CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 138 **Date: APRIL 9, 2004**

CHANGE REQUEST 3218

I. SUMMARY OF CHANGES: CMS has decided that its effort to consolidate the claims crossover process will begin with a smaller-scale implementation on July 6, 2004. From July 6, 2004, until October 1, 2004, approximately eight COBA trading partners will participate as beta-testers in a parallel production crossover process (a pilot for only COBA trading partners using production/live data). During the parallel production period, the eight COBA trading partners will receive consolidated crossover claims as part of the Coordination of Benefits Agreement (COBA) process. In addition, if the eight COBA trading partners have individual Trading Partner Agreements (TPAs) executed with Medicare contractors, they will receive crossover claims based on the terms and conditions of those TPAs.

Through this instruction, the Medicare contractors and shared system maintainers, including the Common Working File (CWF) maintainer, are apprised regarding which portions of Transmittal R-98 (Change Request 3109) are still applicable, which requirements have changed, and which requirements are being moved to the October 4, 2004, systems release or to another future release. In light of CMS' decision to implement the COBA crossover consolidation project on a more limited scale within a parallel production environment, Medicare contractors will continue to follow their current processes for the printing of Medicare Summary Notice (MSN) and Electronic Remittance Advice (ERA) crossover messages throughout the period from July 6, 2004, to October 1, 2004. Medicare contractors will also continue to charge all trading partners to whom they cross Medicare claims. During the parallel production period, CMS' Medicare Coordination of Benefits Contractor (COBC) will **not** be charging the trading partners that participate in the COBA beta-site testing for claims that it crosses to them.

The eligibility-based crossover process will begin to be implemented on a larger scale upon the implementation of the October 2004 systems release. Also, upon the implementation of the October 2004 system release, the initial eight COBA beta-site testers will be converted to full production and will begin to be charged for claims that the COBC crosses over to them. CMS' claim-based COBA crossover process is being delayed until a future systems release.

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

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

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

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

III. FUNDING: *Medicare contractors only:

These instructions should be implemented within your current operating budget.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

Attachment-Business Requirements

Pub. 100-04	Transmittal: 138	Date: April 9, 2004	Change Request 3218

SUBJECT: The Consolidation of the Claims Crossover Process: Smaller-Scale Initial Implementation

I. GENERAL INFORMATION

A. Background: CMS has decided that its effort to consolidate the claims crossover process will begin with a smaller scale implementation on July 6, 2004. From July 6, 2004, until October 1, 2004, approximately eight COBA trading partners will participate as beta-testers in a parallel production crossover process (a pilot for only COBA trading partners using production/live data). During the parallel production period, the eight COBA trading partners will receive consolidated crossover claims as part of the Coordination of Benefits Agreement (COBA) process. In addition, if the eight COBA trading partners have individual Trading Partner Agreements (TPAs) executed with Medicare contractors, they will receive crossover claims based on the terms and conditions of those TPAs.

Through this instruction, CMS is communicating the requirements previously issued via Transmittal R-98 (Change Request 3109) that will remain in the July 6, 2004, systems release. Where there are clarifications to a business requirement that appeared in CR 3109, "revised" appears in the numbered requirement. Where requirements are unchanged, "no change" appears in the numbered requirement. Several claim-based requirements will be delayed to a future systems release date. In addition, approximately three eligibility-based requirements that were previously communicated via Transmittal R-98 will be moved to the October 4, 2004, systems release. Where requirements have been moved to the October 2004 release or some future release, "moved" appears in the numbered requirement.

The Common Working File (CWF) system maintainer shall perform analysis and develop and code requirements that are listed in this change request as of the July 6, 2004, system release. In addition, by July 6, 2004, all system maintainers shall have completed the analysis and coding of all requirements below. In the future, Part B and DME providers and suppliers will receive outreach materials detailing their responsibilities for claim-based Medigap and Medicaid crossover (known collectively as the "claim-based COBA process").

B. Policy: During the parallel production period, CMS'S CWF system will: 1) House the Beneficiary Other Insurance (BOI) auxiliary file, which provides details about a beneficiary's eligibility for crossover to a given COBA trading partner; 2) Apply each trading partner's claims selection criteria; and 3) Return a BOI reply trailer 29 in those instances where a claim is to be sent to the COBC for crossover as part of the parallel production system.

C. Provider Education: As part of business requirement 10, providers should be informed that the claim-based COBA process is being delayed until further notice.

II. BUSINESS REQUIREMENTS

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

Requirement #	Requirements	Responsibility
3218.1 Ch. 28, Sec. 70.6	No change. You shall send processed claim information to the COBC for crossover to a COBA trading partner in response to the receipt of a CWF BOI. You will only receive a CWF BOI reply trailer for claims that the COBA trading partner has selected to receive via the crossover process. You will not receive copies of the COBA Insurance File (COIF) to perform crossover claim selection criteria. The CWF will perform crossover claim selection criteria for COBA trading partners, including claim-based and eligibility file-based trading partners.	Intermediaries, Carriers, and DMERCs
3218.2 Ch. 28, Sec. 70.6	Revised. When a BOI reply trailer is received, the COBA ID will identify the type of crossover (see modified data element 24, Attachment A). Although each COBA ID will consist of a 5-digit prefix that will be all zeroes, you are only responsible for picking up the last 5 digits within these ranges, which will be right justified in the COBA number field. [**Moved to October 2004--**When you receive a BOI reply trailer (trailer 29), you shall annotate your claims history to show that the beneficiary's claim was selected to be crossed over.] **[Moved to a future release—**If you receive a Claim-based reply trailer (trailer 37), you shall annotate your claims history to show that the beneficiary's claims were selected to be crossed over. Claim-based COBA IDs that will be returned via a trailer 37 will fall either in the claim-based Medigap range (55000-59999) or in the claim-based Medicaid range (78000-79999).]	Intermediaries, Carriers, and DMERCs Carriers and DMERCs

3218.3 Ch. 28, Sec. 70.6	Revised. During the COBA parallel production period (July 6, 2004, to October 1, 2004), you shall observe the following business rules when you receive a BOI reply trailer 29 and there is some other indication of crossover eligibility: If you receive a BOI reply trailer 29 with COBA IDs that fall in the ranges of 00001-89999, you shall continue to cross over claims 1) per your existing TPAs and 2) when Medigap or Medicaid information is reported on the claim. In addition, you shall send claims for which you receive BOI reply trailers to the COBC on the 837 v4010A1 flat file or National Council for Prescription Drug Programs (NCPDP) file. **(NOTE:** The COBA trading partner will only be charged for the claims that you continue to cross to it during the parallel production period.) During the parallel production period, you shall not change your current procedures regarding suppression of Medicaid claims when a beneficiary has non-Medigap and/or Medigap insurance. Your Medicaid suppression logic should remain the same as today with your existing trading partners, even when you receive a BOI reply trailer that includes a Medicaid COBA ID.	Intermediaries, Carriers, and DMERCs
3218.4 Ch. 28, Section 70.6	Revised. (Minor modification made to Attachment C.) You shall transmit all non-NCPDP claims received with a COBA ID on the BOI trailer to the COBC in an 837 v4010A1 flat file**,** as described in Transmittal AB-03-060. In a separate transmission, send the claims received in the NCPDP file format to the COBC in that same format. You shall enter the 5-digit COBA ID picked up from the BOI reply trailer 29 in the l000B loop of the NM1 segment in the NM109 field. In a situation where multiple COBA IDs are received for a claim, you shall send a separate 837 or NCPDP transaction to the COBC for each COBA ID. You shall perform the transmission at the end of the regular batch cycle, when claims come off the payment floor, to ensure crossover claims are	Intermediaries, Carriers, and DMERCs

	not processed by the COBA trading partner prior to Medicare final payment. Transmission should occur via Network Data Mover (NDM) over AGNS (AT&T Global Network Service). Refer to Attachment C for a listing of your specific responsibilities for populating the 837 flat files that you will send to the COBC. To assist the COBC in resolving any file transmission or other related problems, each contractor shall provide a technical contact (i.e., contractor name, contact name, telephone number, and e-mail address) to the COBC**.** Each contractor shall be required to send its technical contact information to Brian Pabst at CMS (bpabst@cms.hhs.gov) no later than January 1, 2004.	
3218.5 Ch. 28, Section 70.6	Revised. After you have transmitted claims to the COBC, you will receive a returned response file, via NDM, that indicates the number of claims received and whether the entire file was accepted or rejected. When you receive the reject indicator "R" via the Claims Response File, you are to retransmit the entire file to the COBC. If you receive an acceptance indicator "A," this confirms that your entire COB flat file or NCPDP file transmission was accepted. Refer to Attachment D for a copy of the Claims Response File Layout (80 bytes) and possible edits that will affect COBC's decision to return a reject indicator "R" to the Medicare contractor. Note that if you submit daily claim files to the COBC, you will also receive claim response files daily. COB 837 flat files and NCPDP files that you transmit to the COBC, in accordance with Requirement 4 above, will be assigned the following file names: PCOB.BA.NDM.COBA.Cxxxx.PARTA(+1) [Used for Institutional Claims] PCOB.BA.NDM.COBA.Cxxxx.PARTB(+1) [Used for Professional Claims] PCOB.BA.NDM.COBA.Cxxxx.NCPDP(+1).	Intermediaries, Carriers, and DMERCs

	[Used for Drug Claims] Note that "xxxxx" denotes the Medicare contractor number. Test files will be prefixed with "TCOB" instead of "PCOB." The "TCOB" prefix will be used as part of system (release) testing within the test environment. During the parallel production period, all 837 flat files submitted to the COBC will be prefixed with "PCOB." Files transmitted by you to the COBC shall be stored for 51 business days from the date of transmission. The file names for the Claims Response File returned to you will be created as part of the NDM set-up process. Files transmitted to COBA trading partners by the COBC will be stored for 50 business days from the date of transmission.	
3218.6 Ch. 28, Sec. 70.6	Revised. You shall keep your present crossover process in place, including invoicing for claims crossed to current trading partners, until each of your present trading partners has been transitioned to the COBA process. As trading partners are signed on to national COBAs, they will be advised that it is their responsibility to simultaneously cancel current agreements with you and to cease submission of eligibility files to you. (**NOTE:** During parallel production period, the COBA trading partner will be instructed by CMS to **not** cancel current TPAs with you.) The CMS now expects to complete the transition of current eligibility-based trading partners to COBAs by April 30, 2005.	Intermediaries, Carriers, and DMERCs
3218.7	No change; still deleted.	Intermediaries, Carriers, and DMERCs
3218.8 Ch. 28, Sec. 70.6	Moved Medicare contractor requirements to October 2004. Revised CWF Requirements	Intermediaries, Carriers, DMERCs CWF

	In preparation for the October 2004 larger-scale implementation of the COBA initiative, CWF shall affect the Health Insurance Master Record (HIMR) changes as listed in the revised Attachment F, which are based on the application of the claims selection criteria (see Requirement 16). [**NOTE:** The HIMR shall not be populated by CWF with the outcome of the claims selection criteria until the October 2004 systems release.]	
3218.9 Ch. 28, Sec. 70.6	Revised (Clarification) For workload reporting, you shall provide counts for claims that you cross to current trading partners (including Medicaid) as you do today in CAFM II and in CROWD. You shall separately track claims transmitted to the COBC for crossover to COBA trading partners for future reporting requirements by COBA ID.	Intermediaries, Carriers, and DMERCs
3218.10	No change. A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article to their Web site, and include it in a listserv message if applicable, within one week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin.	Intermediaries, Carriers, and DMERCs
3218.11	No change; still deleted.	CWF
3218.12	No change; still deleted.	COBC, CWF
3218.13 Ch. 27, Sec. 80.15	**[**Moved to October 2004--The CWF shall annotate each claim with an indicator that will inform all users of the claim's crossover status (see Attachment F). In addition, CWF shall annotate each claim with a 10-position COBA ID (5-digit COBA ID preceded by 5 zeroes) to identify the entity to which the claim was crossed or not crossed, in accordance with the COBA.]	CWF
3218.14	[**Moved to October 2004--**The CWF shall allow for the repeating of Requirement 13, so that up to ten (10) COBA IDs may be posted with each individual claim, as applicable.]	CWF

3218.15 Ch. 27, Sec. 80.14 and Ch 28, Sec. 70.6	Revised. (Minor Modification to Attachment G.) On a weekly basis, the nine (9) CWF host sites shall accept a Coordination of Benefits Agreement Insurance File (COIF) from the COBC to facilitate completion of the requirements 16 and 17 below. (The file layout for the COIF, which includes all available COBA claims selection criteria, appears in Attachment G.)	CWF
3218.16 Ch. 27, Sec. 80.14 and Ch. 28, Sec. 70.6	No change. The CWF shall load the initial COIF submission from COBC as well as all future updates. Upon receipt of a claim, CWF shall take the following actions: 1) Search for a COBA eligibility record on the BOI auxiliary record for each beneficiary and obtain the associated COBA ID(s) [**NOTE:** There may be multiple COBA IDs]; 2) Refer to the COIF associated with each COBA ID (note: CWF shall pull the COBA ID from the BOI auxiliary record) to obtain the COBA trading partner's name and claims selection criteria; 3) Apply the COBA trading partner's claims selection criteria; and Transmit a BOI reply trailer to the Medicare contractor only if the claim is to be sent to COBC for crossover.	CWF
3218.17 Ch. 27, Sec. 80.14 and Ch. 28, Sec. 70.6	Revised. The CWF maintainer shall modify the BOI reply trailer 29 (see Attachment B) to include, in addition to COBA ID, the COBA trading partner name(s), an "A" crossover indicator, which specifies that the contractor is to send a claim to the COBC, and the insurer effective and termination dates. The CWF maintainer shall also modify the BOI reply trailer 29 to include a 1-character indicator (Y or N) specifying whether the COBA trading partner's name should appear on the Medicare Summary Notice (MSN). The CWF shall receive this information via the weekly COIF update (see	CWF

	Attachment G). During the parallel production period: (1) CWF will only return an "N" MSN indicator on the BOI reply trailer 29, in accordance with information received via the COIF submission; (2) If a "Y" indicator is returned, you shall ignore it; and (3) You shall follow your current procedures for the printing of MSN crossover messages.	CWF, Intermediaries, Carriers, and DMERCs
Ch. 28, Sec. 50	You shall include the revised language for crossover message "MA 18" on your provider remittance advices. The new language for "MA 18" reads as follows: "The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them." Following receipt of a BOI reply trailer, you shall transmit the claim to the COBC in accordance with Requirement 4 of this instruction.	Intermediaries, Carriers, and DMERCs
Ch. 28, Sec. 50 and Ch. 28, Sec. 70.6	During the parallel production period (July 6, 2004, to October 1, 2004), you shall follow your existing procedures for placement of claims crossover information in CLP-02 (Claims Status Code) and in the NM101, NM102, NM103, NM108, and NM109 segments of Loop 2100 of the provider 835 ERA. You shall also continue with your current procedure for inclusion of COB trading partner names on other kinds of provider remittance advices that you have in production. Beginning with the October 2004 systems release**,** when you receive a BOI reply trailer 29, which indicates that a particular claim should be sent to COBC for crossover, you shall use the returned BOI trailer information to take the following actions on the provider's 835 Electronic Remittance Advice: 1) Record code 19 in the CLP-02 (Claim Status Code) in Loop 2100 (Claim Payment Information) of the 835 ERA (v. 4010-A1). [**NOTE:** You shall record "20" in the CLP-02 (Claim Status Code) in Loop 2100 (Claim Payment Information) when Medicare is the	

	secondary payer.] 2) Update the 2100 Loop (Crossover Carrier Name) on the 835 ERA as follows: • NM101 [Entity Identifier Code]—Use "TT," as specified in the 835 Implementation Guide. • NM102 [Entity Type Qualifier]—Use "2," as specified in the 835 Implementation Guide. • NM103 [Name, Last or Organization Name]—Use the COBA trading partner's name that accompanies the first sorted COBA ID returned to you on the BOI reply trailer. • NM108 [Identification Code Qualifier]—Use "PI" (Payer Identification) NM109 [Identification Code]—Use the first COBA ID returned to you on the BOI reply trailer. (See line 24 of the BOI aux. file record.)	
3218.18 Ch. 27, Sec. 80.14 and Ch. 28, Sec. 70.6	Revised. When a beneficiary's claim is associated with more than one COBA ID, the CWF shall sort the COBA IDs and trading partner names in the following order: 1) Eligibility-based Medigap, 2) Supplemental, 3) TRICARE, 4) Others, and 5) Eligibility-based Medicaid. When two or more COBA IDs fall in the same range (see Attachment A, element 24), CWF shall sort numerically within the range.	CWF
3218.19 Ch. 27, Sec. 80.14 and Ch. 28, Sec. 70.6	Revised. If CWF receives a non-assigned Medicare claim for a beneficiary whose BOI auxiliary file contains a COBA ID with a current effective date in the Medicaid eligibility-based range (70000-77999), it shall reject the claim. The CWF shall return an edit to the carrier or DMERC that specifies that non-assigned Medicare claims cannot be sent to Medicaid. At the same time, CWF shall also return a Medicaid reply trailer 36 to the carrier or DMERC (See Attachment H) that contains the trading partner's COBA ID and beneficiary's effective dates and termination dates under Medicaid.	CWF and Carriers and DMERCs

	If the carrier or DMERC determines that the non-assigned claim's service dates fall during a period when the beneficiary is eligible for Medicaid, it shall convert the assignment indicator from "non-assigned" to "assigned" and retransmit the claim to CWF. After the claim has been retransmitted, CWF will only return a BOI reply trailer to the carrier or DMERC if the claim is to be sent to the COBC to be crossed over.	
3218.20	Revised. Before the future implementation of the claim-based COBA process, CMS shall issue an information packet to carriers and DMERCs describing the COBA claim-based process for the benefit of Part B and DME participating providers and suppliers. The CMS plans to issue these materials to carriers and DMERCs approximately 4 months before the implementation of the claim-based COBA process. Included in the information packet will be a link to a Web site that will contain a listing of currently assigned claim-based COBA IDs. Over time, Medigap insurers and State Medicaid Agencies that had initially decided not to execute COBAs may decide they now want to sign COBAs. When this occurs, CMS will make the necessary update to its Web page on which the Medigap claim-based information is housed.	CMS Carriers and DMERCs
3218.21 Ch. 28, Sec. 20.1, Ch. 28, Sec. 30.1, and Ch. 28, Sec. 70.6	Revised. Contractors shall accept the changes made in § 20.1 and § 30.1 of Chapter 28 until further notice. (**NOTE:** Carrier and DMERC claim-based requirements, previously outlined in § 70.6 of Chapter 28, are being moved to a future systems release.) Revised. Medicare contractors shall **not** cease claim-based crossover operations until CMS so directs in a future systems release.	Carriers and DMERCs

3218.22 Ch. 28, Sec. 70.6	Moved to a future release.	Carriers and DMERCs
3218.23 Ch. 28, Sec. 70.6	Moved to a future release.	Carriers and DMERCS
3218.24 Ch. 27, Sec. 80.14 and Ch. 28, Sec. 70.6	Revised. The CWF shall load the initial COIF submission from COBC as well as all future updates that pertain to claim-based Medigap insurers and State Medicaid Agencies. For claim-based crossover, CWF shall **only** search the COIF if the carrier or DMERC has included a claim-based Medigap ID (55000—59999) or claim-based Medicaid ID (78000--79999) in field 36 of the HUBC or HUDC query. During the parallel production period (July 6, 2004, to October 1, 2004) and until the future implementation of the COBA claims-based initiative, CWF shall ignore claim-based COBA ID values if entered in field 36 of the HUBC or HUDC query. With the future implementation of the claim-based COBA process, when claim-based COBA IDs are entered in field 36 of the HUBC or HUDC query, CWF shall: 1) Search the COIF to locate the claim-based Medicaid and/or Medigap COBA ID and corresponding COBA Trading Partner Name; 2) Apply the Medigap or Medicaid claim-based trading partner's claims selection criteria; 3) Return a Claim-based reply trailer 37 that includes values for claim-based COBA ID (sorted by Medigap, then Medicaid), COBA Trading Partner Name, and MSN Indicator when a claim-based COBA ID is found on the COIF **and** the claim is to be sent to the COBC to be crossed over; 4) Return an alert code 7704 on the "01" response via a Claim-based alert trailer 21 to the carrier or DMERC, as specified in Requirement 23 above, if a claim-based COBA ID in the Medigap claim-based range (55000-59999) is **not**	CWF

	located on the COIF; Return nothing to the carrier or DMERC if a Medicaid claim-based COBA ID (78000-79999) is not found on the COIF.	
3218.25 Ch. 28, Sec. 70.6	Moved to a future release.	Carriers and DMERCs
3218.26 Ch. 28, Sec. 70	Revised. Carriers or DMERCs shall continue to pursue collection of unpaid debts from existing trading partners, even if such entities have been transitioned to the COBA process.	Intermediaries, Carriers, and DMERCs
3218.27 Ch. 28, Sec. 70.6	Revised. Given CMS'S initial plans for a small-scale implementation of the COBA process on July 6, 2004, you shall continue to execute new crossover agreements (Trading Partner Agreements or TPAs) for trading partners that wish to go into live production by August 1, 2004. These new TPAs and extensions of existing TPAs shall allow for future termination no later than April 30, 2005. Trading partners that either wish to go into live crossover production after August 1, 2004, or have current questions regarding the COBA process shall be referred to the COBC at 1-800-999-1118.	Intermediaries, Carriers, and DMERCs

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

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

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

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

Attachments: 8

Attachment A

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

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

The CWF maintainer will:

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

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

Attachment A (continued)

Data Elements Required for the BOI Aux File Record

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

Attachment A (concluded)

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

CWF BOI Trailer Requirements — Attachment B

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

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


        10 :X:-29-COBA-NUM       PIC  X(10).
        10 :X:-29-COBA-NAME      PIC  X(32).
        10 :X:-29-COBA-MSN-IND  PIC  X(01).
        10 :X:-29-COBA-EFF-DATE PIC S9(07) COMP-3.
        10 :X:-29-COBA-TRM-DATE PIC S9(07) COMP-3.
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837 COB Flat File Process Rules — Attachment C (revised)

Part B and DMERC (Professional)

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

2. The 1000B loop of the NM1 segment denotes the crossover partner. If multiple COBA IDs are received via the BOI reply trailer, a separate 837 transaction should be submitted for each COBA ID received. As the crossover partner information will be unknown to the standard systems, the following fields should be formatted as indicated for the NM1 segment:
    a) NM103—Use spaces.
    b) NM109—Include COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29).

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

4. The 2010BB loop denotes the payer name. Per the HIPAA Implementation Guide (IG), this loop should define the secondary payer when sending the claim to the second destination payer. Consequently, given that the payer related to the COBA ID will be unknown by the standard systems, the NM1, N3, and N4 segments should be formatted as follows, with COBC completing any missing information:
    a) NM1 segment—For NM103, use spaces.
    b) NM1 segment—For NM109, include the COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29).
    c) N3 segment—Use all spaces.
    d) N4 segment—Use all spaces.

5. The 2330B loop denotes other payers for the claim. If multiple COBA IDs are returned via the BOI reply trailer, payer information for the additional COBA IDs will be unknown. As with the 2010BB loop, the NM1 segment should be formatted as follows, with COBC completing any missing information:
    a) NM103—Use spaces.
    b) NM109—Include COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29).

    The 2330B loop shall be repeated to allow for inclusion of the Name (NM103) and associated Trading Partner ID (NM109) for each existing trading partner.

6. The 2320 loop defines other subscriber information. Within the SBR segment, the SBR03 and SBR04 segments are used to define the group/policy number and insured group name, respectively. If the information is available for these fields, those values should be propagated accordingly for both current trading partners and COBA trading partners. COBC will inspect these values for COBA related eligibility based claims and overlay as appropriate. Spaces should only be used for COBA-related situations.
    --SBR01 – treat as you currently do.

Part A (Institutional)

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

2. The 1000B loop of the NM1 segment denotes the crossover trading partner. If multiple COBA IDs are received via the BOI reply trailer, a separate 837 transaction should be submitted for each COBA ID received. As the crossover trading partner information will be unknown to the standard systems, the following fields should be formatted as follows for the NM1 segment on the '100' record:
    a) NM103—Use spaces.
    b) NM109—Include COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29).

Attachment C
(concluded)

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

4. The 2010BC loop denotes the payer name. Per the HIPAA IG, this loop should define the secondary payer when sending the claim to the second destination payer. Consequently, since the payer related to the COBA ID will be unknown to the standard systems, the NM1, N3, and N4 segments should be formatted as follows for the '300' record, with COBC completing any missing information:
    a) NM1 segment—For NM103, use spaces.
    b) NM1 segment—For NM109, include COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29).
    c) N3 segment—Use all spaces.
    d) N4 segment—Use all spaces.

5. The 2330B loop of the '575' record denotes other payers for the claim. If multiple COBA IDs are returned via the BOI reply trailer, payer information for the additional COBA IDs will be unknown. As with the 2010BC loop, the NM1 segment should be formatted as follows, with COBC completing any missing information:
    a) NM103—Use spaces.
    b) NM109—Include COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29).

   The 2330B loop shall be repeated to allow for inclusion of the Name (NM103) and associated Trading Partner ID (NM109) for each existing trading partner.

6. The 2320 loop defines other subscriber information. Within the SBR segment, the SBR03 and SBR04 segments are used to define the group/policy number and insured group name, respectively. If the information is available for these fields, those values should be propagated accordingly for both current trading partners and COBA trading partners. COBC will inspect these values for COBA related eligibility based claims and overlay as appropriate. Spaces should only be used for COBA-related situations.
    -- SBR01 – treat as you currently do.

Attachment D

Claims Response File Layout (80 bytes)				
Field	***Name***	***Size***	***Displacement***	***Description***
1.	Contractor Number	5	1-5	Contractor Identification Number
2.	Transaction Set Control Number/Batch Number	9	6-14	Found within the ST02 data element from the ST segment of the ANSI 837 flat file or in field 806-5C from the batch header of the NCPDP file.
3.	Number of claims	9	15-23	Number of Claims contained in the ANSI 837 flat file or NCPDP file. This is a numeric field that will be right justified and zero-filled.
4.	Receipt Date	8	24-31	Receipt Date of ANSI 837 flat file or NCPDP file in CCYYMMDD format
5.	Accept/Reject indicator	1	32	Indicator of either the acceptance or rejection of the ANSI 837 flat file or NCPDP file. Values will either be an “A” for accepted or “R” for rejected.
6.	Filler	48	33-80	Spaces

837 Institutional Edits by the COBC

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

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

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

837 Professional Edits by the COBC

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

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

following must be set:
2320.SBR01 is equal to the value of P
2320.SBR02 is equal to the value of 18
2320.SBR05 is equal to the value of MB
2320.SBR09 is equal to the value of MB
2330B.NM108 is equal to the value of PI
2330B.NM109 is equal to the value in 1000A.NM109
At least one iteration of 2330B.REF where:
2330B.REF01 is equal to the value of F8
2330B.REF02 is greater than spaces (Carrier or DMERC's claim control number)
For occurrences where 2330B.NM103 is equal to spaces (meaning crossing to another COBA ID), the following must be set:
2330B.NM109 is equal to a valid COBA ID and is not equal to the value in 1000B.NM109
2320.SBR02 is equal to the value of S
There is at least one iteration of the 2400 loop
There is not more than 50 iterations of the 2400 loop per 2300 loop
If there is a 2430 loop, the number of 2430 loops cannot be greater than 25 per 2400 loop.
For the iteration of the 2430 loop (i.e., the Medicare adjudication information), 2430.SVD01 is equal to 2330B.NM109.
Segment SE exists

NCPDP Edits by the COBC

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

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

Claims Crossover Extract File **Attachment E**

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

ATTACHMENT F (revised)

CROSSOVER CLAIM DISPOSITION INDICATORS

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

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

COBA INSURANCE FILE

ATTACHMENT G

Field	Start	Length	End	Description
COBA ID	1	10	10	Unique identifier for each COB Agreement
COBA TIN	11	9	19	Tax Identification Number of COBA
COBA Name	20	32	51	Name of COBA Partner (Equivalent to Insurer Name on BOI Auxiliary File)
COBA Address 1	52	40	91	Address 1 of COBA
COBA Address 2	92	40	131	Address 2 of COBA
COBA City	132	25	156	Address city of COBA
COBA State	157	2	158	Postal State Abbreviation of COBA
COBA Zip	159	9	167	Zip plus 4 of COBA
Common Claim Exclusions				**The following fields are 1 byte indicators dictating type of claim exclusions. A value of 'Y' in any of the following fields indicates those types of claims should be excluded.**
Non-assigned	168	1	168	Non-assigned claims
Orig. Claims Paid at 100%	169	1	169	Original claims paid at 100%
Orig. Claims Paid at >100%	170	1	170	Original claims paid at greater than 100% of submitted charge
100% Denied, No Additional Liability	171	1	171	100% denied claims, with no additional beneficiary liability
100% Denied, Additional Liability	172	1	172	100% denied claims, with additional beneficiary liability
Adjustment Claims, Monetary	173	1	173	Adjustments, monetary claims
Adjustment Claims, Non-Monetary/Statistical	174	1	174	Adjustments, non-monetary/statistical claims
Medicare Secondary Payer Claims	175	1	175	Medicare Secondary Payer (MSP) claims
Other Insurance	176	1	176	Claims if other insurance (such as Medigap, supplemental, TRICARE, or other) exists for beneficiary. **Applies to State Medicaid Agencies only.**
NCPDP Claims	177	1	177	National Council Prescription Drug Program Claims
Filler	178	10	187	Future
Hospital Inpatient A	188	1	188	TOB 11 - Hospital: Inpatient Part A
Hospital Inpatient B	189	1	189	TOB 12 - Hospital: Inpatient Part B
Hospital Outpatient	190	1	190	TOB 13 - Hospital: Outpatient
Hospital Other B	191	1	191	TOB 14 - Hospital: Other Part B (Non-patient)
Hospital Swing	192	1	192	TOB 18 - Hospital: Swing Bed
SNF Inpatient A	193	1	193	TOB 21 - Skilled Nursing Facility: Inpatient Part A
SNF Inpatient B	194	1	194	TOB 22 - Skilled Nursing Facility: Inpatient Part B
SNF Outpatient	195	1	195	TOB 23 - Skilled Nursing Facility: Outpatient
SNF Other B	196	1	196	TOB 24 - Skilled Nursing Facility: Other Part B (Non-patient)
SNF Swing Bed	197	1	197	TOB 28 - Skilled Nursing Facility: Swing Bed
Home Health B	198	1	198	TOB 32 - Home Health: Part B Trust Fund
Home Health A	199	1	199	TOB 33 - Home Health: Part A Trust Fund
Home Health Outpatient	200	1	200	TOB 34 - Home Health: Outpatient
Religious Non-Med Hospital	201	1	201	TOB 41 - Christian Science/Religious Non-Medical Services (Hospital)
Clinic Rural Health	202	1	202	TOB 71 - Clinic: Rural Health
Clinic Freestanding Dialysis	203	1	203	TOB 72 - Clinic: Freestanding Dialysis
Clinic Fed Health Center	204	1	204	TOB 73 - Clinic: Federally Qualified Health Center

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

CWF Medicaid Reply Trailer Requirements Attachment H

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

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

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

70 - Crossover Claims Requirements

A3-3602.3

(Rev. 138, 04-09-04)

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

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

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

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

When non-HIPAA inbound claims do not contain data necessary to create a HIPAA compliant outbound X12N 837 HIPAA COB transaction, the shared systems maintainers (except for MCS) and MCS carriers shall gap fill alphanumeric data elements with Xs and numeric data elements with 9s. For example, a 5-character alphanumeric data element would contain "XXXX" and a 5-character numeric data element would contain "99999".

When non-HIPAA inbound claims do not contain a required telephone number to create a HIPAA compliant outbound X12N 837 HIPAA COB transaction, the shared systems maintainers (except for MCS) and MCS carriers shall gap fill the phone number data element with "8009999999."

Data elements with pre-defined implementation guide values such as qualifiers and data elements that refer to a valid code source shall not be gap filled.

On July 6, 2004, CMS will inaugurate the small-scale implementation of the national Coordination of Benefits Agreement (COBA) claims crossover consolidation initiative. From July 6, 2004, to October 1, 2004, the COBA initiative will proceed as part of a parallel production period. The larger-scale implementation of the COBA eligibility-file based crossover process will commence with the October 2004 systems release. Under both the parallel production and larger-scale COBA process, intermediaries and carriers will receive confirmation via a Common Working File (CWF) Beneficiary Other

Insurance (BOI) auxiliary reply trailer that a trading partner has selected a beneficiary's claim for crossover. Upon receipt of a BOI reply trailer, the intermediary or carrier will transfer the processed claim to the COBC via an 837 COB flat file or National Council for Prescription Drug Programs (NCPDP) file to be crossed over to the trading partner.

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

70.1 - FI Requirements

(Rev. 138, 04-09-04)

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

Shared System Claim/COB flat file

If the shared system detects an improper flat file format/size (incorrect record length, record length exceeding 32,700 bytes, etc.), the flat file will be rejected back to the file's submitter (FI or data center) by the shared system with an appropriate error message. If a syntax error occurs at the standard level, FIs must return the entire transmission (ISA to IEA) to the submitter via the ANSI X12N 997.

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

Intermediary responsibilities related to the COB flat file will be significantly modified under the COBA process beginning with July 6, 2004. Refer to Pub.100-04, Chapter 28, §70.6 for details.

Outbound COB

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

transaction. The shared system must retain the data in the SFR for a minimum of 6 months.

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

The shared system maintainer must accommodate the COB transaction.

The flat file creation process and responsibility for sending outbound COB files to crossover trading partners will change appreciably once CMS' COBA process is implemented. The implementation of COBA is scheduled to begin July 6, 2004, and conclude by April 30, 2005. Refer to Pub.100-04, Chapter 28, §70.6 for details regarding intermediary versus Coordination of Benefits Contractor (COBC) responsibilities under the COBA process.

Summary of Process

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

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

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

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

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

For specifics on how the claims crossover process will change as early as July 6, 2004, under the COBA initiative, refer to Pub.100-04, Chapter 28, §70.6.

70.2 - Carrier/DMERC Requirements

(Rev. 138, 04-09-04)

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

Outbound Coordination of Benefits (COB)

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

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

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

The flat file creation process and responsibility for sending outbound COB files to crossover trading partners will change appreciably once CMS' COBA process is implemented. The implementation of COBA is scheduled to begin July 6, 2004, and conclude by April 30, 2005. Refer to Pub.100-04, Chapter 28, §70.6 for details regarding intermediary verses Coordination of Benefits Contractor (COBC) responsibilities under the COBA process.

Summary of Process

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

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

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

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

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

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

For specifics on how the claims crossover process will change as early as July 6, 2004, under the COBA initiative, refer to Pub.100-04, Chapter 28, §70.6.

Medicare Claims Processing Manual

Chapter 27 - Contractor Instructions for CWF

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(Rev. 138, 04-09-04)

80.14- Consolidated Claims Crossover Process

(Rev. 138, 04-09-04)

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

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

Effective July 6, 2004, the COBC will begin to send copies of the Coordination of Benefits Agreement Insurance File (COIF) to the nine CWF host sites on a weekly basis. The COIF will contain specific information that will identify the COBA trading partner, including name, COBA ID, address, and tax identification number (TIN). It will also contain each trading partner's claims selection criteria exclusions (claim or bill types that the trading partner does not want to receive via the crossover process) along with an indicator (Y=Yes; N=No) regarding whether the trading partner wishes its name to be printed on the Medicare Summary Notice (MSN). During the COBA parallel production period, which is estimated to run from July 6, 2004, to October 1, 2004, CWF will exclusively return an "N" MSN indicator to the intermediary or carrier.

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

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

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

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

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

4) *Transmit a BOI reply trailer 29 to the Medicare intermediary or carrier <u>only</u> if the claim is to be sent, via 837 COB flat file or National Council for Prescription Drug Programs (NCPDP) file, to the COBC to be crossed over. (See Pub.100-04, Chap. 28, §70.6 for more information about the claim file transmission process involving the Medicare intermediary or carrier and the COBC.)*

B. BOI Reply Trailer 29 Processes

For purposes of eligibility file-based crossover, if CWF selects a claim for crossover, it shall return a BOI reply trailer 29 to the Medicare intermediary or carrier. The returned BOI reply trailer 29 shall include, in addition to COBA ID(s), the COBA trading partner name(s), an "A" crossover indicator that specifies that the claim has been selected to be crossed over, the insurer effective and termination dates, and a 1-digit indicator ["Y"=Yes; "N"=No] that specifies whether the COBA trading partner's name should be printed on the beneficiary MSN. If a Medicare intermediary or carrier receives an "N" indicator from the BOI reply trailer designating that the trading partner's name is not to be printed on the MSN, it shall print its customary generic crossover message on the MSN rather than including the trading partner's name.

As specified above, during the COBA parallel production period (July 6, 2004, to October 1, 2004), CWF will exclusively return an "N" MSN indicator via the BOI reply trailer, in accordance with the information received via the COIF submission. If an intermediary or carrier receives a "Y" MSN indicator during the parallel production period, it shall ignore it.

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

C. Claim-Based Medigap and Medicaid Crossover Processes Involving CWF

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

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

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

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

3) *Return a Claim-based reply trailer 37 to the carrier or DMERC that includes values for claim-based COBA ID (sorted by Medigap, then*

*Medicaid), COBA Trading Partner Name, and MSN Indicator when a claim-based COBA ID is found on the COIF **and** the claim is to be sent to the COBC to be crossed over;*

4) *Return an alert code 7704 on the "01" response via a Claim-based alert trailer 21 to the carrier or DMERC, as specified in Requirement 23 above, if a claim-based COBA ID in the Medigap claim-based range (55000-59999) is not located on the COIF; and*

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

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

D. CWF Treatment of Non-assigned Medicaid Claims

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

80.15 Claims Crossover Disposition Indicators

(Rev. 138, 04-09-04)

Beginning with the larger-scale implementation of the COBA eligibility file-based crossover process that commences with the October 2004 systems release, CWF shall mark each processed claim with a claims crossover disposition indicator after it has applied the COBA trading partner's claims selection criteria. (See the table below for a listing of the indicators.) Once the claims crossover process is consolidated under the Coordination of Benefits Contractor (COBC), Medicare intermediary and carrier customer service staff will have access to a CWF auxiliary file that will display the crossover disposition of each beneficiary claim. The crossover disposition indicators that will appear on the HIMR detailed history screens (INPH, OUTH, HOSH, PTBH, DMEH, and HHAH) are summarized below.

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

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

Medicare Claims Processing Manual

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

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(Rev. 138, 04-09-04)

20 - Assignment of Claims and Transfer Policy

(Rev. 138, 04-09-04)

B3-4702, B3-3047

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

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

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

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

20.1 - Beneficiary Insurance Assignment Selection

(Rev. 138, 04-09-04)

B3-4702.1, B3-3047, B4-2110.1

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

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

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

	HICN
NAME OF BENEFICIARY	MEDIGAP POLICY NUMBER

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

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

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

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

(Rev. 138, 04-09-04)

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

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

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

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

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

1257 Anywhere Street

Baltimore, Md. 21204

Is shown as

1257 Anywhere St. MD 21204

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

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

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

Once CMS's COBA claim-based Medigap process becomes effective in the future, participating Part B and DME providers and suppliers will be required to enter the CMS-assigned claim-based COBA ID in block 9-D of Form CMS-1500 or in field NM109 of the NM1 segment in loop 2330B of the HIPAA 837 Professional claim or in field 301-C1 of the T04 segment of the NCPDP claim. If a participating Part B or DME provider or supplier fails to include this identifier in the field just described, the claim will not be transferred to the Medigap claim-based crossover insurer. (See §70.6 of this Chapter for more details.)

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

50 – Remittance Advice Messages

(Rev. 138, 04-09-04)

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

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

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

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

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

Beginning with July 6, 2004, implementation of the COBA parallel production period, intermediaries and carriers shall begin to follow the requirements specified in §70.6 of this Chapter with respect to the crossover information that is to be included on the provider's remittance advice. Beginning with the October 2004 systems release, intermediaries and carriers will include COBA trading partner names on the provider Electronic Remittance Advice (ERA) following receipt of a Beneficiary Other Insurance (BOI) reply trailer 29. (See §70.6 of this Chapter for more details.)

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

(Rev. 138, 04-09-04)

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

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

For applicable cost sharing policy, see Pub 100-06, the Medicare Financial Management Manual, Chapter 1.

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

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

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

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

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

70.3 - Standard Medicare Charges for COB Records

(Rev. 138, 04-09-04)

A1-1600, B1-4601

See Chapter 1 of Pub 100-06, the Medicare Financial Management Manual.

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

70.6 - Consolidation of the Claims Crossover Process

(Rev. 138, 04-09-04)

The CMS has decided to streamline the claims crossover process to better serve our customers. Beginning with July 6, 2004, and running through October 1, 2004, approximately eight COBA trading partners will participate in the beta-site testing of the consolidated claims crossover or Coordination of Benefits Agreement (COBA) process. During this time, the COBA beta-site testers will participate in a parallel production crossover process (a pilot for only COBA trading partners using production/live data). During this time, the eight COBA trading partners will receive consolidated crossover claims as part of the Coordination of Benefits Agreement (COBA) process. In addition, if the eight COBA trading partners have individual Trading Partner Agreements (TPAs) executed with Medicare contractors, they will receive crossover claims based on the terms and conditions of those TPAs. The COBC will not charge the COBA beta-testers for crossed over claims during the parallel production period. Medicare intermediaries and carriers will, however, continue to charge these partners for claims that they continue to cross over to them during the beta-testing period.

Under the consolidated claims crossover process, trading partners will be transitioned from the current Trading Partner Agreement (TPA) process with intermediaries and carriers to new agreements called Coordination of Benefits Agreements (COBA). These agreements, which will be negotiated on behalf of CMS by the Coordination of Benefits Contractor (COBC), will be entered into directly between CMS and the COBA trading partners. Through the COBA process, each COBA trading partner will send one national eligibility file that includes eligibility information for each Medicare beneficiary that it insures to the COBC. The COBC will transmit the beneficiary eligibility file(s) to the Common Working File (CWF) via a maintenance transaction. The transaction is known as the Beneficiary Other Insurance (BOI) auxiliary file. (See Chapter 27, §80.14, of Publication 100-04, Medicare Claims Processing Manual, for more details about the contents of the BOI auxiliary file.)

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

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

The effort to consolidate the claims crossover function will be implemented via a phased-in approach, beginning with a small-scale implementation on July 6, 2004, involving approximately ten COBA trading partners that will serve as beta-site testers. The transition of existing eligibility-file based trading partners to the COBA process should be completed by April 30, 2005.

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

Effective July 6, 2004, the COBC will begin to send initial copies of the COBA Insurance File (COIF) to the nine CWF host sites. The COIF will contain specific information that will identify the COBA trading partner, including name, COBA ID, address, and tax identification number (TIN). It will also contain each trading partner's claims selection

criteria along with an indicator (Y=Yes or N=No) of whether the trading partner wishes its name to be printed on the Medicare Summary Notice (MSN).

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

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

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

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

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

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

BOI Reply Trailer and Claim-based Reply Trailer Processes

1. *BOI Reply Trailer Process*

For eligibility file-based crossover, intermediaries and carriers shall send processed claims information to the COBC for crossover to a COBA trading partner in response to the receipt of a CWF BOI reply trailer 29. Intermediaries or carriers will only receive a BOI reply trailer 29 under the consolidated crossover process for claims that CWF has selected for crossover after reading each COBA trading partner's claims selection criteria as reported on the weekly COIF submission.

When a BOI reply trailer 29 is received, the COBA assigned ID will identify the type of crossover (see the Data Elements Required for the BOI Aux File Record Table in Chapter 27, §24). Although each COBA ID will consist of a five-digit prefix that will be all zeroes, Intermediaries and Carriers are only responsible for picking up the last five digits within these ranges, which will be right justified in the COBA number field. In addition to the trading partner's COBA ID, the BOI reply trailer shall also include the COBA trading partner name(s), an "A" crossover indicator that specifies that the claim has been selected to be crossed over, and a one-digit indicator ["Y"=Yes; "N"=No] that specifies whether the COBA trading partner's name should be printed on the beneficiary MSN. If a Medicare intermediary or carrier receives an "N" indicator from the BOI reply trailer designating that the trading partner's name is not to be printed on the MSN, the Medicare intermediary or carrier shall print its customary generic crossover message(s) on the MSN rather than including the trading partner's name.

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

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

2. Medicare Summary Notice (MSN) and Electronic Remittance Advice (ERA) Crossover Messages During the Parallel Production Period

During the COBA parallel production period (July 6, 2004, to October 1, 2004): 1) CWF will only return an "N" MSN indicator on the BOI reply trailer 29, in accordance with information received via the COIF submission; 2) If a "Y" indicator is returned, the intermediary or carrier shall ignore it; and 3) the intermediary or carrier shall follow its existing procedures for the printing of MSN crossover messages.

During the COBA parallel production period, intermediaries and carriers shall follow their current procedures for the reporting of crossover claims information in CLP-02 (Claim Status Payment) and in the NM101, NM102, NM103, NM108, and NM109 segments of Loop 2100 of the provider Electronic Remittance Advice (ERA). They shall also continue with their current procedure for inclusion of COB trading partner names on other kinds of provider remittance advices that you have in production.

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

During the COBA parallel production period (July 6, 2004, to October 1, 2004), the intermediary or carrier shall observe the following business rules when it receives a BOI reply trailer 29 and some other indication of crossover eligibility:

If the intermediary or carrier receives a BOI reply trailer 29 with COBA IDs that fall in the ranges of 00001-89999, it shall continue to cross over claims a) per your existing TPAs and b) when Medigap or Medicaid information is reported on the claim. (NOTE: The preceding claim-based scenario does not apply to intermediaries.) In addition, the intermediary or carrier shall send claims for which it receives BOI reply trailers to the COBC on the 837 v4010A1 flat file or National Council for Prescription Drug Programs (NCPDP) file. (NOTE: The COBA trading partner will only be charged for the claims that the intermediary or carrier continues to cross to it during the parallel production period.)

During the parallel production period, the intermediary or carrier shall not change its current procedures regarding suppression of Medicaid claims when a beneficiary has

non-Medigap and/or Medigap insurance. The intermediary or carrier's Medicaid suppression logic should remain the same as today with its existing trading partners, even when it receives a BOI reply trailer that includes a Medicaid COBA ID.

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

Intermediaries or carriers shall transmit all non-NCPDP claims received with a COBA ID via a BOI reply trailer to the COBC in an 837 v.4010A1 flat file, as described in Transmittal AB-03-060. In a separate transmission, DMERCs shall send the claims received in the NCPDP file format to the COBC. Intermediaries and Carriers shall enter the 5-digit COBA ID picked up from the BOI reply trailer 29 in the 1000B loop of the NM1 segment in the NM109 field. In a situation where multiple COBA IDs are received for a claim, intermediaries and carriers shall send a separate 837 or NCPDP transaction to the COBC for each COBA ID. Intermediaries and carriers shall perform the transmission at the end of their regular batch cycle, when claims come off the payment floor, to ensure crossover claims are not processed by the COBA trading partner prior to Medicare's final payment. Transmission should occur via Network Data Mover (NDM) over AGNS (AT&T Global Network Services).

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

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

a) ISA (Interchange Control Header Segment);

b) IEA (Interchange Control Trailer Segment);

c) GS (Functional Group Header Segment); and

d) GE (Functional Group Trailer Segment).

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

NM103—Use spaces; and

NM109—Include COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29).

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

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

NM1 segment—For NM109, include HICN;

N3 segment—Use all spaces; and

N4 segment—Use all spaces.

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

NM1 segment—For NM103, use spaces;

NM1 segment—For NM109, include the COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29);

N3 segment—Use all spaces; and

N4 segment—Use all spaces.

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

NM103—Use spaces; and

NM109—Include COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29) .

The 2330B loop shall be repeated to allow for the inclusion of the name (NM103) and associated Trading Partner ID (NM109) for each existing trading partner.

The 2320 loop denotes other subscriber information. Within the SBR segment, the SBR03 and SBR04 segments are used to define the group/policy number and insured group name, respectively. If the information is available for these fields, those values should be propagated accordingly for both current trading partners and COBA trading partners. The COBC will inspect these values for COBA related eligibility based claims and overlay as appropriate. Spaces should only be used for COBA-related situations.

---SBR01—Treat as normally do.

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

As the ISA, IEA, and GS segments are included in the '100' record with other required segments, the '100' record must be passed to the COBC. However, as the values for

these segments will be recalculated, spaces may be placed in all of the fields related to the ISA, IEA, and GS segments.

The 1000B loop of the NM1 segment denotes the crossover trading partner. If multiple COBA IDs are received via the BOI reply trailer, a separate 837 transaction should be submitted for each COBA ID received. As the crossover trading partner information will be unknown to the standard systems, the following fields should be formatted as follows for the NM1 segment on the'100' record:

NM103—Use spaces; and

NM109—Include COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29).

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

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

NM1 segment—For NM109, include HICN;

N3 segment—Use all spaces; and

N4 segment—Use all spaces.

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

NM1 segment—For NM103, use spaces;

NM1 segment—For NM109, include COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29);

N3 segment—Use all spaces; and

N4 segment—Use all spaces.

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

NM103—Use spaces; and

NM109—Include COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29).

The 2330B loop shall be repeated to allow for the inclusion of the name (NM103) and associated Trading Partner ID (NM109) for each existing trading partner.

The 2320 loop denotes other subscriber information. Within the SBR segment, the SBR03 and SBR04 segments are used to define the group/policy number and insured group name, respectively. If the information is available for these fields, those values should be propagated accordingly for both current trading partners and COBA trading partners. The COBC will inspect these values for COBA related eligibility based claims and overlay as appropriate. Spaces should only be used for COBA-related situations.

---SBR01—Treat as normally do.

D. COBC Processing of COB Flat Files or NCPDP Files

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

Claims Response File Layout (80 bytes)				
Field	*Name*	*Size*	*Displacement*	*Description*
1.	*Contractor Number*	*5*	*1-5*	*Contractor Identification Number*
2.	*Transaction Set Control Number/Batch Number*	*9*	*6-14*	*Found within the ST02 data element from the ST segment of the ANSI 837 flat file or in field 806-5C from the batch header of the NCPDP file.*
3.	*Number of claims*	*9*	*15-23*	*Number of Claims contained in the ANSI 837 flat file or NCPDP file. This is a numeric field that will be right justified and zero-filled.*
4.	*Receipt Date*	*8*	*24-31*	*Receipt Date of ANSI 837 flat file or NCPDP file in CCYYMMDD format*
5.	*Accept/Reject indicator*	*1*	*32*	*Indicator of either the acceptance or rejection of the ANSI 837 flat file or NCPDP file. Values will either be an "A" for accepted or "R" for rejected.*
6.	*Filler*	*48*	*33-80*	*Spaces*

Claims response files will be returned to Medicare contractors after receipt and initial processing of a claim file. Thus, for example, if an intermediary or carrier sends a COB flat file daily, the COBC will return a claim response file to that contractor on a daily basis.

COB 837 flat files and NCPDP files that will be transmitted by the intermediary or carrier to the COBC will be assigned the following file names:

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

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

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

Note that "xxxxx" denotes the Medicare contractor number. Test files will be prefixed with "TCOB" instead of "PCOB." The "TCOB" prefix will be used as part of the system (release) testing within the test environment. During the parallel production period (July 6, 2004, to October 1, 2004), all 837 flat files submitted to the COBC will be prefixed with "PCOB."

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

The file names for the Claims Response File returned to the intermediary or carrier will be created as part of the NDM set-up process.

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

E. The Future COBA Claim-Based Process Involving CWF

The CWF shall load the initial COIF submission from COBC as well as all future updates that pertain to claim-based Medigap insurers and State Medicaid Agencies.

Once claim-based crossover becomes effective in the future, CWF shall only search the COIF if the carrier or DMERC has included a claim-based Medigap ID (55000-59999) or claim-based Medicaid ID (78000-79999) in field 36 of the HUBC or HUDC query. During the parallel production period (July 6, 2004, to October 1, 2004) and until the future implementation date for the claim-based COBA crossover process, CWF shall ignore claim-based COBA ID values if entered in field 36 of the HUBC or HUDC query.

Beginning with the implementation of the COBA claim-based crossover process, if claim-based COBA IDs are entered in field 36 of the HUBC or HUDC query, CWF shall:

Search the COIF to locate the claim-based Medicaid and/or Medigap COBA ID and corresponding COBA trading partner name;

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

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

Return an alert code 7704 on the "01" response via a Claim-based alert trailer 21 to the carrier or DMERC if a claim-based COBA ID in the Medigap claim-based range (55000-59999) is not located on the COIF;

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

COBA Claim-Based Crossover Process

Until further notice from CMS, carriers and DMERCs shall not cease their existing claim-based Medigap and/or Medicaid crossover processes. Carriers and DMERCs will receive COBA claim-based crossover requirements as part of a future instruction.

G. Transition to the National COBA and Customer Service Issues

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

*Intermediaries and carriers shall keep their present crossover process in place, including invoicing for claims crossed to current trading partners, as described in Pub. 100-06, Financial Management, Chapter 1, §450 and §460, until each of their present trading partners has been transitioned to the COBA process. As trading partners are signed on to national COBAs, they will be advised that it is their responsibility to simultaneously cancel current agreements with intermediaries and carriers and to cease submission of eligibility files. (**NOTE:** During the parallel production period, the COBA trading partner will be instructed by CMS to not cancel current TPAs with you.) By current estimates, CMS expects to complete the transition of current eligibility file-based trading partners to COBAs by April 30, 2005.*

Given CMS's initial plans for a small-scale implementation of the COBA process on July 6, 2004, you shall continue to execute new crossover agreements (Trading Partner Agreements or TPAs) for trading partners that wish to go into live production by August 1, 2004. These new TPAs and extensions of existing TPAs shall allow for future termination no later than April 30, 2005. Trading partners that either wish to go into live crossover production after August 1, 2004, or have current questions regarding the COBA process shall be referred to the COBC at 1-800-999-1118.

2. Workload Reporting In Light of COBA

For workload reporting purposes, intermediaries and carriers shall provide counts for those claims that they individually cross to current trading partners (including Medicaid), just as they currently do in CAFM II and in CROWD. Intermediaries and carriers shall separately track claims transmitted to the COBC for crossover to the COBA trading partners for future reporting requirements by COBA ID.

3. Customer Service

Beginning with the larger-scale implementation of the COBA process, which takes effect as part of the October 2004 systems release, intermediary and carrier customer service personnel shall answer provider/supplier and beneficiary questions about a claim's crossover status by referring to the intermediary or carrier's internal claims history. During the parallel production period (July 6, 2004, to October 1, 2004), the intermediary and carrier shall proceed with its current claims crossover customer service process. In addition, the intermediary or carrier's claims history shall not be updated with crossover information based upon the receipt of a CWF BOI reply trailer 29.

Beginning with the October 2004 systems release, intermediary and carrier customer service staff shall access information regarding why a claim did not cross by referring to various detailed history screens on the Health Insurance Master File (e.g., INPH, OUTH, HOSH, PTBH, DMEH, and HHAH). [See Chapter 27, §80.15 of the Medicare Claims

Processing Manual for a listing of all claims crossover disposition indicators.] In addition to specifying why a claim did not cross over to a COBA trading partner, the HIMR detailed listing screens will also display an indicator "A," which confirms that a claim was selected to be crossed over to the COBA ID shown. The BOI auxiliary file will identify the name associated with the COBA ID.

The intermediary and carrier will receive instructions on the use of the new HIMR screens from the CWF maintainer well in advance of October 4, 2004.

80 - Electronic Transmission - General Requirements

(Rev. 138, 04-09-04)

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

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

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

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

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

building the outbound COB transaction. This is to show any changes in data element values as a result of claims adjudication. The shared system must retain the data in the SFR for a minimum of six months.

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

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

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

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

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

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

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

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

Non-Medicare data (and Medicare data elements where field sizes are in excess of the core system) are written to the SFR; and adjudicated data is combined with repository data to create the outbound COB. *Under the COBA process, the COBC will receive flat files containing processed Medicare claims. After applying each trading partner's claims selection criteria, the COBC will then transmit outbound COB transactions to the COBA trading partner. Implementation of this process will occur throughout the period July 6, 2004, to April 30, 2005. Refer to §70.6 of this chapter for more details.*

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

(Rev. 138, 04-09-04)

The intermediary or carrier charges Medigap and other complementary insurers (but not Medicaid) for the cost of preparing and sending COB transactions. The transfer agreement must include a description of data elements on the invoice (bill). (See §70.3 above.) *Once CMS has fully consolidated the claims crossover process under the COBC on/about May 1, 2005, that entity will have exclusive responsibility for the collection and reconciliation of crossover claim fees for those Medigap and non-Medigap claims that are sent to the COBC to be crossed over.*

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

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

80.3 - Medigap Electronic Claims Transfer Agreements

(Rev. 138, 04-09-04)

B3-4709, B4-2110.1

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

At a minimum, all transfer agreements include:

Functions of the carrier;

Functions of the Medigap insurer;

Fees and payment schedules;

Confidentiality/Disclosure of information furnished;

Office of Inspector General (OIG) review access;

Contract periods and automatic renewal provisions;

Contract termination provisions; and

Dated signatures of authorized carrier/Medigap insurer representatives

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

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

80.3.1 - Intermediary Crossover Claim Requirements

(Rev. 138, 04-09-04)

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

Outbound COB

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

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

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

The shared system maintainer must accommodate the COB transaction.

The flat file creation process and responsibility for sending outbound COB files to crossover trading partners will change appreciably once CMS's COBA process is implemented. The implementation of COBA is scheduled to begin July 6, 2004, and conclude by April 30, 2005. See §70.6 for details about intermediary verses COBC responsibilities under the COBA process.

Summary of Process

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

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

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

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

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

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

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

80.3.2 - Carrier/DMERC Crossover Claim Requirements

(Rev. 138, 04-09-04)

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

Outbound Coordination of Benefits (COB)

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

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

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

The flat file creation process and responsibility for sending outbound COB files to crossover trading partners will change appreciably once CMS's COBA process is implemented. The implementation of COBA is scheduled to begin on a small-scale on July 6, 2004, and conclude by April 30, 2005. See §70.6 of this chapter for details about carrier/DMERC versus COBC responsibilities under the COBA process.

Summary of Process

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

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

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

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

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

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

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

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