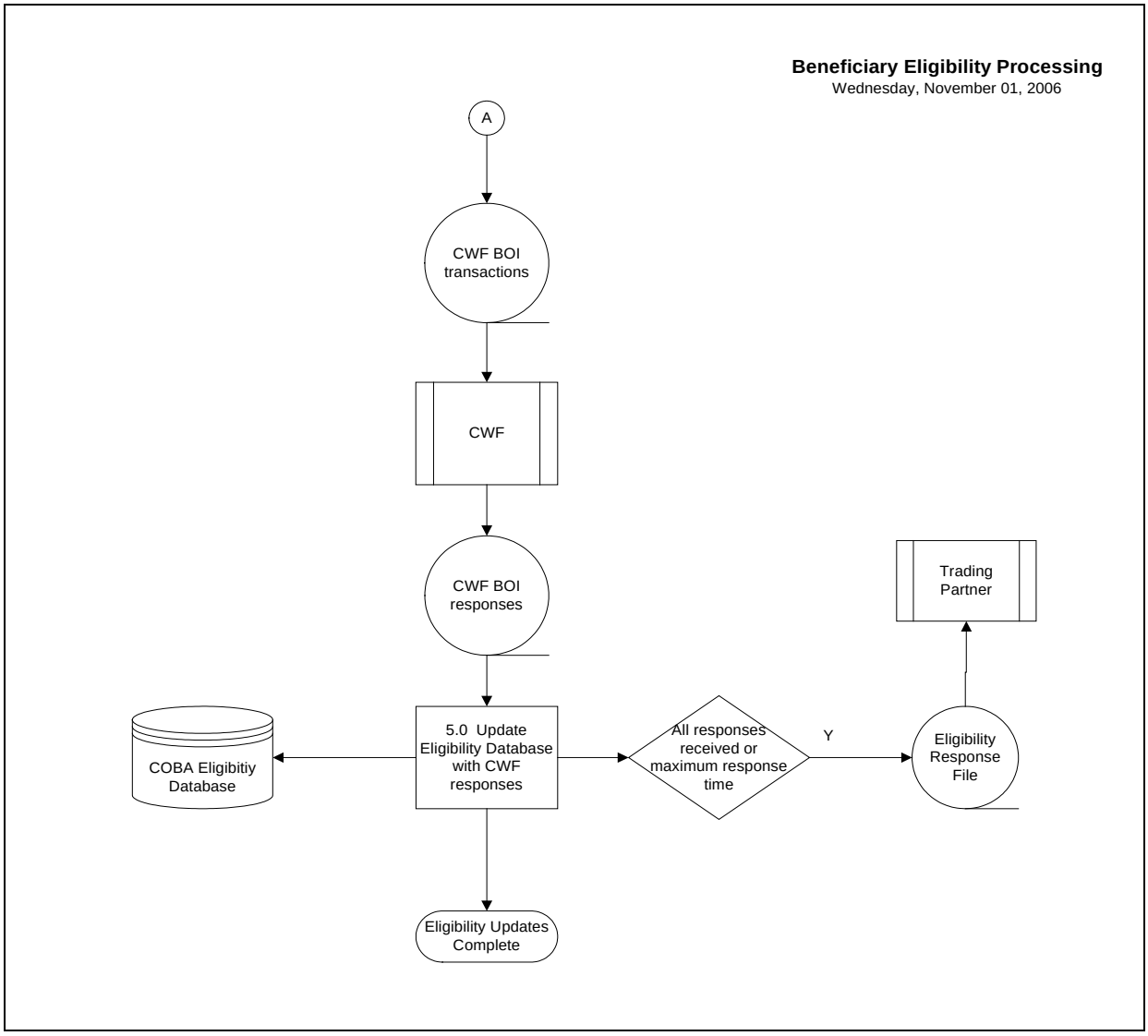


Figure 3-3: EO1 Flowchart (Part 2)



3.4.5.1. E01 Flowchart Narrative

1) Eligibility File is received from the trading partner containing add, update, and delete transactions. The BCRC system will perform file-level edits on the Eligibility File to either accept or reject the incoming file. The BCRC database will be updated with the file status of "A" (Accepted) or "S" (Severe error). The Eligibility Acknowledgement File (EAK) is created and returned to the trading partner indicating the file status along with an Error Description if there was a severe error.

2) BCRC performs record level match edit processing prior to sending the record to CWF. If a record fails the BO match editing, it is not sent to CWF for further processing and the BCRC database is updated with the corresponding BO error. The BO error will be transmitted back to the trading partner on the Eligibility Response File (ERF).

3) Eligibility records with requested changes that passed BCRC BO edits are applied to the BCRC database.

4) BCRC formats the requested changes to CWF specifications and transmits the records to the appropriate CWF host site.

5) BCRC receives and processes CWF responses. All “01” (accepted at CWF) responses are applied to the BCRC database. BCRC will continue to recycle response not received and update the database on a daily basis. Once all of the CWF Response files are received or 8 business days has elapsed since the transmission of the Eligibility File, the Eligibility Response File (ERF) will be returned to the trading partner. If a record is still recycling when the ERF is created, the record will have a disposition code of “50,” “52,” 60, AB, or CI, which signifies that the record still being processed by CMS. Trading partners should resubmit the record with their next file.

3.4.6. Sample Eligibility Acknowledgement and Response File

The following page displays a sample COBA Eligibility Acknowledgement and Response File. Refer to the Eligibility File Process previously described in this section for more information regarding the generation and purpose of this file.

Figure 3-4: Sample Eligibility Acknowledgement Files

```
XXXXXXXXXA  TEST12        RITA        19230129F1988010319880103R08062187        5220070206                        D
XXXXXXXXXA  TEST12        RITA        19230129F2004010800000000R08062187        0120070206            XXXXXXXXXA  A
XXXXXXXXXA  TEST13        ALICE       19191130F1978093000000000R01583874        5120070206            XXXXXXXXXA  A
XXXXXXXXXA  TEST13        ALICE       19191130F1978093019780930R01583874        BO20070206BO99                    D
XXXXXXXXXA  TEST14        IRENE       19210819F1987010119870101R17832422        5220070206                        D
XXXXXXXXXA  TEST14        IRENE       19210228F1987010100000000R17832422        BO20070206BO99                    A
XXXXXXXXXA  TEST15        ROBERT      19170326M1989010120041031R18428615        5520070206            XXXXXXXXXA  C
XXXXXXXXXA  TEST16        CHRISTINE   19320603F1997060119970601R50508471        5120070207            XXXXXXXXXA  D
XXXXXXXXXA  TEST16        CHRISTINE   19320603F1998060100000000R50508471        5220070206                        A
XXXXXXXXXA  TEST17        LEO         19280105M1999010119990101R58301791        5520070207            XXXXXXXXXA  D
XXXXXXXXXA  TEST17        LEO         19280105M2001010100000000R58301791        0120070206            XXXXXXXXXA  A
XXXXXXXXXA  TEST18       DOLORES      19320209F1997020100000000R03423388        0120070206            XXXXXXXXXA  A
XXXXXXXXXA  TEST19       CATHERINE    19411125F2006110100000000R58856079        0120070206            XXXXXXXXXA  A
XXXXXXXXXA  TEST20       JEAN         19130917F1990010100000000R50712903        0120070206            XXXXXXXXXA  A
XXXXXXXXXA  TEST20       JEAN         19110917F1990010119900101R50712903        BO20070206BO99                    D
XXXXXXXXXA  TEST21       KENNETH      19170627M1989010119890101R00926906        0120070206            XXXXXXXXXA  D
XXXXXXXXXA  TEST21       KENNETH      19160228M1989010100000000R00926906        BO20070206BO99                    A
XXXXXXXXXA  TEST22       RUTH         19190427F1992010100000000R61044706        0120070206            XXXXXXXXXA  A
XXXXXXXXXA  TEST22       RUTH         19190427F1992010119920101R51044706        BO20070206BO99                    D
XXXXXXXXXD  TEST23       KATHRYN      19200825F1989010119890101R07898715        0120070206            XXXXXXXXXD  D
XXXXXXXXXD  TEST23       KATHRYN      19200825F1989010100000000R07898715        BO20070206BO99                    A
XXXXXXXXXD  TEST24       KELLY        19170413F1992010100000000R03837919        0120070206            XXXXXXXXXD  A
XXXXXXXXXD  TEST24       EVA          19170413F1992010119920101R03837919        BO20070206BO99                    D
XXXXXXXXXA  TEST25       RUTH         19130821F1989010119890101R11771137        0120070206            XXXXXXXXXA  D
XXXXXXXXXA  TEST25       RUTH         19230821F1989010100000000R11771137        BO20070206BO99                    A
XXXXXXXXXA  TEST26       BUSTER       19150726M1980070119800701R00927432        0120070206            XXXXXXXXXA  D
```

```
XXXXXXXXXA  TEST26      BUSTER      19150726M1990070100000000R00927432          0120070206          XXXXXXXXXA  A
XXXXXXXXXA  TEST27      GLADYS      19131030F1989010120070101R26841594          0120070206          XXXXXXXXXA  C
XXXXXXXXXA  TEST28      LENNA       19150707F1989010120061029R02264594          0120070206          XXXXXXXXXA  C
XXXXXXXXXA  TEST29      MAXINE      19210903F1988010100000000R00926766          BO20070206BO01                  A
XXXXXXXXXA  TEST30      MICHAEL     19411117M2006110100000000R58075546          0120070206          XXXXXXXXXA  A
XXXXXXXXXA  TEST31      LARRY       19411109M2006110100000000R58328084          0120070206          XXXXXXXXXA  A
XXXXXXXXXB  TEST32      LARUE       19340321F2000090100000000R23677760          0120070206          XXXXXXXXXB  A
XXXXXXXXXA  TEST33      DENNIS      19411108M2006110100000000R14806983          0120070206          XXXXXXXXXA  A
```

3.5. E02 Eligibility (Drug) File Submission Process

Overview

Title 1 of the Medicare Modernization Act (MMA) of 2003 established a new voluntary outpatient prescription drug benefit under Part D of Title XVIII of the Social Security Act effective January 1, 2006. This new drug benefit, along with an employer subsidy for qualified retiree health plans, is referred to as **Medicare Part D.**

Purpose

The other drug coverage information supplied by the trading partners will enable CMS to pass along information so that pharmacies can electronically coordinate benefits in real time with other payers that provide drug coverage for Medicare beneficiaries

3.5.1. Drug Coverage and the COBA Program

Because the COBA program is designed to coordinate benefits with supplemental payers/insurers, prescription drug benefit information must be incorporated into the Eligibility Files exchanged between trading partners and the BCRC. Trading partners should submit drug coverage eligibility information through one of two channels: (1) an eligibility record, known as the **E02 record**, through the COBA program or via (2) the expanded mandatory insurance reporting (MIR) file format.

IMPORTANT: The CMS has made changes to the E-02 eligibility drug process as of July 2010 to convert all Full File process to Add/Update/Delete. The CMS has issued and posted E-02 file layout and process changes for the benefit of all COBA trading partners. Trading Partner will begin receiving an E02 Eligibility File Acknowledgement (EFA) and an E02 Eligibility Response File (ERF), similar to the E01 process.

Regardless of the channel selected by a given trading partner, CMS will handle the information as follows:

- CMS will collect and compare supplemental payers' drug coverage information submitted by the trading partner with a beneficiary's enrollment in Medicare Part D.
- Where a match occurs, CMS will pass the other drug coverage information to the Part D plans and notify the supplemental payers about the beneficiary's entitlement to Medicare Part D benefits via a response file.
- Where no match occurs, CMS will drop the information from its files.

CMS prefers that trading partners submit drug coverage information for their **inactive** (retired) covered beneficiaries through the COBA process and that trading partners submit drug coverage information for their **active** (not retired) covered beneficiaries through the expanded MIR file format. The COBA process cannot be used to submit drug coverage for the insurers' active covered beneficiaries.

3.5.1.1. E02 Eligibility File Acknowledgment (EFA)

Syntactical data validation routines will be applied to all Eligibility Files. The BCRC will initially edit the Eligibility File and transmit an EFA back to the trading partner containing a matching header record from the submitted file, a count of E02 records submitted, whether the Eligibility File was accepted (Status code = "A") or had a fatal (severe) error (Status code = "S"), and an error description. If a severe error occurs, it is the trading partner's responsibility to correct the

error and retransmit the file to the BCRC. The table below provides the error type and definition of Eligibility File fatal errors. The COBA Eligibility File (E02) Acknowledgement Layout is available for download at http://www.cms.gov/Medicare/Coordination-of-Benefits/COBAgreement/.

Table 3-9: E02 Eligibility File Acknowledgment Severe Error Types

Error Type	Description
FULL FILE REPLACEMENT NOT ALLOWED	Full File replacement no longer allowed, only A/U/D eligibility files accepted.
INVALID COBA ID	The COBA ID on the file does not conform to the required specifications, i.e., must be prefixed with zeros to a length of 10.
INVALID HEADER FORMAT	E00 record does not conform to format stated in the file format.
MULTIPLE FILES ENCOUNTERED WITH THE SAME COBA ID	More than one file has been submitted at the same time for a single COBA ID.
QUERY NOT ALLOW – NO E02 DRUG ELIGIBILITY INFORMATION SUBMITTED IN PRIOR 12 MONTHS	Query only file sent in when no E02 drug information has been submitted within the prior 12 months.
RECORD COUNT IN TRAILER DOES NOT MATCH ACTUAL RECORD COUNT OR TRAILER COUNT DOES NOT MATCH RECORD COUNT	The record count denoted in the trailer record does not match the actual record count.
TRAILER TOTAL DOES NOT MATCH RECORD TOTAL	E01 count plus E02 count within trailer does not match the overall total.

3.5.2. COBA Drug Coverage Record Layouts

The information collected in the E02 is used to create a Coordination of Benefits (COB) record that will be transmitted to the beneficiary's Part D Plan and the TrOOP Facilitation Contractor for appropriate claims payment order determinations, TrOOP calculation, and point-of-sale COB. Please note the following:

- The E02 record is **not** used in the COBA process to trigger crossing over of supplemental Part D claims to supplemental insurers after Medicare has made payment.
- E02 submissions should be submitted for your members who have supplemental drug coverage. If you are a Prescription Drug Plan (PDP), do not submit the Part D coverage that falls under the PDP plan.
- It is possible that a member can appear on an E02 record for supplemental drug coverage and not on the E01 record for supplemental hospital and medical coverage in the following cases:
  - The member only carries supplemental drug coverage. Since no COB Agreement exists, a separate privacy agreement must be signed and a unique COBA ID will be assigned.
  - The insurer is supplying the drug coverage but does not want to receive claims for the member as the result of its E01 submission in association with existing supplemental hospital and medical coverage. If the insurer has signed a COB Agreement and has a COBA ID, there is no need to have a unique COBA ID for the E02 drug coverage, unless requested.
- The submitter of the E02 must have signed a COB Agreement (except in the situation above where the member only carries supplemental drug coverage) or must administer drug coverage

benefits for the trading partner that has signed the COB Agreement. In this situation, those administering the drug coverage must be listed in Section V of the COBA Attachment.

- Insurers who do not know if their members with drug coverage are "active" (working aged, according to the Medicare Secondary Payer rules) or "inactive" (retired) must obtain that information prior to including the member on the E02 file. Only "inactive" members may be included on the E02 record. The "active" members are reported through the expanded MIR file reporting process and are **not** to be included on the E02 file.
- In all situations listed above, the E02 record can be used for exchange of data purposes.
- Note: The COBA ID is a 10 position numeric field, which must be prefixed with leading zeroes (e.g., 0000012345).
- Insurers in COBA production that submit drug eligibility data may **Query** using the E02 record to receive a response file identifying the member as having Part D coverage. A supplemental drug coverage COB record will not be created when the Transaction Type is 'Q' Query Only.

3.5.2.1. E02 Query Process and Required Matching Criteria

As of July 2010, the E-02 query process will be strictly limited to those COBA trading partners that submit drug eligibility data via the E-02 file. Effective with July 2010, COBA Trading Partners that attempts to perform a query transaction and have not contributed drug eligibility information within the prior 12 months will receive a severe error.

As of July 2010, CMS is making available through its BCRC the Health Eligibility Wrapper (HEW) 270/271 software to allow "production" COBA trading partners to make routine eligibility queries. COBA trading partners will be expected to designate in their re-executed COBA Attachment that CMS made available during the first quarter of calendar year (CY) 2010 their intention to use the HEW 270/271 compliant software.

HEW-Required Matching Criteria

- When only the Social Security number (SSN) is known and at least three of the four personal identifiers' match, the HICN will be returned.
- When the HICN is correct, and at least three of the four personal identifiers match, the correct personal identifier that did not match initially will be returned on the response file. Note: When the HICN sent on the query is incorrect, the corrected HICN will not be returned.
- In the situations listed above and when the HICN and three of the four personal identifiers do match, Medicare Part A, B, and C enrollment data will be returned.

E-02-Required Matching Criteria

- When only the Social Security number (SSN) is known and at least three of the four personal identifiers' match, the HICN will be returned.
- When the HICN is correct, and at least three of the four personal identifiers match, the correct personal identifier that did not match initially will be returned response file. Note: When the HICN sent on the query is incorrect, the corrected HICN will not be returned.
- In the situations listed above and when the HICN and three of the four personal identifiers do match, Medicare Part A, B, C, and D enrollment data will be returned.

- When the HICN and three of the four personal identifiers match, CMS will create a COB record
- When populating the BIN/PCN fields, the partner should only use its drug specific BIN and/or PCN or the BIN/PCN that the Pharmacy Benefit Manager (PBM) has acquired for coverage that is supplemental to Part D. The partner should populate the BIN/PCN fields with the drug specific BIN/PCN despite whether or not it knows that the individual is enrolled in Part D. If the individual is enrolled in Part D, a COB record will be created using the drug specific BIN/PCN record, which designates coverage supplemental to Part D. Otherwise, when the individual is not Part D enrolled, the COB Contractor will reject the E02 and no COB record will be created.

Definition – Part D Enrollment/Termination (Applicable to Those Who Submit Drug Eligibility Files to CMS to Supplement Medicare Part D)

- Current Part D Plan Enrollment Date: Refers to a Medicare beneficiary that is eligible, has applied for, and has coverage through a Part D Plan.
- Current Part D Plan Termination Date: Refers to the date that beneficiary is no longer receiving benefits under the Part D Plan.
- In the response files CMS sends you, the Current Part D Plan Enrollment Date provides the effective date of coverage for the Part D benefit by the specific Part D Plan listed as the Current Medicare Part D Plan Contractor Number. The Current Part D Plan Termination Date is the date that beneficiary is no longer receiving benefits under that Part D Plan. These dates are the most important for our data-sharing partners because they let you know whether the beneficiary has actually elected coverage under Part D and the time period in which the Part D coverage is in effect. In summary, a Medicare beneficiary can be eligible for Part D, but unless the beneficiary is enrolled in a Part D Plan, the beneficiary is not receiving Part D benefits.

Personal Identifiers

- Surname
- First Name
- Date of Birth
- Beneficiary Sex Code

Refer to the COBA Drug Coverage Eligibility (E02) Record Layout and the COBA Drug Coverage Eligibility Response (E02) Record Layout, which are available for download at http://www.cms.gov/Medicare/Coordination-of-Benefits/COBAgreement/.

3.5.2.2. Conventions for Describing Data Values

Table 3-10 defines the data types used by COB for its external interfaces (inbound and outbound). The formatting standard defined for each data type corresponds to the data type identified for each field within the interface layout.

This key is provided to assist in the rules behind the formatting of data values contained within layout fields.

A flowchart of the COBA Drug and Part D processing is included in the Flowcharts that follow the E02 Edit Error Listing.

Table 3-10: Data Type Keys

The following standards should be used unless otherwise noted in layouts.

Field	Format Standard	Example
Numeric	• Zero through 9 (0 → 9) • Padded with leading zeroes • Populate empty fields with spaces	• Numeric (5): "12345" • Numeric (5): "00045" • Numeric (5): " "
Alpha	• A through Z • Left justified • Non-populated bytes padded with spaces	• Alpha (12): "TEST EXAMPLE" • Alpha (12): "EXAMPLE "
Alpha-Numeric	• A through Z (all alpha) + 0 through 9 (all numeric) • Left justified • Non-populated bytes padded with spaces	• Alphnum (8): "AB55823D" • Alphanum (8): "MM221 "
Text	• A through Z (all alpha) + 0 through 9 (all numeric) + special characters: • Comma (,) • Ampersand (&) • Space ( ) • Dash (-) • Period (.) • Single quote (') • Colon (:) • Semicolon (;) • Number (#) • Forward slash (/) • At sign (@) • Left justified • Non-populated bytes padded with spaces	• Text (8): "AB55823D" • Text (8): "XX299Y " • Text (18): "ADDRESS@DOMAIN.COM" • Text (12): " 800-555-1234" • Text (12): "#34 "
Date	• Format is field specific • Fill with all zeroes if empty (no spaces are permitted)	• CCYYMMDD (e.g. "19991022") • Open ended date: "00000000"
Filler	• Populate with spaces	-
Internal Use	• Populate with spaces	-

3.5.3. E02 Edit Error Listing

The errors and disposition codes for the records with drug coverage that would apply are as follows:

Table 3-11: Disposition Code

Disposition	Description
51	HICN/SSN Not Found
55	Less Than 3 Fields Match

Table 3-12: Edit Error Listing

SP Code	Description
SP 12	Invalid HIC Number. Field must contain alpha or numeric characters. Field cannot be blank or contain spaces.
SP 13	Invalid Beneficiary Surname. Field must contain alpha characters. Field cannot be blank, contain spaces or numeric characters.
SP 14	Invalid Beneficiary First Name Initial. Field must contain alpha characters. Field cannot be blanks, contain spaces, numeric characters or punctuation marks.
SP 15	Invalid Beneficiary Date of Birth. Field must contain numeric characters. Field cannot be blanks, contain spaces or alpha characters. Day of the month must be correct. For example, if month = 02 and date = 30, the record will reject.
SP 16	Invalid Beneficiary Sex Code. Field must contain numeric characters. Field cannot be blank, contain spaces or alpha characters. Acceptable numeric characters include the following: 1 = Male 2 = Female
SP 19*	Invalid Transaction Type. Field must contain numeric characters. Field cannot be blank, contain alpha characters or spaces. Acceptable numeric characters must include the following: 0 = Add Record 1 = Delete Record 2 = Update Record
SP 24	Invalid Network Indicator. Field must contain numeric characters. Acceptable numeric characters include the following: 0 = Non-network (paper or Batch) 1 = Network (Point of Sale)
SP 31	Invalid Effective Date. Field must contain numeric characters. Field cannot be blank, contain spaces, alpha characters or all zeros. Number of days must correspond with the particular month.
SP 32	Invalid Coverage End Date. Date not in proper format.
SP 62	Incoming termination date is less that effective date. MSP termination date must be greater than the effective date.

***Note:** BCRC converts the inbound transaction type from alpha characters into numeric values. Additionally, the BCRC will provide RX specific errors (Table 2-13).

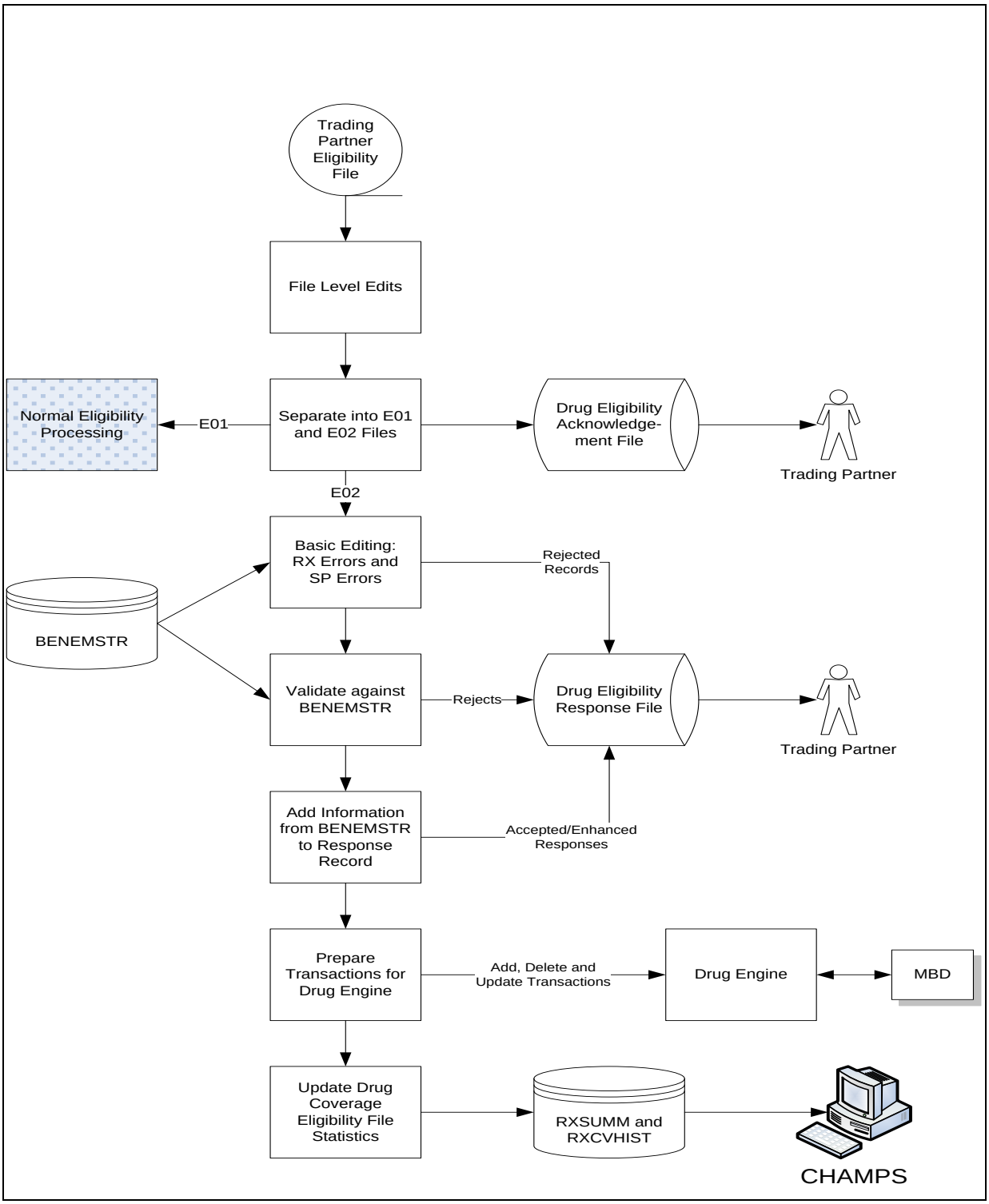
Table 3-13: RX Codes

RX Code	Description
RX 01	Missing RX ID
RX 02	Missing RX BIN
RX 03	Missing RX Group Number
RX 04	Missing Group Policy Number
RX 05	Missing Individual Policy Number
RX 07	No Part D Dates Found
RX 12	Invalid Supplemental Type

3.5.4. E02 Flowchart

The following flowchart displays the process flow of receiving, editing, and validating trading partner's drug records.

Figure 3-5: E02 Flowchart Process



3.5.5. Notification Timeframes for Non-Receipt, Indecipherable, and/or Damaged Files

If the Eligibility File is not readable, the receiving party agrees to notify the sender within seven (7) business days from receipt of the file by telephone. The sender shall send a replacement Eligibility File to the receiving party. Until receipt of the replacement Eligibility File, the CMS Contractor will transfer claims based on the last transmitted Eligibility File that was readable and was posted to CMS' Common Working File.

If the sender does not receive an Eligibility File Acknowledgement within three (3) business days from the transmission date, the sender shall contact the CMS Contractor by telephone.

3.6. Claims File Process

Overview

Well over 1 billion Medicare claims are processed annually. Approximately 600 million of those are crossed over to other payers, including 200 million to Medicaid. CWF will annotate claims that are to be crossed over. Only these claims will be sent to BCRC.

Process

Medicare contractors, courtesy of their Data Centers, submit all claims for crossover to the BCRC nightly via 837 flat file formats and/or NCPDP. **IMPORTANT:** It is a CMS requirement that Medicare contractors are only to send adjudicated claims to the BCRC once they have met their claims payment floor requirements. Under current directives, Medicare contractors must not pay adjudicated Part A, B, or DMEPOS electronic claims until they have reached a system's age of 14 calendar days (factoring in a 3 day transmission timeframe) as determined by the Julian date within each claim's Internal Control Number (ICN) or Document Control Number (DCN). Incoming claims submitted via hard copy of via Direct Data Entry (DDE) are held for 29 days from date of receipt—again, as determined by the Julian date within the claim's ICN or DCN. Adjustment claims, fully denied claims, and claims applied entirely to the deductible are not held on the Medicare contractors' claims payment floor. Thus, upon initiation of testing or upon moving into production, COBA trading partners will note that the above exception claims will show up in about 2 or 3 calendar days rather than 11-14 days.

The BCRC will edit claims for required elements. Any files that fail business edits for claim structure will not be processed. Instead, the BCRC will ask the contractors to re-transmit the entire file. Upon acceptance of the file, the BCRC will run the file through its customized claims translator to convert the file to an outbound HIPAA ANSI format and perform HIPAA validation. Then, after referencing the frequency and media type specifications established in the COBA database for the trading partner, the BCRC will sort the claims by COBA IDs for transmission to the trading partners.

The BCRC's translator will edit to the level of compliance mandated by the HIPAA 837 Implementation Guide or as directed by CMS' Business Applications Management Group. "Gap filling" will always occur when mandatory fields do not contain values. The Medicare contractors' system will be responsible for producing "gap filling" on the 837 flat files for crossover. Medicare gap-filling procedures tied to 4010-A1 claims are available for download at http://www.cms.hhs.gov/COBAgreement/01_overview.asp. **Note:** Medicare gap-filling instructions for 5010 may be referenced in the HIPAA 5010 Companion Guide.

IMPORTANT: In accordance with acceptable EDI parameters and following CMS directive, the BCRC transmits all outbound crossover claim files only in an 80-byte wrapped format.

3.6.1. File Structure

A COBA trading partner will receive up to three claims files (Institutional, Professional, and NCPDP) per COBA ID (1 per format) or three per all COBA IDs, based upon the exclusion criteria selected in the COB Agreement. All electronic claims, with the exception of NCPDP transfer claims, must be received in the current HIPAA ANSI institutional/professional claim formats approved by the Secretary of the U. S. Department of Health & Human Services. NCPDP batch COB claims will be sent in the current NCPDP format also approved by the Secretary of Health & Human Services. (Note: Data validation routines will be applied to all outbound files.)

The physical file is broken down by ST-SE segment, not by contractor identification number. The originating Medicare contractor number will appear in the 1000A Loop. COBA IDs that may be referenced in the 1000B loop within the ST-SE envelope can be used to distinguish claims by individual trading partners. There will be one functional group per ISA to IEA envelope (i.e., one functional group per transmission). The ISA-IEA can contain multiple ST-SE envelopes that can contain up to 5,000 claims per ST-SE envelope. There is no way to limit how many ST to SE envelopes will be in a transaction (ISA to IEA). There will be separate ST-SE groups for each contractor.

Trading partners should not expect separate GS-GE functional groups for each Medicare contractor. There will be only one GS-GE functional group per transmission (i.e., a single 837 COB file (ISA to IEA).

Each claim for service submission request may contain up to four occurrences of claims/service data. The Medicare contractor will enter the Medicare paid amount and any deductible and coinsurance amount applied to the item on the COB file. Medicare adjudicates Part B-oriented claims, including outpatient facility-oriented claims, at the line level. By contrast, it adjudicates Part A inpatient-oriented claims at the claim level.

A HIPAA crosswalk document is provided in Table 3-14.

Table 3-14: Medicare Part A & B 837 HIPAA Claims from COBA

Header Type	Name	Description
ISA Interchange Control Header	-	-
ISA06	Interchange Sender ID	Literal “COBA” (without quotes)
ISA08	Interchange Receiver ID	PAYER SUPPLIED ID (specified in the COBA contract)
ISA13	Interchange Control Number	EDI 837 File ID (Unique ID for each ISA transmitted)
GSA Functional Group Header	-	-
GS02	Application Sender’s Code	Literal “COBA” (without quotes)
GS03	Application Receiver’s Code	PAYER SUPPLIED ID (specified in the COBA contract)
ST	Transaction Set Header	-

Header Type	Name	Description
Loop ID - 1000A Submitter Name	-	-
NM1	Submitter Name (NM101 = 41)	NM109 will contain the Medicare contractor's ID.
Loop ID – 1000B Receiver Name	-	-
NM1	Receiver Name (NM101 = 40)	NM109 will contain the Payer's COBA ID.
Loop ID - 2010BA Subscriber Name	-	-
NM1	Subscriber Name (NM101 = IL)	NM109 contains the Supplement Insurance ID if the eligibility file contains the subscriber ID. Otherwise, Medicare HIC# of the insured.
Loop ID - 2010BB (837P) 2010BC (837I) Payer Name	-	-
NM1	Payer Name (NM101 = PR)	NM109 will contain the Payer's COBA ID.
Loop ID - 2330A Other Subscriber Name	-	-
NM1	Other Subscriber Name (NM101 = IL)	NM109 will contain the Medicare HIC# of the insured.

- **Data Elements**

The following information will be reported in the data elements:

- ISA05 – ZZ
- ISA06 (Interchange Sender ID) – COBA
- ISA07 and ISA08 – defined by the trading partner
- GS02 (Application Sender Code) – COBA
- GS03 – This will contain the same value as ISA08; whatever the trading partner requests in ISA08 will also display here.
- NM109 in loop 1000A—CMS contractor-assigned ID
- NM109 in loop 1000B—COBA ID
- NM109 [NM1 segment] in loop 2010BB (Professional)—COBA ID
- NM109 [NM1 segment] in loop 2010BC (Institutional)—COBA ID NM109 in loop 2330B—COBA ID (Note: If the trading partner referenced in the 2330B loop has executed a COBA, its COBA ID will appear in the NM109 field. If the trading partner has not executed a COBA but does have a crossover agreement directly with a Medicare contractor, the NM109 field will contain the ID that the contractor uses to identify that trading partner.

Note: All Medicare secondary payer claims should be edited for balancing purposes at both the line level and claim level. This is a Medicare contractor function, not a BCRC function.

- **Adjusted Claims**

Adjusted claims can be identified in the Claims Adjustment segment (CAS), as found in the 2320 loop (claim level) and in the 2430 loop (line level), for both the 837 Institutional and Professional claim. The value reported in 2300 CLM05-3 also will indicate whether the claim is original versus adjustment.

- **Multiple Providers with the same Medicare number**

The 837 will contain the Contractor ID found in the 1000A loop, which will result in a unique combination of provider number and Medicare contractor ID.

- **NM109 of the 2330A Other Subscriber Name loop**

If the trading partner provides a supplemental insurer ID on the incoming Eligibility File, the BCRC will populate the NM109 field of 2330A in the first iteration of the 2320 loop with that value. If no supplemental insurer ID is provided, the BCRC will populate this field with the HIC number.

- **EIN**

The EIN cannot be reported for a billing provider in an 837 file with a leading zero followed by the nine-byte EIN.

The 837P COB files will contain the national provider identifier (NPI) for the billing provider in loops 2010AA (billing provider) in NM109, qualified in NM108 with XX. The NPI of the referring physician will appear in 2310A NM109. The NPI of the rendering physician will appear in 2310B NM109 and in 2420A NM109. Finally, the NPI of the ordering provider will appear in 2420E NM109.

At a minimum, the 837-I COB files will contain the NPI for the billing provider in loop 2010AA NM109, with NM108=XX. (**Note:** The pay-to provider address will be reported in the 2010AB N3 and N4 segments if this address differs from that of the billing provider, as reported in the 2010AA N3 and N4 segments.) The 837-I claims will also typically include the NPI for the Attending Physician in 2310A NM109 and in 2320A NM109.

A unique identifier can be created for ISA 13, Interchange Control Number.

The sender, receiver, creation date, and the ISA control number will uniquely identify the generation of the file.

- **REF Segments**

Under 4010-A1, the only REFs that will be created for provider information on crossover claims are those that qualify the Billing Provider for EIN/Tax ID. In terms of 837-P, the BCRC will also pass along REF segments containing OB or LU qualifiers.

Under 5010, the **only** REF that will be created is the one that qualifies the Billling Provider in 2010AA REF. From CMS' perspective, this meets the compliance requirements that came into play with the full implementation of the NPI in May 2008.

3.6.2. Test Claims

The BCRC will provide parallel test claim files to the payers during transitional periods leading up to the mandatory conversion date to new claims format. During the testing phase, the BCRC will populate "T" for "Test" to the ISA-15. Extensive parallel production testing will hopefully mitigate the potential for any problems during implementation.

3.6.3. NCPDP

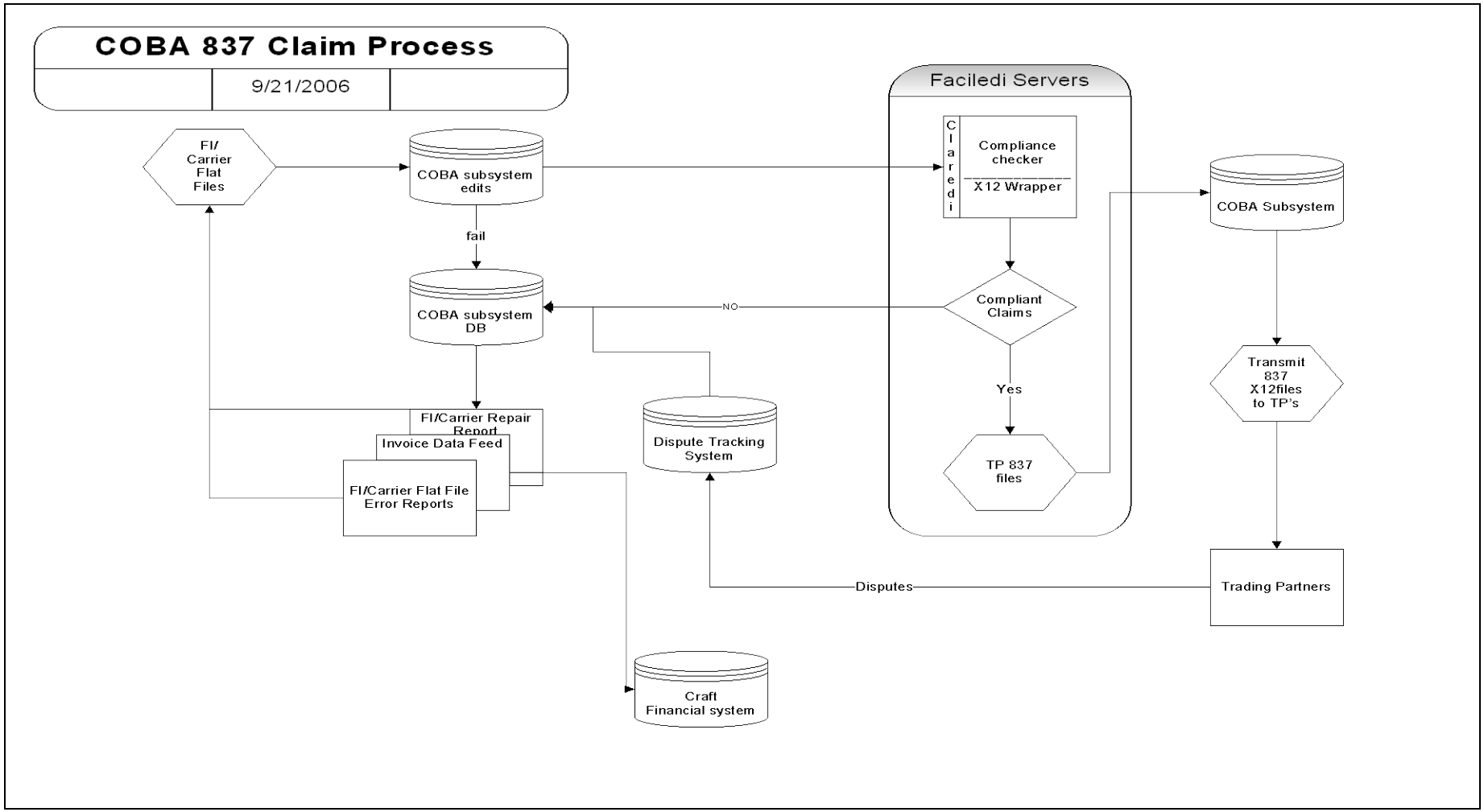
NCPDP batch COB claims will always reflect a provider assignment indicator value that equates to “accepts assignment.” Depending upon the type of transmission, the trading partner may receive only 1 service line per NCPDP claim.

For questions regarding examples of Part B drug claims that would fall within the scope of the National Council for Prescription Drug Programs implementation guide, refer to the NCPDP Web site at http://www.ncpdp.org.

3.6.4. COBA Claims File Process

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

Figure 3-6: COBA Claims File Process



3.6.5. Formats

Prior to January 2012, the BCRC will forward all COBA claims in the following American National Standards Institute (ANSI) X12N file formats—ANSI 837 Version 4010A1 (Institutional) and ANSI 837 4010A1 (Professional)—and the National Council for Prescription Drug Programs (NCPDP) version 5.1 batch standard 1.1 format for drug claim transactions. As COBA trading partners transition to the new claims standards, they will receive 837 institutional professional claims in the HIPAA ANSI 837 5010 format first in test mode and later in production. The same is true of NCPDP claims. During the transitional timeframe, interested COBA trading partners will first receive NCPDP D.0 test claims and later will receive these claims in production.

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

For HIPAA 4010A1 and NCPDP 5.1 Claims:

- The ASC X12N 837: Professional Implementation Guide
- The ASC X12N 837: Institutional Implementation Guide
- The NCPDP: Retail Pharmacy Transactions

For HIPAA 5010 and NCPDP D.0 Claims:

- TR-3 837 Institutional and Professional Guides
- NCPDP D.0 Implementation Guide

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

3.6.6. Frequency

The COBA process will support a daily, weekly, bi-weekly, and monthly transfer of claims. The trading partner will need to indicate the frequency with which it wishes to receive electronic claims in the COBA Attachment. The trading partner may also specify the day (for weekly or bi-weekly) or date (for monthly transfer) that it wishes to receive claims. However, the time of day cannot be specified.

Additionally, the trading partner must provide 15 days advance written notification to the BCRC for any modifications to its existing COBA claims selection criteria.

3.6.7. Companion Guides

For guidance regarding values that may appear on outbound 837 institutional and professional claims (version 4010A1), the interested party should refer to:

http://www.cms.hhs.gov/transmittals/Downloads/R83OTN.pdf

COBA trading partners wishing to test the HIPAA 5010 and NCPDP D.0 transactions with BCRC will receive the applicable Companion Guides first by COBVA e-mail broadcast. Trading partners that need copies of the Companion Guides should speak to their designated EDI representative.

3.6.8. Claims Adjustment Reason Codes and Remittance Advice Remark Codes

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

- **Claim Adjustment Reason Codes:** These codes communicate why a claim or service line was "adjusted" (or paid at a value less than was billed).
- **Remittance Advice Remark Codes:** Remark Codes add greater specificity to an adjustment reason code.

3.6.9. HIPAA Issues Logs (Agree/Disagree)

CMS tracks all HIPAA-related Medicare crossover claim issues in a HIPAA Issues Log that is posted to the CMS Web site at http://www.cms.gov/Medicare/Coordination-of-Benefits/COBAgreement/. The log is used by CMS' Medicare contractors to schedule HIPAA claim-related fixes to their shared systems; by the trading partners to identify and schedule HIPAA claim-related fixes; and by CMS and the BCRC to monitor HIPAA claim-related fixes that impact COBA production. Regular updates to the HIPAA Issues Log are posted to the Web site along with the date the issue is closed.

If the issue is ruled as an "Agree" by CMS' Division of Medicare Billing Procedures (DMBP), CMS will monitor the necessary fixes by CMS' Medicare contractor shared systems. If the issue is ruled as a "Disagree," the trading partner is expected to "ready" its systems to accept the claim as described on the HIPAA Issues Log. Prior to COBA production, CMS expects the trading partner to schedule the fixes to ensure completion by its scheduled COBA production date.

Trading partners should continue to monitor the "Agree" and "Disagree" HIPAA claim-related issues and continue to "ready" their systems when notified of a "Disagree" ruling. The following procedures will be implemented when DMBP has ruled on a HIPAA-related claim issue:

1) Trading partners are notified via COBVA e-mails of the status of both issues as follows: "Disagree," when a final DMBP ruling is received, and "Agree," when resolution is final/may be a future date.

2) The CMS Web site is updated bi-weekly, at a minimum, with the "Disagree" issues. "Agree" issues will move to the Web site as Medicare contractor fix dates are met or other resolution is final.

3) The BCRC will lift edits on "Disagree" issues 60 calendar days from the COBVA e-mail notification noted in (1) above. Trading partners should be prepared to receive Medicare crossover claims as described in the specific Loop ID immediately after the edit is lifted.

3.7. Dispute File Process

Overview

In a continuous effort to improve the COBA (Coordination of Benefits Agreement) Dispute Process, the following information has been developed to provide our COBA trading partners with a basic outline of the COBA dispute process. The BCRC, on behalf of CMS, will only consider disputes filed using the COBA dispute file layout. All disputes must be launched before the COBA claims invoice payment due date. For Medicaid agencies that utilize the dispute file process, this means no greater than 60 days after the BCRC transmits the crossover claims to them. In addition, if a COBA trading partner is disputing a claim on the basis of dispute reason code "000700," the COBA trading partner must cite the loop, segment, and element that it is

determining to be non-compliant (e.g., 2310B NM103). The COBA trading partner must also provide a detailed explanation when it registers dispute reason code “000999” (other).

The Claims Dispute File Layout and Specifications, which is available for download at http://www.cms.gov/Medicare/Coordination-of-Benefits/COBAgreement/, must be referenced when you are filing a dispute. The file layout contains important information, including the technical requirements of a dispute file, necessary for resolution. For all three levels of dispute, it is required that a COBA Problem Inquiry Request Form is completed and submitted to cobva@ghimedicare.com. The COBA Problem Inquiry Request Form is also available for download at http://www.cms.gov/Medicare/Coordination-of-Benefits/COBAgreement/.

Please note that prior to filing a dispute, COBA trading partners should review the BCRC/HIPAA Issues Logs at the same CMS Web site listed above. If the issue associated to a potential dispute is listed under the Agree tab, the Medicare contractor(s) should have a fix scheduled to correct the issue, avoiding future disputes. If the issue is listed under the Disagree tab, CMS has ruled that the issue is HIPAA compliant; therefore, the proposed dispute will not be accepted.

3.7.1. Dispute Submission Process

- **ANSI 837 Processing Errors**

  Some claims may be flagged as errors when a trading partner processes the ANSI 837 claims received from the BCRC, through its pre-editor/translator. A trading partner should identify to the BCRC ANSI 837 or NCPDP claims that it should not have received or which contain invalid data or values. Below are three possible levels of claims dispute for the ANSI 837 files, with the appropriate reporting method indicated for each. Note that a COBA Problem Inquiry Request Form (COBAF020) must be completed for all three levels of claim disputes. All COBAF020 forms must be sent to the general EDI representative e-mail address, cobva@ghimedicare.com.

  ISA-IEA (Interchange (ISA-IEA) Level) (Batch and Transmission Level for NCPDP Claims)

  In the interchange level, all the claims transmitted in the interchange are rejected. Report ISA-IEA disputes via the COBA Problem Inquiry Request Form (COBAF020) process. Include the following information on the COBAF020, and in addition, report all rejected claims or claim disputes to the BCRC through the Claim Dispute Flat File: ISA Date, Dispute Reason Code, and one ICN (claim number) from the transmitted file.

  In addition to sending the COBA Problem Inquiry Request Form (COBAF020) via e-mail to cobva@ghimedicare.com, you **must** also call your EDI representative directly or the general EDI representative line to report the problem

  ST-SE (Transaction ST-SE Level)

  At the transaction level, all the claims in a transaction set (ST – SE envelope) are rejected. Report ST-SE level disputes using Claim Dispute Flat File and send completed COBA Problem Inquiry Request Form (COBAF020) to the BCRC via e-mail. Include the following information: ISA Control Number, ISA Date, ST Control Number, Dispute Reason Code, and one ICN number from the transmitted file.

  It is advised that you also call your EDI representative directly or the general EDI representative line to report the problem.

Claim Level (Claim/Transmission Level Segments for NCPDP Claims)

Report rejected claims or claims disputed at claim level to the BCRC through the Claim Dispute Flat File and email a completed COBA Problem Inquiry Request Form (COBAF020) denoting your dispute to cobva@ghimedicare.com.

Step 1. Trading partner prepares a file in the Claim Dispute Flat File Layout, which includes a list of the Dispute Reason Codes. The file must include a Dispute Reason Code.

Step 2. The trading partner transmits the dispute file to the BCRC to the following filename: 'PCOB.BA.NDM.COBA.CBXXXXX.DISPUTE(+1) XXXXX = TP assigned COBA ID. For SFTP/HTTPS users please see Section 3.3.2.2.2.

Step 3. Trading partner notifies the BCRC via e-mail that a dispute file has been transmitted; a completed COBA Problem Inquiry Request Form (COBAF020) (Note: The count must include the header and trailer record).

Step 4. The BCRC will acknowledge receipt of the dispute file via e-mail.

Step 5. Upon completion of the investigation an addition e-mail notification will be sent to the trading partner. Please note:

If the investigation determines the claim(s) should not have crossed, the claim(s) is flagged as dispute resolution (A – Agree).

If the investigation determines the claim(s) crossed correctly, the claim(s) is flagged as dispute resolution (R – Reject).

Note: Disputed claims that are accepted (A-Agree) are sent to the COBA Receivable Financial Tracking System for credit adjustments. Conversely, payment is expected for rejected disputed claims (R-Reject) that the BCRC had already transmitted to the trading partner. A dispute can occur before or after an invoice is generated for the particular claim(s).

Post Invoice - If the trading partner has already been billed for the accepted disputed claim(s), a credit is issued for the claims that can be applied to the current or future invoice.

Pre-invoice - If the trading partner has not been billed for the claim, it will be removed from the crossover claim table and will not appear in the next invoice.

Again, please note that disputes must be submitted to the BCRC by the claims invoice due date. The BCRC will not accept any type of claim disputes on invoices past the due date that is printed on the invoice. The invoice due date is thirty (30) calendar days from its date of issue.

- **Duplicate Claim**

  The BCRC front-end edits and HIPAA validation software are designed to capture duplicate files sent by Medicare contractors. Within the BCRC HIPAA validation software, a signature value is created of each ST-SE transaction set, which is calculated based on the position and value of each byte of data within the transaction set. For each ST-SE transaction set a comparison of the signature value is performed against those received over the past six (6) months. If all bytes of data in the incoming ST-SE transaction set match with a previously submitted ST-SE transaction set, the signature values will be the same and the transaction set is rejected as a duplicate. .However, if one byte of data differs, the incoming file is considered unique and will crossover to trading partners. Following are two possible levels of claims

dispute for the ANSI 837 files, with the appropriate reporting method for each indicated. Note that a COBA Problem Inquiry Request Form (COBAF020), must be completed for all three levels of claim disputes. All COBAF020 forms must be sent to the general EDI representative e-mail address.

ISA-IEA (Interchange (ISA-IEA) Level) (Batch and Transmission Level for NCPDP Claims)

In the interchange level, all the claims transmitted in the interchange are rejected. Report ISA-IEA disputes via the COBA Problem Inquiry Request Form (COBAF020) process. The following information must be indicated on the form for an ISA-IEA level dispute: ISA Control Number, ISA Date, Dispute Reason Code, and one ICN (claim number) from the transmitted file.

In addition to sending the COBA Problem Inquiry Request Form (COBAF020) via e-mail to cobva@ghimedicare.com, you **must** also call your EDI representative directly or the general EDI representative line to report the problem.

Claim Level (Claim/Transmission Level Segments for NCPDP Claims) and ST-SE (Transaction ST-SE Level)

Report disputed duplicate claims at the claim level and claims within an ST-SE envelope to the BCRC, through the Dispute Flat File; then e-mail the completed COBA Problem Inquiry Request Form (COBAF020) to cobva@ghimedicare.com. Your designated EDI representative will apprise you if this procedures needs to change in the future.

Step 1. Trading partner prepares a file in the Claim Dispute Flat File Layout, which includes a list of Dispute Reason Codes. The file must include a Dispute Reason Code.

Step 2. The trading partner transmits the dispute file to the BCRC to the following filename: ‘PCOB.BA.NDM.COBA.CBXXXXX.DISPUTE(+1) XXXXX = TP assigned COBA ID. For SFTP/HTTPS users please see Section 3.3.1.

Step 3. Trading partner notifies the BCRC via e-mail that a dispute file has been transmitted; a completed COBA Problem Inquiry Request Form (COBAF020). (Note: The count must include the header and trailer record).

Step 4. Upon notification of the dispute file transmission, the BCRC will download the file to a customized application for investigation.

Step 5. Upon completion of the investigation, the BCRC will upload the dispute file to the BCRC mainframe; e-mail notification will be sent to the trading partner. Please note:

If the investigation determines the claim(s) should not have crossed, the BCRC flags the claim(s) as dispute resolution A (Agree).

` If the investigation determines the claim(s) crossed correctly, the BCRC flags the claim(s) as dispute resolution R (Reject).

Note: Disputed claims that are accepted (A-Agree) are sent to the COBA Receivable Financial Tracking System for credit adjustments and rejected disputed claims (R-Reject) are transmitted to the trading partner. A dispute can occur before or after an invoice is generated for the particular claim(s).

Post Invoice - If the trading partner has already been billed for the accepted disputed claim(s), the BCRC will issue a credit for the claims that can be applied to the current or future invoice.

Pre-invoice - If the trading partner has not been billed for the claim, the BCRC will remove it from the crossover claim table. The claim will also not appear in the next invoice.

SECTION 4: COBA FINANCIAL DETAILS

4.0 COBA Financial Process Overview

The BCRC utilizes an online billing system, db-eBills, to generate invoices, and this system is used by the trading partner to review and dispute invoices, and if the trading partner chooses, to submit payment.

Trading partners are invoiced on a monthly basis for the claims crossed over to them from the BCRC. Payment is due within 30 calendar days from the date of the invoice. Trading partners are expected to adhere to the crossover fee terms in their Agreement and to submit disputes through the established automated dispute file process no later than the due date of the invoice.

4.1. Db e-Bills

This Electronic Invoice Presentation and Payment (EIPP) system is provided and maintained by Deutsch Bank. E-billing is required; however, the trading partner does not have to pay electronically. Trading partners have a choice of payment remittance options.

The BCRC generates invoices to the trading partner via db-eBills. One monthly invoice is created in db-eBills for each trading partner. The invoice is available online no later than the fifth business day of the month. A trading partner is able to review the invoice, raise disputes on the invoice or line item level, when applicable, apply credit notes, and perform payment authorization. The trading partner can opt to make payment within db-eBills through direct debit of their account using an ACH transaction or to issue a check. db-eBills supports both single and joint authorization of payments. Additionally, db-eBills offers an e-mail notification feature, which if selected by the trading partner, would provide e-mail notification to the trading partner each time an invoice is available online for review and approval.

Db-eBills provides access to timely invoice information and the ability to authorize payment electronically, and it is a multi-user system with flexible access rights that can be adapted to the trading partner's existing invoice approval and payment process. A detailed description of db-eBills, and its many available features is provided in the Electronic Billing Introductory Package, which is available for download at http://www.cms.gov/Medicare/Coordination-of-Benefits/COBAgreement/.

4.2. Crossover Fee Requirements

Fees referenced in the trading partner's Agreement under Section III.D.1a and 1b and the provisions under Payment Terms apply when a trading partner moves from a test environment to the production environment. These fees, which may be found at http://www.cms.gov/Medicare/Coordination-of-Benefits/COBAgreement/, do not apply to State Medicaid Agencies and are subject to change via electronic notice (e.g., COBVA broadcast) from CMS.

The Trading partner will receive one invoice for each billing location on a monthly basis. That invoice could contain multiple COBA IDs. Please note the following important payment requirements:

- The Trading partner will be invoiced for claims for those Medicare beneficiaries provided on an Eligibility File and/or meet the claims selection criteria denoted on the COBA Attachment

that are transferred to the trading partner in the formats described in Section III.B of the COBA Attachment.

- The BCRC issues the monthly invoices for all crossover charges, and payment is expected within 30 calendar days from the date of the invoice. An unpaid invoice becomes delinquent on the 31st calendar day from the date of the invoice.
- CMS may terminate an Agreement if an invoice remains delinquent for a period of 90 calendar days.
- The trading partner must utilize the Coordination of Benefits Trading Partner Dispute Process, as explained in Section 3 of this guide, to dispute a charge. The BCRC will review documented evidence from the trading partner of erroneous crossover claims, and if the BCRC determines that the trading partner was charged for erroneous crossover claims, an adjustment will be made.
- The BCRC will not accept any type of claim disputes on invoices past the due date that is printed on the invoice. Note: The invoice due date is thirty (30) calendar days from its issued date.

SECTION 5: CUSTOMER SERVICE

5.0 Customer Service Overview

The EDI Department is responsible for coordinating the COBA processes for new and existing trading partners. Each trading partner is assigned an EDI representative as its primary contact, and backups are established in that representative's absence. The EDI Representatives are available to provide you with high-quality and efficient service from 8:30 a.m. through 6:30 p.m., Eastern Time (EST), Monday through Friday, except holidays and can be reached via e-mail at cobva@ghimedicare.com.

The BCRC also has a general line through which the EDI Department may be reached: 1-646-458-6740. However, trading partners should submit their inquiries through the Coordination of Benefits Agreement Problem Inquiry Request Submission process to ensure prompt attention. One of the many benefits of this streamlined process is that it allows the BCRC to more readily identify if a situation is an isolated issue or a mass problem.

5.1. BCRC - COBA Problem Inquiry Request Form Submission

The Coordination of Benefits & Recovery Center (BCRC) has implemented a COBA (Coordination of Benefits Agreement) Problem Inquiry Request process in order to streamline the report of problems and inquiry request processes for our COBA partners.

Inquiries submitted on a COBA Problem Inquiry Request Form (COBAF020), available for download at http://www.cms.gov/Medicare/Coordination-of-Benefits/COBAgreement/, are logged into a centralized database and tracked to ensure each submitted request is addressed timely. Additionally, this process provides the BCRC with a resource through which we can identify commonly reported issues and the impact of these issues on our trading partners and the COBA program.

5.1.1. Form Submission and Processing

Submit all problem inquiries on the COBA Problem Inquiry Request Form.

- Complete all fields on the form.
- Each form must provide the company's name and COBA ID(s), which was assigned to you by CMS. The COBA ID (s) must match our information on file.
- The completed COBA Problem Inquiry Request Form must be submitted to the Electronic Data Interchange (EDI) Department by e-mail at cobva@ghimedicare.com. **Note: Do not include PHI information.** Submit all PHI information under-separate-cover by fax to (646) 458-6761. Indicate on the Fax Cover Sheet, "COBA Problem Inquiry Request Submitted" and include the submission date.
- The BCRC will assign a ticket number to the COBA Problem Inquiry Request Form within 24 hours of receipt. Refer to this assigned ticket number when contacting the BCRC (per the escalation process below) with inquiries related to the request, and indicate this number on the Fax Cover Sheet when faxing back-up documents to the BCRC.
- Within 48 hours from ticket number notification, the BCRC will send a follow-up e-mail to you indicating the status of your request and when applicable, the corrective action taken.

5.1.2. Escalation Process

The BCRC places great importance in providing exceptional service to our customers. To that end, we have developed the following escalation process to ensure our customers' needs are met:

- If a representative of the EDI Department does not respond to your inquiry or issue within 48 hours, contact the EDI Supervisor.
- If the EDI Supervisor or the supervisor's designee does not respond to your inquiry or issue within 24 hours, contact the EDI Manager.
- If the EDI Manager does not respond to your inquiry or issue within 24 hours, contact the BCRC Project Director.

Note: For issues requiring immediate attention, do not wait for the duration of the grace periods specified in the Escalation Process before making your next contact.

5.2. Quick Reference: BCRC Contact Information

Below is the BCRC mailing address and general contact information referenced in this guide.

Benefits Coordination & Recovery Center
441 9th Avenue
5th Floor
New York, NY 10001
Attn: EDI Department

EDI Department General Contact #

(646) 458-6740

EDI Department Facsimile

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

General E-mail

cobva@ghimedicare.com

5.3. Helpful Information and References

COBVAs

At CMS's direction the BCRC will issue important notices and alerts to all COBA trading partners via its Coordination of Benefits Agreement Voluntary Agreement (COVBA) communication channel. The COBVA broadcasts are always conveyed to COBA trading partners via e-mail.

The following documents may be downloaded at:

http://www.cms.gov/Medicare/Coordination-of-Benefits/COBAgreement/:

COBA Base Agreement
COBA Attachment
Crossover Fees
HIPAA Closed Disagree and Agree Issues Logs
Trading Partner Customer Service Point of Contact List
Termination Procedures
Medigap Claim-based COBA IDs for Billing Purposes

5.4. Other Useful Technical Guides and Web Sites

837 Implementation Guides

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

NCPDP Implementation Guides

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

By the end of calendar year 2010, COBA trading partners will be able to reference the "Revised Coordination of Benefits Agreement (COBA) Companion Guide for HIPAA 5010 COB Transactions" on the CMS COBA web site by referencing the following:

http://www.cms.gov/Medicare/Coordination-of-Benefits/COBAgreement/.