| CMS Manual System | **Department of Health & Human Services (DHHS)** |
|---|---|
| Pub 100-04 Medicare Claims Processing | **Centers for Medicare & Medicaid Services (CMS)** |
| **Transmittal 4069** | **Date: June 8, 2018** |
| | **Change Request 10737** |

**SUBJECT: Alignment of Coordination of Benefits Agreement (COBA) Internet Only Manual References**

**I. SUMMARY OF CHANGES:** Recently, the Centers for Medicare & Medicaid Services (CMS) modified chapter 27 of the Claims Processing Manual (Pub.100-04). This modification included renumbering of certain sections in chapter 27. Through this instruction, CMS updates relevant sections of chapter 28 of the Claims Processing Manual to ensure they properly reference the newly numbered sections in chapter 27 and make appropriate reference to the Benefits Coordination & Recovery Center (BCRC) as opposed to the Coordination of Benefits Contractor (COBC).

**EFFECTIVE DATE: July 9, 2018**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: July 9, 2018**
***Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.***

**II. CHANGES IN MANUAL INSTRUCTIONS:** (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

| R/N/D | CHAPTER / SECTION / SUBSECTION / TITLE |
|---|---|
| R | 28/20/ Assignment of Claims and Transfer Policy |
| R | 28/40/ MSN Messages |
| R | 28/60/ Returned Medigap Notices |
| R | 28/70/ Coordination of Medicare With Medigap and Other Complementary Health Insurance Policies |
| R | 28/70/70.3 - Standard Medicare Charges for COB Records |
| R | 28/70/70.6- Consolidation of the Claims Crossover Process |
| R | 28/70/70.6.2- Coordination of Benefits Agreement (COBA) Full Claim File Repair Process |
| R | 28/70/70.6.3- Coordination of Benefits Agreement (COBA) Eligibility File Claims Recovery Process |
| R | 28/70/70.6.4- Coordination of Benefits Agreement (COBA) Medigap Claim-Based Crossover Process |
| R | 28/80- Electronic Transmission - General Requirements |

**III. FUNDING:**
**For Medicare Administrative Contractors (MACs):**
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

**IV. ATTACHMENTS:**

**Business Requirements**
**Manual Instruction**

# Attachment - Business Requirements

| Pub. 100-04 | Transmittal: 4069 | Date: June 8 2018 | Change Request: 10737 |
|---|---|---|---|

**SUBJECT: Alignment of Coordination of Benefits Agreement (COBA) Internet Only Manual References**

**EFFECTIVE DATE: July 9, 2018**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: July 9, 2018**

## I. GENERAL INFORMATION

**A. Background:** Through change request (CR) 10497, the Centers for Medicare & Medicaid Services (CMS) updated chapter 27 of the Claims Processing Manual (Pub.100-04). As a result of this modification, many sections within chapter 27 were eliminated, resulting in a renumbering of the remaining sections. The CMS has determined that language within various sections of chapter 28 of the Claims Processing Manual that are reserved for the Coordination of Benefits Agreement (COBA) Medicare crossover process must now be updated to align with the newly numbered sections in chapter 27.

The CMS is also updating various portions of chapter 28 so that remaining references to the Coordination of Benefits Contractor (COBC) are updated to the Benefits Coordination & Recovery Center (BCRC).

**B. Policy:** All Medicare Administrative Contractors (MACs) shall now follow the updated guidance in Pub.100-04 chapter 28 to ensure they are being directed to the correct sections in the newly revised chapter 27 Common Working File requirements section. Additionally, all MACs shall now refer to the contractor that administers the COBA crossover process on behalf of CMS as the BCRC rather than as the COBC.

## II. BUSINESS REQUIREMENTS TABLE

*"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.*

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| 10737.1 | In referencing section 70.6 in chapter 28 of Pub. 100-04, contractors shall be aware that information previously located in Pub. 100-04 chapter 27, section 80, subsection 80.14 regarding the Consolidated Claims Crossover Process was moved to section 80, subsection 4. | X | X | X | X | | | | | RRB-SMAC |
| 10737.1.1 | In referencing section 70.6 in chapter 28 of Pub. 100-04, contractors shall be aware that information previously located in Pub. 100-04 chapter 27, section 80, subsection 80.15 regarding Claims Crossover Disposition and Coordination of Benefits Agreement | X | X | X | X | | | | | RRB-SMAC |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| | By-Pass Indicators was moved to section 80, subsection 5. | | | | | | | | | |
| 10737.1.2 | In referencing the mass adjustment claims portion of section 70.6 in chapter 28, contractors shall be aware that information previously located in Pub. 100-04 chapter 27, section 80, subsection 80.16 regarding Special Mass Adjustment and Other Adjustment Crossover Requirements was moved to section 80, subsection 6. | X | X | X | X | | | | | RRB-SMAC |
| 10737.1.3 | In referencing the mass adjustment claims portion of section 70.6 in chapter 28, contractors shall be aware that information previously located in Pub.100-04, chapter 27, section 80, subsection 80.18 regarding Inclusion and Exclusion of Specified Categories of Adjustment Claims for Coordination of Benefits Agreement (COBA) Crossover Purposes was moved to section 80, subsection 8. | X | X | X | X | | | | | RRB-SMAC |
| 10737.1.4 | In referencing section 70.6.4 of chapter 28, contractors shall be aware that information previously located in Pub. 100-04 chapter 27, section 80, subsection 80.17 regarding the Coordination of Benefits Agreement (COBA) Medigap Claim-Based Crossover Process was moved to section 80, subsection 7. (Note: This guidance only applies to A/B MACs Part B and DME MACs.) | | X | | X | | | | | RRB-SMAC |
| 10737.2 | All MACs shall now refer to the contractor that administers the COBA crossover process on behalf of CMS as the BCRC rather than as the COBC. | X | X | X | X | | | | | |

## III. PROVIDER EDUCATION TABLE

| Number | Requirement | Responsibility | | | | |
|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | CEDI |
| | | A | B | HHH | | |
| | None | | | | | |

## IV. SUPPORTING INFORMATION

**Section A: Recommendations and supporting information associated with listed requirements:** N/A

*"Should" denotes a recommendation.*

| X-Ref Requirement Number | Recommendations or other supporting information: |
|---|---|

**Section B: All other recommendations and supporting information:** N/A

## V. CONTACTS

**Pre-Implementation Contact(s):** Brian Pabst, 410-786-2487 or brian.pabst@cms.hhs.gov

**Post-Implementation Contact(s):** Contact your Contracting Officer's Representative (COR).

## VI. FUNDING

**Section A: For Medicare Administrative Contractors (MACs):**
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

**ATTACHMENTS: 0**

## 20 - Assignment of Claims and Transfer Policy

***(Rev.4069, Issued: 06-08 – 18, Effective: 07- 09- 18, Implementation: 07- 09-18)***

A Medicare beneficiary who has a Medigap policy may authorize the participating physician/practitioner 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, Medicare must transfer Medicare claims information to the Medigap insurer. The Medigap insurer pays the physician/provider/supplier directly. The Medigap insurer, in turn, reimburses CMS's designated COBA contractor for the 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 A/B MAC (*Part* B) and DME MAC systems must have the capability to distinguish between claims of participating and nonparticipating physicians/practitioners and suppliers. This is because Medigap assignment of claims and transfer policy does not apply to nonparticipating physicians/practitioners 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 physician/practitioner and supplier of durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) will only include the CMS-issued Medigap claim-based COBA ID (ID range 55000 through 55999), which will be assigned by CMS's *Benefits Coordination & Recovery Center (BCRC)*, if: (1) the physician/practitioner 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.

## 40 - MSN Messages

***(Rev.4069, Issued: 06-08 – 18, Effective: 07- 09- 18, Implementation: 07- 09-18)***

All A/B MACs and DME MACs shall use the following messages, as appropriate, on the beneficiary's MSN for each approved claim for which they have sent or will send a transaction to a Medigap insurer through the *BCRC*:

MSN # 35.1 - "This information is being sent to your private insurer(s). Send any questions regarding your benefits to them." (**Note:** add if possible: Your private insurer(s) is/are).

MSN # 35.2 - "We have sent your claim to your Medigap insurer. Send any questions regarding your Medigap benefits to them." (**Note:** add if possible: Your Medigap insurer is.).

All MACs use the following messages, as appropriate, to explain why a transaction was not or will not be sent to the Medigap insurer:

Effective with October 1, 2007, A/B MACs and DME MACs shall ensure that MSN #35.3 reads as follows:

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

Spanish translation of MSN # 35.3:
"No se enviará copia de esta notificación a su asegurador de Medigap debido a que la información estaba incompleta o era inválida. Favor de someter una copia de esta notificación a su asegurador Medigap."

MSN #35.4 - “A copy of this notice will not be forwarded to your Medigap insurer because your provider does not participate in the Medicare program. Please submit a copy of this notice to your Medigap insurer.

MSN #35.5 - “We did not send this claim to your private insurer. They have indicated no additional payment can be made. Send any questions regarding your benefits to them.” (This would be expressed on a RA by the absence of transfer information.)

MSN #35.6 - “Your supplemental policy is not a Medigap policy under Federal and State law/regulation. It is your responsibility to file a claim directly with your insurer.”

MSN #35.7 - “Please do not submit this notice to them.” (Add-on to other messages as appropriate).

MSN’s must be sent in all instances except for the following claim types: laboratory, demonstrations, exact duplicates, and statistical adjustments. These four types require the suppression of notices.

## 60 - Returned Medigap Notices

***(Rev.4069, Issued: 06-08 – 18, Effective: 07- 09- 18, Implementation: 07- 09-18)***

A/B MACs (*Part* B) and DME MACs ceased this responsibility on October 1, 2007, when CMS’s *BCRC* assumed full responsibility for the COBA claim-based Medigap process.

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

***(Rev.4069, Issued: 06-08 – 18, Effective: 07- 09- 18, Implementation: 07- 09-18)***

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.

**Cost Calculation Process Leading Up to the *BCRC’s* Assumption of Claim-Based Medigap Crossovers**

Up to and including the final claims transferred under their pre-existing mandatory Medigap (claim-based) crossover processes (note: the “final” claims should be those processed by the A/B MAC (*Part* B) or DME MAC just before the October 2007 release is installed), A/B MACs (*Part* B) and DME MACs 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)

Effective October 1, 2005, CMS fully consolidated the eligibility file-based claims crossover process, as it relates to Medigap insurers and other commercial payers, under the *BCRC.* Refer to §70.6 and succeeding sub-sections for A/B MAC (*Part* B) and DME MAC requirements and responsibilities relating to the national Coordination of Benefits Agreement (COBA) consolidated crossover process. Refer to §70.6.4 for all MAC requirements relating to the COBA Medigap claim-based crossover process, which was inaugurated on October 1, 2007. (See also Pub.100-04 chapter 27 §80.*7*.)

Following crossover consolidation, all A/B MACs (*Part* B) and DME MACs shall continue to pursue collection of unpaid debts from Medigap insurers and other existing trading partners, even after such entities have been transitioned to the COBA process. Those MACs that maintained claim-based crossover arrangements with Medigap insurers shall pursue collection of their invoices up through and including their invoices for the final claims transfer to the Medigap entities. These invoices should have been issued no later than one (1) month following the last claims transfer to the Medigap insurers.

**Suppression of Sanctioned Provider Claims from Claim-Based Medigap Crossovers**

Effective with April 2, 2007, all A/B MACs (*Part* B) and DME MACs shall suppress fully denied provider sanctioned claims for their mandatory Medigap crossover process with Medigap insurers, as authorized by §1842(h)(3)(B) of the Social Security Act and §4081(a)(B) of the Omnibus Budget Reconciliation Act of 1987 [Public Law 100-230].

**NOTE:** All A/B MACs (*Part* B) and DME MACs shall continue to suppress 100 percent paid and 100 percent denied claims from their mandatory Medigap crossovers, per previous CMS guidance.

## 70.3 - Standard Medicare Charges for COB Records

***(Rev.4069, Issued: 06-08 – 18, Effective: 07- 09- 18, Implementation: 07- 09-18)***

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

The *BCRC* now has exclusive responsibility for the collection and reconciliation of crossover claim fees for those Medigap and non-Medigap claims that A/B MACs and DME MACs send to the *BCRC* to be crossed to trading partners.

## 70.6 - Consolidation of the Claims Crossover Process

***(Rev.4069, Issued: 06-08 – 18, Effective: 07- 09- 18, Implementation: 07- 09-18)***

**Background – Medicare Claims Crossover Process—General**

Through the Benefits Coordination & Recovery Center (BCRC), Medicare transmits outbound 837 Coordination of Benefit (COB) and Medigap claims to COB trading partners and Medigap plans, collectively termed "trading partners," on a post-adjudicative basis. This type of transaction, originating at individual A/B MACs and DME MACs following their claims adjudication activities, includes incoming claim data, as modified during adjudication if applicable, as well as payment data. All A/B MACs and DME MACs are required to accept all ASC X12 837 segments and data elements permitted by the in-force applicable guides on an initial ASC X12 837 professional or institutional claim from a provider, but they are not required to use every segment or data element for Medicare adjudication. Segments and data elements determined to be extraneous for Medicare claims adjudication shall, however, be retained by the A/B MACs (*Part* B) and DME MACs within its store-and-forward repository (SFR). Incoming claims data shall be subjected to standard syntax and applicable implementation guide (IG) edits prior to being deposited in the SFR to assure non-compliant data will not be forwarded on to another payer as part of the Medicare crossover process. SFR data shall be re-associated with those data elements used in Medicare claim adjudication, as well as with payment data, to create an ASC X12 837 IG-compliant outbound COB/Medigap transaction. The shared systems shall always retain the data in the SFR for a minimum of 6 months.

The ASC X12 837 institutional and professional implementation guides require that claims submitted for secondary payment contain standard claim adjustment reason codes (CARCs) to explain adjudicative decisions made by the primary payer. For a secondary claim to be valid, the amount paid by the primary payer plus the amounts adjusted by the primary payer shall equal the billed amount for the services in the claim. A tertiary payer to which Medicare may forward a claim may well need all data and adjustment codes Medicare receives on a claim. A tertiary payer could reject a claim forwarded by Medicare if the adjustment and payment data from the primary payer or from Medicare did not balance against the billed amounts for the services and the claim. As a result, shared systems shall reject inbound Medicare Secondary Payer (MSP) claims if the paid and adjusted amounts do not equal the billed amounts and if the claims lack standard CARCs to identify adjustments to the total amount billed.

As a rule, the shared system maintainers shall populate an outbound COB/Medigap file as an ASC X12 837 flat file with the Employer Identification Number (EIN)/Tax ID or SSN (for a sole practitioner) present in the provider's file, unless otherwise specified within §70.6.5 or §70.6.6 of this chapter. With the adoption of the National Provider Identifier (NPI), the shared system shall report qualifier XX in NM108 and the NPI

value in NM109. The shared system shall report the provider's EIN/TAX ID within the REF segment of the billing provider loop, as appropriate. In addition, unless otherwise stated within §70.6.5 or §70.6.6 of this chapter, the shared systems shall populate the provider loops on outbound ASC X12 837 claims with the provider's first name, last name, middle initial, address, city, state and zip code as contained in the Medicare provider files, the information for which is derived from the Provider Enrollment Chain and Ownership System (PECOS).

**Background—Specific COBA Crossover Process**

The CMS has streamlined the claims crossover process to better serve its customers. Under the consolidated claims crossover process, trading partners execute national agreements called Coordination of Benefits Agreements (COBAs) with CMS's BCRC. 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 BCRC. The BCRC will transmit the beneficiary eligibility file(s) to the Common Working File (CWF) via the HUBO maintenance transaction. The transaction is also termed the "Beneficiary Other Insurance (BOI)" auxiliary file. (See Pub.100-04, chapter 27, §80.*4* for more details about the contents of the BOI auxiliary file.)

During August 2003, the CMS modified CWF to accept both the HUBO (BOI) transaction on a regular basis and COBA Insurance File (COIF) as a weekly file replacement. Upon reading both the BOI and the COIF, CWF applies 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.

Upon receipt of a BOI reply trailer (29) that contains (a) COBA ID (s) and other crossover information required on the Health Insurance Portability and Accountability Act (HIPAA) ASC X12 835 Electronic Remittance Advice (ERA), all A/B MACs and DME MACs shall send processed claims via an ASC X12 837 COB flat file or National Council for Prescription Drug Programs (NCPDP) file to the BCRC. The BCRC, in turn, will cross the claims to the COBA trading partner in the HIPAA ASC X12 837 or NCPDP formats, following its validation that the incoming Medicare claims are formatted correctly and pass HIPAA or NCPDP compliance editing.

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

For more information regarding the COBA Medigap claim-based crossover process, which was enacted on October 1, 2007, consult §70.6.4 of this chapter.

## I. A/B MAC (*Part* A, *Part* B, or *Part* HH*H*) or DME MAC Actions Relating to CWF Claims Crossover Exclusion Logic

### A. Determination of Beneficiary Liability for Claims with Denied Services

Effective with the January 2005 release, the A/B MAC (*Part* B) and DME MAC shared systems shall include an indicator "L" (beneficiary is liable for the denied service[s]) or "N" (beneficiary is not liable for the denied service[s]) in an available field on the HUBC and HUDC queries to CWF for claims on which all line items are denied. The liability indicators (L or N) shall be reflected at the header or claim level rather than at the line level.

For purposes of applying the liability indicator L or N at the header/claim level and, in turn, including such indicators in the HUBC or HUDC query to CWF, the A/B MACs (*Part* B) and DME MAC shared systems shall follow these business rules:

- The L or N indicators are not applied at the header/claim level if any service on the claim is payable by Medicare;

- The "L" indicator is applied at the header/claim level if the beneficiary is liable for any of the denied

services on a fully denied claim; and

- The "N" indicator is applied at the header/claim level if the beneficiary is not liable for all of the denied services on a fully denied claim.

Effective with October 2007, the CWF maintainer shall create a 1-byte beneficiary liability indicator field within the header of its HUIP, HUOP, HUHH, and HUHC Part A claims transactions (valid values for the field="L," "N," or space).

As A/B MACs (*Part* A) and A/B MACs (*Part* HH*H*) adjudicate claims and determine that the beneficiary has payment liability for any part of the fully denied services or service lines, they shall set an "L" indicator within the newly created beneficiary liability field in the header of their HUIP, HUOP, HUHH, and HUHC claims that they transmit to CWF. In addition, as A/B MACs (*Part* A) and A/B MACs (*Part* HH*H*) adjudicate claims and determine that the beneficiary has no payment liability for any of the fully denied services or service lines - that is, the provider must absorb all costs for the fully denied claims - they shall include an "N" beneficiary indicator within the designated field in the header of their HUIP, HUOP, HUHH, and HUHC claims that they transmit to CWF. NOTE: A/B MACs (*Part* A) and A/B MACs (*Part* HH*H*) shall not set the "L" or "N" indicator on partially denied/partially paid claims.

Upon receipt of an HUIP, HUOP, HUHH, or HUHC claim that contains an "L" or "N" beneficiary liability indicator, CWF shall read the COBA Insurance File (COIF) to determine whether the COBA trading partner wishes to receive "original" fully denied claims with beneficiary liability (crossover indicator "G") or without beneficiary liability (crossover indicator "F") or "adjustment" fully denied claims with beneficiary liability (crossover indicator "U") or without beneficiary liability (crossover indicator "T").

If CWF determines that the COBA trading partner wishes to exclude the claim, as per the COIF, it shall suppress the claim from the crossover process.

CWF shall post the appropriate crossover disposition indicator in association with the adjudicated claim on the HIMR detailed history screen (see §80.*5* of this chapter).

In addition, the CWF maintainer shall create and display the new 1-byte beneficiary liability indicator field within the HIMR detailed history screens (INPL, OUTL, HHAL, and HOSL), to illustrate the indicator ("L" or "N") that appeared on the incoming HUIP, HUOP, HUHH, or HUHC claim transaction.

**CWF Editing for Incorrect Values**

If an A/B MAC (*Part* A) or A/B MAC (*Part* HH*H*) sends values other than "L," "N," or space in the newly defined beneficiary liability field in the header of its HUIP, HUOP, HUHH, or HUHC claim, CWF shall reject the claim back to the A/B MAC for correction. Following receipt of the CWF rejection, the A/B MAC (*Part* A) and A/B MAC (*Part* HH*H*) shall change the incorrect value placed within the beneficiary liability field and retransmit the claim to CWF.

**B. Developing a Capability to Treat Entry Code "5" and Action Code "3" Claims As Recycled "Original" Claims For Crossover Purposes**

Effective with July 2007, in instances when CWF returns an error code 5600 to an A/B MAC and DME MAC, thereby causing it to reset the claim's entry code to "5" and action code to "3," the MAC shall set a newly developed "N"(non-adjustment) claim indicator ("treat as an original claim for crossover purposes") in the header of the HUBC, HUDC, HUIP, HUOP, HUHH, and HUHC claim in the newly defined field before retransmitting the claim to CWF. The A/B MAC and DME MAC shared system shall then resend the claim to CWF.

Upon receipt of a claim that contains entry code "5" or action code "3" with a non-adjustment claim header value of "N," the CWF shall treat the claim as if it were an "original" claim (i.e., as entry code "1" or action

code "1") for crossover inclusion or exclusion determinations. If CWF subsequently determines that the claim meets all other inclusion criteria, it shall mark the claim with an "A" ("claim was selected to be crossed over") crossover disposition indicator.

Following receipt of a Beneficiary Other Insurance (BOI) reply trailer (29) for the recycled claim, the A/B MACs' and DME MACs' shared systems shall ensure that, as part of their ASC X12 837 flat file creation processes, they populate the 2300 loop CLM05-3 (Claim Frequency Type Code) segment with a value of "1" (original). In addition, the A/B MACs' and DME MACs' shared systems shall ensure that, as part of their ASC X12 837 flat file creation process, they do not create a corresponding 2330 loop REF*T4*Y segment, which typically signifies "adjustment."

**C. Developing a Capability to Treat Claims with Non-Adjustment Entry or Action Codes as Adjustment Claims For Crossover Purposes**

Effective with July 2007, in instances where A/B MACs and DME MACs must send adjustment claims to CWF as entry code "1" or as action code "1" (situations where CWF has rejected the claim with edit 6010), they shall set an "A" indicator in a newly defined field within the header of the HUBC, HUDC, HUIP, HUOP, HUHH, or HUHC claim.

If A/B MACs and DME MACs send a value other than "A" or spaces within the newly designated header field within their HUBC, HUDC, HUIP, HUOP, HUHH, and HUHC claims, CWF shall apply an edit to reject the claim back to the MAC. Upon receipt of the CWF rejection edit, the MACs' systems shall correct the invalid value and retransmit the claim to CWF for verification and validation.

Upon receipt of a claim that contains entry code "1" or action code "1" with a header value of "A," the CWF shall take the following actions:

- Verify that, as per the COIF, the COBA trading partner wishes to exclude **either** adjustments, monetary adjustments, non-monetary, **or both**; and

- Suppress the claim if the COBA trading partner wishes to exclude **either** adjustments, monetary adjustments, non-monetary, **or both**.

**NOTE:** The expectation is that such claims do not represent mass adjustments tied to the MPFS or mass adjustments-other.

If A/ B MACs and DME MACs receive a BOI reply trailer (29) on a claim that had an "A" indicator set in its header, the A/B MACs' or DME MACs' systems shall ensure that, as part of their ASC X12 837 flat file creation processes, they populate the 2300 loop CLM05-3 ("Claim Frequency Type Code") segment with a value that designates "adjustment" rather than "original" to match the 2330B loop REF*T4*Y that they create to designate "adjustment claim."

If an A/B MAC's or DME MAC's shared system does not presently create a loop 2330B REF*T4*Y to designate adjustments, it shall not make a change to do so as part of this instruction.

**<u>Correcting Invalid Claim Header Values Sent to CWF</u>**

If A/B MACs and DME MACs send a value other than "A," "N," or spaces within the newly designated header field within their HUBC, HUDC, HUIP, HUOP, HUHH, and HUHC claims, CWF shall apply an edit to reject the claim back to the A/B MAC or DME MAC. Upon receipt of the CWF rejection edit, the A/B MACs' or DME MACs' systems shall correct the invalid value and retransmit the claim to CWF for verification and validation.

**D. CWF Identification of National Council for Prescription Drug Claims**

Currently, the DME MAC shared system is able to identify, through the use of an internal indicator, whether a

submitted claim is in the National Council for Prescription Drug Programs (NCPDP) format. Effective with January 2005, the DME MAC shared system shall pass an indicator "P" to CWF in an available field on the HUDC query when the claim is in the NCPDP format. The indicator "P" should be included in a field on the HUDC that is separate from the fields used to indicate whether a beneficiary is liable for all services that are completely denied on his/her claim.

The CWF shall read the new indicators passed via the HUBC or HUDC queries for purposes of excluding 100 percent denied claims with or without beneficiary liability and NCPDP claims. After applying the claims selection options, CWF will return a BOI reply trailer (29) to the A/B MAC or DME MAC only in those instances when the COBA trading partner expects to receive a Medicare processed claim from the BCRC.

Effective with July 2007, CWF shall reject claims back to DME MACs if their HUDC claim contains a value other than "P" in the established field used to identify NCPDP claims.

**E. CWF Identification and Auto-Exclusion of ASC X12 837 Professional Claims That Contain Only Physician Quality Reporting Initiative (PQRI) Codes**

Effective October 6, 2008, the CWF maintainer shall create space within the header of its HUBC claim transmission for a 1-byte PQRI indicator (valid values=Q or space).

In addition, CWF shall create a 2-byte field on page 2 of the HIMR claim detail in association with the new category "COBA Bypass" for the value "BQ," which shall designate that CWF auto-excluded the claim because it contained only PQRI codes (see §80.*5* of this chapter for more details regarding the bypass indicator).

Prior to transmitting the claim to CWF for normal processing, the A/B MAC (*Part* B) shared system shall input the value "Q" in the newly defined PQRI field in the header of the HUBC when **all** service lines on a claim contain PQRI (status M) codes.

Upon receipt of a claim that contains a "Q" in the newly defined PQRI field (which signifies that the claim contains only PQRI codes on all service detail lines, CWF shall auto-exclude the claim from the national COBA eligibility file-based and Medigap claim-based crossover processes. Following exclusion of the claim, CWF shall populate the value "BQ" in association with the newly developed "COBA Bypass" field on page 2 of the HIMR A/B MAC (*Part* B) and DME MAC claim detail screens.

Prior to October 6, 2008, all A/B MACs and DME MACs shall update any of their provider customer service materials geared towards crossover claims related inquiries to reflect the newly developed "BQ" by-pass value, which designates that CWF auto-excluded the claim because it only contained PQRI codes.

The Next Generation Desktop (NGD) contractor shall also modify its user screens and documentation to reflect the new "BQ" code.

**F. CWF Identification and Exclusion of Claims Containing Placeholder National Provider Identifiers (NPIs)**

Effective October 6, 2008, the CWF maintainer shall create space within the header of its HUIP, HUOP, HUHH, HUHC, HUBC, and HUDC claims transactions for a new 1-byte "NPI-Placeholder" field (acceptable values=Y or space).

In addition, the CWF maintainer shall create space within page two (2) of the HIMR detail of the claim screen for 1) a new category "COBA Bypass"; and 2) a 2-byte field for the indicator "BN." (See Pub. 100-04, chapter 27, §80.*5* for more details regarding the "BN" bypass indicator.)

**NOTE:** With the implementation of the October 2008 release, the CWF maintainer shall remove all current logic for placeholder provider values with the implementation of this new solution for identifying claims

that contain placeholder provider values.

As A/B MACs and DME MACs adjudicate **non VA MRA** claims that fall within any of the NPI placeholder requirements, their shared system shall take the following combined actions:

1) Input a "Y" value in the newly created "NPI Placeholder" field on the HUIP, HUOP, HUHH, HUHC, HUBC, or HUDC claim transaction if a placeholder value exists on or is created anywhere within the SSM claim record. **NOTE**: The A/B MAC and DME MAC shared systems shall include spaces within the "NPI Placeholder" field when the claim does not contain a placeholder NPI value; **and**

2) Transmit the claim to CWF, as per normal requirements.

Upon receipt of claims where the NPI Placeholder field contains the value "Y," CWF shall auto-exclude the claim from the national COBA crossover process. In addition, CWF shall populate the value "BN" in association with the newly developed "COBA Bypass" field on page 2 of the HIMR Part B and DME MAC claim detail screen and on page 3 of the HIMR intermediary claim detail screen. (See Pub.100-04, chapter 27, §80.*4* for more details.)

Prior to October 6, 2008, all A/B MACs and DME MACs shall update any of their provider customer service materials geared towards crossover claims related inquiries to reflect the newly developed "BN" by-pass value, which designates that CWF auto-excluded the claim because it contained a placeholder provider value.

The Next Generation Desktop (NGD) contractor shall also modify its user screens and documentation to reflect the new "BN" code.

**G. New CWF Requirements for Other Federal Payers**

Effective with October 3, 2011, the CWF maintainer shall expand its logic for "Other Insurance," which is COIF element 176, to include TRICARE for Life (COBA ID 60000-69999) and CHAMPVA (COBA ID 80214), along with State Medicaid Agencies (70000-79999), as entities eligible for this exclusion.

Through these changes, if either TRICARE for Life or CHAMPVA wishes to invoke the "Other Insurance" exclusion, and if element 176 is marked on the COIF for these entities, CWF shall suppress claims from the national COBA crossover process if it determines that the beneficiary has active additional supplemental coverage.

As part of this revised "Other Insurance" logic for TRICARE and CHAMPVA, CWF shall interpret "additional supplemental coverage" as including entities whose COBA identifiers fall in any of the following ranges:

00001-29999 (Supplemental);
30000-54999 (Medigap eligibility-based);
80000-80213 (Other Insurer); and
80215-88999 (Other Insurer).

The "Other Insurance" logic for State Medicaid Agencies includes all of the following COBA ID ranges:

00001-29999 (Supplemental);
30000-54999 (Medigap eligibility-based);
60000-69999 (TRICARE);
80000-80213 (Other Insurance)
80214 (CHAMPVA)
80215-88999 (Other Insurer).

NOTE: As of October 3, 2011, CWF shall now omit COBA ID range 89000-89999 as part of its Other Insurance logic for State Medicaid Agencies.

CWF shall mark claims that it excludes due to "Other Insurance" with crossover disposition indicator "M" when storing them within the CWF claims history screens. (See §80.*5* of chapter 27 for additional information concerning this indicator.)

**II. A/B MAC and DME MAC Actions Relating to CWF Claims Crossover Inclusion or Inclusion/Exclusion Logic**

**A. Inclusion of Two Categories of Mass Adjustment Claims for Crossover Purposes**

All A/ B MACs and DME MACs shall continue to identify mass adjustment claims-MPFS and mass adjustment claims—other by including an "M" (mass adjustment claims—MPFS) or "O" (mass adjustment claims—other) within the header of the HUIP, HUOP, HUHH, HUHC, HUBC, and HUDC claim transactions, as specified in Pub.100-04, chapter 27, §80.*6*. (Refer to Pub.100-04, chapter 27, §80.*8* for CWF specific requirements relating to the unique inclusion of mass adjustment claims for crossover purposes.)

Effective January 5, 2009, the BCRC, at CMS's direction, modified the COIF to allow for the unique inclusion of mass adjustment claims—MPFS updates and mass adjustment claims—other. The CWF maintainer shall 1) create these new fields, along with accompanying 1-byte file displacement, within its version of the COIF; and 2) accept and process these new fields when the BCRC transmits them as part of its regular COIF updates.

Upon receipt of a HUIP, HUOP, HUHH, HUHC, HUBC, or HUDC claim transaction that contains an "M" or "O" mass adjustment indicator, CWF shall undertake all additional actions with respect to determination as to whether the claim should be included or excluded for crossover purposes as specified in chapter 27, §80.8.

**A/B MAC and DME MAC Flat File Requirements**

Before the A/B MAC and DME MAC shared systems send "mass adjustment claims—MPFS" to the BCRC via an ASC X12 837 flat file transmission, they shall take the following actions with respect to the fields that correspond to the loop 2300 NTE01 and NTE02 segments on the ASC X12 837 COB flat file only if there was not a pre-existing 2300 NTE segment on the incoming Medicare claim:

1) Populate "ADD" in the field that corresponds to NTE01; and

2) Populate "MP," utilizing bytes 01 through 02, in the field that corresponds to NTE02.

Before the A/B MAC and DME MAC shared systems send "mass adjustment claims—other" to the BCRC via an ASC X12 837 flat file transmission, they shall take the following actions with respect to the fields that correspond to the loop 2300 NTE01 and NTE02 segments on the 837 COB flat file only if there was not a pre-existing 2300 NTE segment on the incoming Medicare claim:

1) Populate "ADD" in the field that corresponds to NTE01; and

2) Populate "MO," utilizing bytes 01 through 02, in the field that corresponds to NTE02.

**B. Inclusion and Exclusion of Recovery Audit Contractor (RAC)-Initiated Adjustment Claims**

Effective January 5, 2009, at CMS's direction, the BCRC modified the COIF to allow for the unique inclusion and exclusion of RAC-initiated adjustment claims. The CWF maintainer shall 1) create these new fields, along with accompanying 1-byte file dis-placement, within its version of the COIF; and 2) accept and process these new fields when the BCRC transmits them as part of its regular COIF updates. In addition, the CWF

maintainer shall create a 1-byte RAC adjustment value in the header of its HUIP, HUOP, HUHH, HUHC, HUBC, and HUDC claims transactions (valid values="R" or spaces).

Through this instruction, all A/B MAC and DME MAC shared systems shall develop a method for uniquely identifying all varieties of RAC-requested adjustments, which occur as the result of post-payment review activities.

**NOTE**: Currently, fewer than five (5) MACs process RAC adjustments.

Prior to sending its processed 11X and 12X type of bill RAC-initiated adjustment transactions to CWF for normal verification and validation, the A/B MAC (*Part* A) and A/B MAC (*Part* HH*H*) shared system shall input the "R" indicator in the newly defined header field of the HUIP claim transaction if the RAC adjustment claim meets either of the following conditions:

1) The claim resulted in Medicare changing its payment decision from paid to denied (i.e., Medicare paid $0.00 as a result of the adjustment performed)**; or**

2) The claim resulted in a Medicare adjusted payment that falls below the amount of the inpatient hospital deductible.

Prior to sending RAC-initiated adjustment claims **with all other type of bill designations to CWF** for normal processing, the A/ B MAC (*Part* A) and A/B MAC (*Part* HH*H*) shared system shall input an "R" indicator in the newly defined header field of the HUOP, HUHH, and HUHC claim.

Prior to sending their processed RAC adjustment transactions to CWF for normal verification and validation, the A/B MAC (*Part* B) and DME MAC shared systems shall input the "R" indicator in the newly defined header field of the HUBC and HUDC claim transactions.

**Unique COBA ID Assignment to Trading Partners That Accept RAC-Initiated Adjustment Claims Only and Attendant A/B MAC and DME MAC Responsibilities**

The BCRC will assign a unique COBA ID range (88000-88999) to COBA trading partners that elect to "include" RAC-initiated adjustment claims for crossover purposes and will not, at CMS's direction, charge the trading partner the standard crossover fee for that category of adjustment claims. Therefore, when A/B MACs and DME MACs receive a BOI reply trailer (29) on a claim that contains only a COBA ID in the range 88000 through 88999 (which designates RAC adjustment), the A/B MAC and DME MAC shall not expect payment for the claim.

Before the A/B MAC and DME MAC shared systems send "tagged" RAC-initiated adjustment claims to the BCRC via an ASC X12 837 flat file transmission, they shall take the following actions with respect to the fields that correspond to the loop 2300 NTE01 and NTE02 segments on the ASC X12 837 COB flat file only if there was **not** a pre-existing 2300 NTE segment on the incoming Medicare claim:

1) Populate "ADD" in the field that corresponds to NTE01; and

2) Populate "RA," utilizing bytes 01 through 02, in the field that corresponds to NTE02.

## III. CWF Crossover Processes In Association with the Coordination of Benefits Contractor

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

Effective July 6, 2004, the BCRC began to send initial copies of the COBA Insurance File (COIF) to the nine CWF host sites. The COIF contains specific information that will identify the COBA trading partner, including name, COBA ID, address, and tax identification number (TIN). It also contains 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). Effective with the October 2004 systems release, the COIF also contains a 1-digit Test/Production Indicator that will identify whether a COBA trading partner is in test (T) or production (P) mode. The CWF shall return that information as part of the BOI reply trailer (29) to A/B MACs and DME MACs.

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

- 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.];

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

- Apply the COBA trading partner's selection criteria; and

- Transmit a BOI reply trailer to the A/B MAC and DME MAC only if the claim is to be sent, via 837 COB flat file or NCPDP file, to the BCRC to be crossed over.

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

### 1. BOI Reply Trailer Process

For eligibility file-based crossover, all A/B MACs and DME MACs shall send processed claims information to the BCRC for crossover to a COBA trading partner in response to the receipt of a CWF BOI reply trailer (29). A/B MACs and DME MACs 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, A/B MACs and DME MACs 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. As discussed above, effective with the October 2004 systems release, CWF shall also include a 1-digit Test/Production Indicator on the BOI reply trailer (29) that is returned to the A/B MACs and DME MACs.

**MSN Crossover Messages**

Effective with the October 2004 systems release, the A/ B MACs and DME MACs began to receive BOI reply trailers (29) that contain an MSN indicator "Y" (Print trading partner name on MSN) or "N" (Do not print trading partner name on MSN).

When a COBA trading partner is in full production (Test/Production Indicator=P), the A/ B MAC and DME MAC shall read the MSN indicator returned on the BOI reply trailer (29). If the A/B MAC or DME MAC receives an MSN indicator "N," it shall print its generic crossover message(s) on the MSN rather than including the trading partner's name. Examples of existing generic MSN messages include the following:

**(For all COBA ID ranges other than Medigap)**

MSN #35.1 - “This information is being sent to private insurer(s). Send any questions regarding your benefits to them.”

**(For the Medigap COBA ID range)**

MSN#35.2 - “We have sent your claim to your Medigap insurer. Send any questions regarding your Medigap benefits to them.”

Beginning with the October 2004 systems release, A/B MACs and DME MACs shall follow these procedures when determining whether to update its claims history to show that a beneficiary’s claim was selected by CWF to be crossed over.

- If the A/B MAC or DME MAC receives a BOI reply trailer (29) that contains a Test/Production Indicator “T,” it shall not update its claims history to show that a beneficiary’s claim was selected by CWF to be crossed over.

- If the A/B MAC or DME MAC receives a BOI reply trailer (29) that contains a Test/Production Indicator “P,” it shall update its claims history to show that a beneficiary’s claim was selected by CWF to be crossed over.

Effective January 5, 2009, when CWF returns a BOI reply trailer (29) to an A/B MAC and DME MAC that contains only a COBA ID in the range 89000 through 89999, the A/B MAC and DME MAC shared system shall suppress all crossover information, including name of insurer and generic message#35.1, from all beneficiary MSNs.

A/B MACs and DME MACs shall not update their claims histories to reflect transference of “tagged” claims with COBA ID range 89000 through 89999 to the BCRC.

**ASC X12 835 (Electronic Remittance Advice)/Provider Remittance Advice Crossover Messages**

Beginning with the October 2004 release, when CWF returns a BOI reply trailer (29) that contains a “T” Test/Production Indicator to *the* A/B MACs and DME MACs, they shall not print information received from the BOI reply trailer (29) in the required crossover fields on the ASC X12 835 Electronic Remittance Advice or other provider remittance advices that are in production.

Beginning with the October 2004 release, when CWF returns a BOI reply trailer (29) that contains a “P” Test/Production Indicator to the A/B MACs and DME MACs, they shall use the returned BOI trailer information to take the following actions on the provider’s 835 Electronic Remittance Advice:

a. Input code 19 in CLP-02 (Claim Status Code) in Loop 2100 (Claim Payment Information) of the 835 ERA (v. 4010-A1). [NOTE: Record “20” in CLP-02 (Claim Status Code) in Loop 2100 (Claim Payment Information) when Medicare is the secondary payer.]

b. Update the 2100 Loop (Crossover Contractor 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

Effective with January 5, 2009, if CWF returns only COBA ID range 89000 through 89999 on a BOI reply trailer (29) to an A/B MAC and DME MAC, the associated shared system shall suppress all crossover information (the entire 2100 loop) on the 835 ERA.

**CWF Sort Routine for Multiple COBA IDs**

Effective with October 3, 2011, 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 (30000-54999); 2) Medigap claim-based (55000-59999); 3) Supplemental (00001-29999); 4) Other Insurer (80000-80213); 5) Other Insurance (80215-88999); 6) TRICARE (60000-69999); 7) CHAMPVA (80124); 8) Medicaid (70000-79999); and 9) Other-Health Care Pre-payment Plan [HCPP] (89000-89999). 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.*4* for more details), CWF shall sort numerically within the same range.

## IV. A/B MAC and DME MAC Actions Relating to the Transition to the ASC X12 837 Version 5010 and NCPDP Version D.O

### A. CWF COIF and BOI Reply Trailer (29) Processes

Effective January 5, 2009, the BCRC , at CMS's direction, created a new 1-byte "5010 Test/Production Indicator" and a new 1-byte "NCPDP D.0 Test/Production Indicator" on the COBA Insurance File [COIF] (valid values= "N"—not applicable or not ready as yet; "T"—test; "P"—production). In addition, the CWF maintainer shall add a new "5010 Test/Production Indicator" and an "NCPDP D.0 Test/Production Indicator" to the BOI reply trailer (29) format. (See Pub.100-04 chapter 27, §80.*7* for additional details regarding CWF requirements relating to the new crossover claim formats.)

### B. Transmission of the COB Flat File or NCPDP File to the BCRC

Regardless of whether a COBA trading partner is in test mode (Test/Production Indicator returned via the BOI reply trailer 29=T) or production mode (Test/Production Indicator returned via the BOI reply trailer 29=P), A/B MACs and DME MACs shall transmit all non-NCPDP claims received with a COBA ID via a BOI reply trailer to the BCRC in an ASC X12 837 flat file, as described in Transmittal AB-03-060. In a separate transmission, DME MACs shall send the claims received in the NCPDP file format to the BCRC. A/B MACs and DME MACs 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, A/B MACs and DME MACs shall send a separate ASC X12 837 or NCPDP transaction to the BCRC for each COBA ID. A/B MACs and DME MACs shall perform the transmission at the end of their regular batch cycle, when claims are removed from their payment floor, to ensure crossover claims are not processed by the COBA trading partner prior to Medicare's final payment. Transmission to the BCRC shall occur via Connect: Direct or other CMS dictated connectivity.

Effective with October 4, 2005, when the A/B MAC and DME MAC shared systems transfer processed claims to the BCRC as part of the COBA process, they shall include an additional 1-digit alpha character ("T"=test or "P"=production) as part of the BHT03 identifier (Beginning of the Hierarchical Transaction Reference Identification) that is included within the ASC X12 837 flat file or NCPDP submissions. The shared systems shall determine that a COBA trading partner is in test or production mode by referring to the BOI reply trailer (29) originally received from CWF for the processed claim. (See §70.6.1 of this chapter for further details about the BHT03 identifier.)

Effective October 2, 2006, the Virtual Data Center (VDC), formerly the Enterprise Data Centers (EDCs),

shall transmit a combined COBA "test" and "production" ASC X12 837 flat file and a combined "test" and "production" NCPDP file, as applicable, to the BCRC.

**NOTE**: This requirement changes the direction previously provided in October 2005 through the issuance of Transmittal 586.

**Flat File Conventions for Transmission to the BCRC For Production COBA Crossover Claims Prior to July 2012**

With respect to ASC X12 837 COB flat file submissions to the BCRC, A/B MACs (*Part* B) and DME MACs shall observe these process rules:

The following segments shall not be passed to the BCRC:

1. ISA (Interchange Control Header Segment);
2. IEA (Interchange Control Trailer Segment);
3. GS (Functional Group Header Segment); and
4. 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, the shared system shall ensure that a separate ASC X12 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 BCRC completing any missing information:

NM1 segment—For NM103, NM104, NM105, and NM107, use spaces;
NM1 segment—For NM109, include beneficiary's Medicare ID;
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 BCRC 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 BCRC 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 BCRC 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 ASC X12 837 COB flat file submissions to the BCRC, A/B MACs (*Part* A) and A/B MACs (*Part* HH*H*) 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 BCRC. 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, the A/B MAC or DME MAC system shall ensure that 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 BCRC completing any missing information:

NM1 segment – For NM103, NM104, NM105, and NM107, use spaces;
NM1 segment—For NM109, include beneficiary's Medicare ID;
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 BCRC 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 BCRC 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. The BCRC 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.

**C. BCRC Processing of COB Flat Files or NCPDP Files**

When an A/B MAC and DME MAC receives the reject indicator "R" via the Claims Response File, it is to retransmit the entire file to the BCRC. If the A/B MAC or DME MAC 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), BCRC will cross the claims to the COBA trading partner. The format of the Claims Response File that will be returned to each A/B MAC and DME MAC by the BCRC, following its COB ASC X12 837 flat file or NCPDP file transmission, appears in the table below. (See §70.6.1 for specifications regarding the receipt and processing of the BCRC Detailed Error Reports.)

**Claims Response File Layout (80 bytes)**

| Field | Name | Size | Displacement | Description |
|---|---|---|---|---|
| 1 | A/B MAC or DME MAC Number | 5 | 1-5 | A/B MAC or DME MAC Identification Number |
| 2 | Transaction Set Control Number/ Batch Number | 9 | 6-14 | Found within the ST02 data element from the ST segment of the ASC X12 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 ASC X12 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 ASC X12 837 flat file or NCPDP file in CCYYMMDD format |
| 5 | Accept/Reject indicator | 1 | 32 | Indicator of either the acceptance or rejection of the ASC X12 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 A/B MACs and DME MACs after receipt and initial processing of a claim file. Thus, for example, if an A/B MAC or DME MAC sends a COB flat file daily via the VDC, the BCRC will return a claim response file to that entity on a daily basis.

ASC X12 COB 837 flat files and NCPDP files that will be transmitted by the VDC on behalf of each A/B MAC and DME MAC, as applicable, to the BCRC will be assigned the following file names, regardless of whether a COBA trading partner is in test or production mode:

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 A/B MAC or DME MAC number.

A/B MACs and DME MACs shall perform the ASC X12 837 flat file and NCPDP file transmission at the end of the regular batch cycle, when claims come off the payment floor, to ensure crossover claims are not processed by the trading partner prior to Medicare's final payment.

Files transmitted by the VDC to the BCRC shall be stored for 51 business days from the date of transmission.

The file names for the Claims Response File returned to the A/B MAC and DME MAC via the VDC will be created as part of the NDM set-up process.

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

**E. The COBA Medigap Claim-Based Process Involving CWF**

Refer to §70.6.4 of this chapter for more information regarding this process.

**F. COBA Customer Service Issues**

1. Customer Service

    a. A/ B MACs and DME MACs shall use the BCRC and CMS COBA Problem Inquiry Request Form to identify and send COBA related problems and issues to the COB contractor for research.

    In order to track trading partner requests for research of 837 ASC X12 issues, CMS requires A/B MACs and DME MACs to submit a COBA Problem Inquiry Request Form to the BCRC or CMS. This process is being implemented to reduce the number of duplicate issues being researched and to ensure your requests are processed timely. The standard form enables CMS and BCRC to track issues through completion and manage the process of addressing post-COBA production issues. Upon receipt the submitter shall receive a response from the BCRC with the assigned contact information.

    CMS is also requiring A/B MACs and DME MACs to use the COBA Problem Inquiry Request Form when requesting a BCRC representative to research a COBA issue. The combined BCRC-CMS COBA Problem Inquiry Request Form appears below.

**A/B MAC and DME MAC: COBA PROBLEM INQUIRY REQUEST FORM**

**(Completed by Submitter – control number if applicable  Write in this column only**

| | | |
|---|---|---|
| **MAC ID#** (Enter the A/B MAC or DME MAC ID # assigned by CMS) | | |
| **MAC Reference ID** (If applicable - BHT03) | | |
| **Reported By** (Enter submitter's last name, first name) | | |
| **Date Submitted** (Enter current date – MM/DD/YR) | | |
| **Contact #** (Enter submitter's phone #) | | |
| **E-mail Address** (Enter submitter's e-mail address) | | |
| **COBA ID #** | | |

**Description of Problem** (Check applicable category)

☐ **HIPAA Error Code**

| | |
|---|---|
| ICN Date (Date file was transmitted to the BCRC) | |
| HIPAA Error Code(s) | |
| Part A/Part B/NCPDP Claim | |

☐ **Technical Issue** (Claims file transmission failures)

| | |
|---|---|
| File Name | |
| Transmission Date | |

Summary of Issue- Provide detail of problem and note if back-up information will be faxed, e.g., Sample Claims to be Faxed on MM/DD/YR. Indicate whether you would like your issue on the next HIPAA issues log **– do not include any PHI information on this form if sent via email.** All PHI information must be submitted via fax to the BCRC to the attention of your BCRC representative at 646-458-6761. **Do not include PHI information on the fax cover sheet.** Claim examples of issues to be addressed must include the beneficiary Medicare ID and the claim ICN/DCN.

BCRC USE ONLY. Date: Ticket #:

## V. Identification of Mass Adjustments for COBA Crossover Purposes

All A/B MACs and DME MACs and their shared systems shall develop a method for differentiating "mass adjustments tied to the Medicare Physician Fee Schedule (MPFS) updates" and "all other mass adjustments" from all other kinds of adjustments and non-adjustment claims.

**NOTE:** For appropriate classification, all adjustments that do not represent "mass adjustments-MPFS" or "mass adjustments-other" shall be regarded as "other adjustments.") DME MACs and their shared system shall only be required to identify mass adjustments-other, which represents a current functionality available within VMS. This is because DME MACs do not use pricing from the MPFS when processing their claims.

**Working Definition of "Mass Adjustment"**

For COBA crossover purposes, a "mass adjustment" refers to an action that an A/B MAC or DME MAC undertakes using special software (e.g., Super-Op Events or Express Adjustments) to pull together claims with the anticipated purpose of making monetary changes to a high number of those claims. If, however, A/B MACs and DME MACs do not have special software to perform high volume adjustments (i.e., typically adjustments to 100 or more claims), but instead must perform their high volume adjustments manually, this action also fulfills the definition of a "mass adjustment."

**Inputting a One-Byte Header Value on Claim Transactions to Designate Mass Adjustment and**

**Associated Processes**

Before A/B MACs and DME MACs cable their claims to CWF for verification and validation, they shall populate a 1-byte "mass adjustment" indicator in the header of their HUBC, HUDC, HUIP, HUOP, HUHH, or HUHC entry code "5" or action code "3" claim transactions. The CWF maintainer shall create a new 1-byte field within the header of its HUBC, HUDC, HUIP, HUOP, HUHH, or HUHC claims transactions for this purpose.

A/ B MACs and DME MACs shall determine whether the "M" or "O" indicator applies in relation to a given claim at the point that they initiate a mass adjustment action on that claim using a manual process or an automated adjustment process; e.g., Super Op Events or Express Adjustments. Upon making this determination, the A/B MACs and DME MACs and their shared systems shall populate one (1) of the following mass adjustment claim indicators, specific to the particular claim situation, within the header of the A/B MACs or DME MACs' processed claims that they will cable to CWF for verification and validation:

"M"—if mass adjustment claim tied to an MPFS update; **or**
"O"—if mass adjustment claim-other.

If A/B MACs and DME MACs send values other than "M" or "O" within the newly designated field within the header of their HUBC, HUDC, HUIP, HUOP, HUHH, or HUHC entry code "5" or action code "3" claims, CWF shall apply an edit to reject the claims back to the MAC. Upon receipt of the CWF rejection edit, the shared systems shall correct the invalid value and retransmit the claims to CWF for verification and validation.

**VI. Special ASC X12 835 Remittance Advice and MSN Requirements for Health Care Pre-Payment Plans (HCPPs) and Health Maintenance Organization (HMO) Cost Plans that Receive Crossover Claims**

Effective January 5, 2009, at CMS's direction, the BCRC assigned all COBA HCPP and HMO Cost Plan participants a unique 5-byte COBA ID that falls within the range 89000 through 89999. The CWF system shall accept the reporting of this COBA ID range.

Upon receipt of a BOI reply trailer (29) that contains only a COBA ID in the range 89000 through 89999, the A/B MAC and DME MAC shared systems shall suppress all crossover information (including name of the insurer; generic message; and specific code (for ASC X12 835, code MA-18; for MSN, code 35.1) indicating that the claim will be crossed over) from the associated ASC X12 835 remittance advice and beneficiary MSN. (See §70.6.1 of this chapter for A/B MAC or DME MAC requirements relating to the BCRC Detailed Error Report processes and receipt of claims that contain COBA ID range 89000 through 89999.)

**VII. Special Suppression Requirements for Part A Credit Claim Portion of Debit-Credit Claim Pairing**

Effective with the April 2009 release, the A/B MAC (*Part* A) and A/B MAC (*Part* HH*H*) shared system shall suppress sending the credit claim portion of the debit-credit pairing (that transaction which cancels the original claim) associated with each affiliated A/B MAC's (A, HH*H*) adjustment claims to the BCRC. Upon suppressing the credit claim, the A/B MAC (*Part* A) and A/B MAC (*Part* HH*H*) system shall mark the claims history of its affiliate MAC to reflect this action.

## 70.6.2 – Coordination of Benefits Agreement (COBA) Full Claim File Repair Process

***(Rev.4069, Issued: 06-08 -18, Effective: 07- 09- 18, Implementation: 07- 09-18)***

Effective with the July 2006 release, CMS implemented a full claim file repair process at its A/B MACs and DME MACs to address situations where one or more of the MAC shared systems inadvertently introduced a severe error condition into the claims processing cycle, with the effect being that the Health Insurance

Portability and Accountability Act (HIPAA) ASC X12 837 Coordination of Benefits (COB) Institutional and Professional crossover claims files or National Council for Prescription Drug Programs (NCPDP) claim files become unusable for COB purposes**.**

When an A/B MAC or DME MAC, the *BCRC,* or a COBA trading partner identifies a shared system problem that will prevent, or has prevented, the COBA trading partner from accepting an ASC X12 837 COB institutional or professional claims file from the *BCRC*, the A/B MAC and DME MAC shall work with its shared system maintainer to assess the feasibility of executing a full claim file repair. A/B MACs and DME MACs shall utilize the *BCRC* Detailed Error Reports to determine the percentage of errors present for each error source code—"111" (flat file) errors, "222" (ASC X12 837 COB) errors, and "333" (trading partner dispute) errors. When A/B MACs and DME MACs or their shared system maintainers determine that the error percentages are at or above the parameters discussed later within this section, the A/B MACs and DME MACs shall begin the process of analyzing the claim files for a possible full claim repair process. If the A/B MACs and DME MACs and their shared systems subsequently initiate a full claim file repair process, that process shall be accomplished within a maximum of 14 work days, unless determined otherwise by CMS.

Effective July 2, 2007, A/B MACs and DME MACs and their systems shall now base their decision making calculus for initiation of a claims repair of "111" (flat file) errors upon the number of errors received rather than upon an established percent parameter, as specified in §70.6.1 of this chapter. If an A/B MAC or DME MAC receives even one (1) "111" error via the *BCRC* Detailed Error Report, the MAC, working with its Data Center or shared system as necessary, shall immediately attempt a repair of the claims file, in accordance with all other requirements communicated within this section.

**1. A/B MAC or DME MAC or Shared System Identification of a Full Claim File Problem and Subsequent Actions**

When an A/B MAC or DME MAC, working with its shared system maintainer, identifies a severe error condition that will negatively impact the claims that it has transmitted to the *BCRC*, the A/ B MAC or DME MAC shall, upon detection, immediately notify CMS and the *BCRC* by calling current *BCRC* or CMS COBA crossover contacts and sending e-mail communications to: COBAProcess@cms.hhs.gov and cobva@ghimedicare.com.

The A/B MAC or DME MAC shall work closely with its system maintainer to determine the timeframes for developing, testing, and applying a fix to correct the severe error(s) that was/were identified within the 837 or NCPDP files that were previously transmitted to the *BCRC*. The A/B MAC and DME MAC shared system maintainers shall then report the timeframes for developing, testing, and applying a fix to the full claim file problem in accordance with their procedures as outlined in their systems maintenance contract. If CMS determines that the time frames for affecting a full claim file repair of the previously transmitted claims exceed what is considered reasonable (a maximum of 14 work days, unless determined otherwise by CMS), a designated COBA team representative will notify the A/B MACs and DME MACs and their shared system maintainers via e-mail to abort the full claim file repair process. (**NOTE**: This process will remain unchanged with the transition to future claim versions.)

Upon receipt of a notification from the CMS COBA team representative that indicates that the timeframes for fixing a full claim file problem exceed those that are acceptable to CMS, the A/B MACs' and DME MACs' shared systems shall abort the full claim file repair process. A/B MACs and DME MACs shall then follow the requirements provided in §70.6.1 of this chapter with respect to the special provider notification and other COBA crossover operational processes. In such cases, however, A/B MACs and DME MACs shall not be required to wait the customary five (5) business days before generating the special provider notification letters to their affected physicians, suppliers, or other providers of service.

**2. Alerting A/B MACs or DME MACs to the Possible Need for a Full Claim File Repair via the *BCRC* Detailed Error Reports and Subsequent MAC Actions**

**a. Severe Error Percentage Parameters and Suppression of the Special Provider Notification Letters**

Effective with July 2006, the CMS, working in conjunction with the *BCRC*, modified the *BCRC* Detailed Error Report layouts, as found in §70.6.1 of this chapter, to include the following new elements: Total Number of Claims for Date of Receipt; Total Number of "111" (flat file) Errors and corresponding percentage; Total Number of "222" (HIPAA ASC X12 837 COB) Errors and corresponding percentage; and Total Number of "333" (trading partner dispute) Errors and corresponding percentage.

Effective with July 2007, CMS directed its A/B MACs and DME MACs to now base their severe error decision calculus upon the number of "111" errors received rather than percentage of such errors. Therefore, when an A/B MAC or DME MAC or its shared system maintainer receives a *BCRC* Detailed Error Report that indicates that the trading partner is in production and the number of "111" (flat file) errors is equal to or greater than one, the A/ B MAC's and DME MAC's shared system shall suppress the generation of special provider notifications, as provided in § 70.6.1 of this chapter, until after the severe error condition(s) has/have been analyzed. (**NOTE:** If the "222" and/or "333" errors indicated on the *BCRC* Detailed Error Report do **not** exceed the four (4) percent parameter, then the A/B MAC and DME MAC shall continue with the generation of the provider notification letters for those errors while it is analyzing the "111" severe error(s).)

**IMPORTANT:** Effective October 1, 2007, A/B MACs and DME MACs and their systems shall have the capability to initiate a claims repair process, internally or at CMS direction, for situations in which they encounter high volume "222" or "333" error rejections that do not meet or exceed the established error threshold parameters. Before initiating a claims repair for error situations that fall below the established percentage parameters, the affected A/B MACs and DME MACs shall first contact a member of the CMS COBA team to obtain clearance for that process.

When an A/B MAC or DME MAC or its shared system maintainer receives a *BCRC* Detailed Error Report that indicates that the trading partner is in production and the percentage of "222" (HIPAA ASC X12 837) errors and "333" (trading partner dispute) errors is equal to or greater than four (4) percent, the shared system shall suppress the generation of special provider notifications, as provided in §70.6.1 of this chapter, until after the severe error condition(s) has/have been analyzed. **NOTE:** If the number of "111" errors indicated on the *BCRC* Detailed Error Report is **not** equal to or greater than one (1), then the A/B MAC or DME MAC shall continue with the generation of the provider notification letters for those errors while it is analyzing the "222" and "333" severe errors.

For each of the severe error situations discussed above, A/B MACs and DME MACs, or their shared systems, shall suppress the special provider notification for a minimum of five (5) business days. The shared systems shall also have the capability to adjust the parameters for generation of the provider notification letters, as referenced in §70.6.1 of this chapter, of up to 14 work days while analysis of the claims that are being "held" for possible full claim file repair is proceeding.

Effective October 1, 2007, all A/B MACs and DME MACs shall have the capability to suppress their provider notification letters for a timeframe of up to 14 work days, or longer at CMS direction, where they initiate a claims repair process when claims with "222" or "333" errors fall below the "normally established" four (4) percent threshold.

Also, for each of the situations discussed above, the A/B MACs and DME MACs' shared systems shall establish percentage parameters for each error source code (222 and 333) that allow for flexibility within a range (e.g., 1 to 10 percent).

**b. Additional Information Highlighting Possible Severe Error Conditions on the *BCRC* Detailed Error Reports.**

Effective with July 2006, the *BCRC* will report one of the following error sources and error codes/trading partner dispute codes that may be indicative of a severe error condition on the returned *BCRC* Institutional and Professional Detailed Error Reports:

1.) Error source code "111" will be reported in field 10, along with a 6-digit error code in field 11 (note: unlike routine reporting of flat file errors, a full claim file error condition would be indicated if there were numerous instances of the same error code repeated throughout a Report); the description of the problem(s) that has/have caused the full claim file to be unusable will be reported in field 12 (error description);

2.) Error source code "222" will be reported in field 10, along with a 6-digit error code in field 11 that begins with an "N"; the description of the problem(s) that has/have caused the full claim file to be unusable will be reported in field 12 (error description);

3.) Error source code "333" will be reported in field 10; an error/trading partner dispute code "999" (trading partner dispute—"other") will be reported in field 11, left-justified and followed by spaces; and a description of the problem(s) that has/have caused the full claim file to be unusable will be reported in field 12 (error description).

DME MACs and their shared systems shall process NCPDP Detailed Error Reports returned from the *BCRC* that contain the following combination of error source codes, error/trading partner dispute codes, and error descriptions within the Reports:

1.) Error source code "111" will be reported in field 9, along with a 6-digit error code in field 10 (NOTE: *U*nlike routine reporting of flat file errors, a full claim file error condition would be indicated if there were numerous instances of the same error code repeated throughout a Report); and a description of the problem(s) that has/have caused the full claim file to be unusable will be reported in field 11; **or**

2.) Error source code "333" will be reported in field 9; an error/trading partner dispute code "999" will be reported in field 10, left-justified and followed by spaces; and a description of the problem(s) that has/have caused the full claim file to be unusable will be reported in field 11 (error description).

**c. A/B MAC and DME MAC Actions Following Suppression of the Special Provider Notification Letters to Analyze Possible Severe Error Conditions**

When A/B MACs and DME MACs receive *BCRC* Detailed Error Reports that contain "222" or "333" errors with percentages that are at or above the established parameters—or if the MACs receive "111" errors that are at or above zero ("0")—they shall work closely with their shared system maintainers to determine the timeframes for developing, testing, and applying a fix to correct the severe error(s) that was/were identified within the ASC X12 837 or NCPDP files that were previously transmitted to the *BCRC*. The shared system maintainers shall then report the timeframes for developing, testing, and applying a fix to the full claim file problem in accordance with their procedures as outlined in their systems maintenance contract. If CMS determines that the timeframes for affecting a full claim file repair of the previously transmitted claims exceed what is considered reasonable (a maximum of 14 work days, unless determined otherwise by CMS), a designated COBA team representative will notify the A/B MACs and DME MACs and their shared system maintainers via e-mail to abort the full claim file repair process.

As noted above, effective October 1, 2007, all A/B MACs and DME MACs shall have the capability to suppress their provider notification letters for a timeframe of up to 14 work days, or longer at CMS direction, where they initiate a claims repair process when claims with "222" or "333" errors fall below the "normally established" four (4) percent threshold.

Upon receipt of a notification from the CMS COBA team representative that indicates that the timeframes for fixing a full claim file problem exceed those that are acceptable to CMS, the A/B MACs and DME MACs' shared systems shall abort the full claim file repair process. A/B MACs and DME

MACs shall then follow the requirements provided in §70.6.1 of this chapter with respect to the special provider notification and other COBA crossover operational processes. In such cases, however, A/B MACs and DME MACs shall not be required to wait the customary five (5) business days before generating the special provider notification letters to their affected physicians/practitioners, suppliers, or other providers of service.

In the event that CMS indicates that a full claim file repair process is feasible, the A/B MACs and DME MACs' shared systems shall have the ability to cancel the generation of the provider notification letters, as stipulated in §70.6.1 of this chapter, for the "repaired" claims **and** only generate the provider notification letters for the claims containing legitimate 111, 222, or 333 errors not connected with the severe error condition(s).

**3. Steps for Ensuring that Only "Repaired" Claims are Re-transmitted to the *BCRC***

Once the A/B MACs and DME MACs' shared systems have determined that they are able to affect a "timely" repair to the full claim files that were previously transmitted to the *BCRC*, they shall take the following actions:

a) Apply the fix to the unusable claims;

b) Compare the claims files previously sent to the *BCRC* with the repaired claims file to isolate the claims that previously did **not** contain the error condition(s);

c) Strip off the claims that did not contain the error condition(s), including claims that contained 111, 222, and 333 errors that were not connected with the severe error condition(s). For the latter set of claims (those with 111, 222, and 333 errors that were not connected to the severe error condition), MACs shall then generate the provider notification letters, as stipulated in §70.6.1 of this chapter and specified in the concluding paragraph of the above sub-section entitled, "Contractor Actions Following Suppression of the Special Provider Notification Letters to Analyze Possible Severe Error Conditions";

d) Recreate the job; and

e) Send only the "repaired" claims to the *BCRC*.

The shared systems shall add an indicator"18" to the BHT02 (Beginning of the Hierarchical Transaction/Transaction Set Purpose Code) segment of the HIPAA ASC X12 837 flat file to designate that the file contains only repaired claims. In addition, the shared systems shall include the repaired claims in different ST-SE envelopes to differentiate the repaired claims from normal ASC X12 837 flat file transmissions.

The DME MAC shared system shall add an indicator "R" after the COBA ID reported in the Batch Header Record in the Receiver ID field (field number 880-K7) of the NCPDP claim when transmitting the repaired claims to the *BCRC*.

**4. COBA Repair Process Changes Effective with July 2012**

**A. <u>Repairing Flat File ("111") Errors</u>**

All A/B MACs and DME MACs shall effectuate repair of even one "111" errored COB claim if the COBA trading partner is currently in "production" mode. (**NOTE:** Parties interested in previewing a listing of all "111" errors that the *BCRC* will apply to incoming COB flat files should refer to §70.6.1.1 of this chapter.) The shared systems shall accept the "111" error codes (see §70.6.1.1 of this chapter) that the *BCRC* generates during its application of business level editing to incoming ASC X12 837 COB flat files. The shared systems shall also make modifications to any "111" error tables that they maintain **<u>only</u>** in association with ASC X12 837 COB flat files.

**IMPORTANT:** A/B MACs and DME MACs shall **only** issue special provider notification letters in association with their receipt of "111" errors if: 1) the timeframe for effectuating a claims repair falls outside acceptable parameters (e.g., will take 30-60 days or longer); and 2) the volume of affected claims is low (i.e., under 1,000 claims per week). A/B MAC and DME MAC crossover contacts should contact a member of the CMS COBA team if they have questions regarding how they should proceed in association with a given "111" error situation.

## B. Repairing "222" and "333" Errors Associated With "Production" New Version Format Claims

A/B MACs and DME MACs and their shared systems shall repair "222" or "333" errors in association with "production" new format version claims if the error percentage they encounter meets or exceeds four (4) percent.

A/B MACs and DME MACs shall alert their shared system or Data Center, as per established protocol, for purposes of initiating each needed claims repair process in association with new format version COB claims. **IMPORTANT:** A/B MACs and DME MACs that wish to effectuate a repair of new format version "production" claims whose error percentage falls below four (4) percent shall contact a member of the CMS COBA team before attempting that action. (**NOTE:** As a rule, CMS will grant approval for such a repair if the volume of errored claims justifies that action **and** if the timeframe for repair is acceptable.)

In accordance with §70.6.1 of this chapter, A/B MACs and DME MACs shall issue special provider notification letters in those instances where 1) error percentages for "222" and "333" errors fall below four (4) percent; 2) the volume of errors on "production" new format version COB is **not** substantial enough to cause the A/B MAC or DME MAC to request a claims repair; or 3) the timeframes for claim repair, as determined by the associated shared system, are **not** acceptable to CMS.

## C. Generally Applicable Requirements

While A/B MACs and DME MACs are **not** expected to initiate the repair of "test" claims, they shall*:* 1) continue to monitor the *BCRC* Detailed Error Reports; and 2) notify their shared systems of errors returned so that necessary shared system changes to improve HIPAA compliance rates may be realized.

## D. New Date Parameter Logic and Cutover Claims Repair Requirements

To ensure appropriate cutover to the HIPAA ASC X12 COB flat file format, all shared systems shall develop new date parameter logic to become operational as of January 1, 2012. All shared systems shall ensure that the new logic addresses all of the following scenarios: repairing any errored old format claims in the current claim format; converting claims held in suspense from an old format to the current claim format; converting previously adjudicated old format claims to the current "skinny" non-SFR COB claim format in adjustment claim situations; and converting claims held in "provider alert status" from an earlier) format to the current "skinny' non-SFR COB claim format.

For claims repair scenarios involving claims previously sent to the *BCRC* in the prior format just prior to January 1, 2012, the shared systems shall retransmit repaired claims to the *BCRC* in the current format. To that end, all shared systems shall utilize CMS-issued mapping and gap-filling guidance provided in chapter 24 §40.4 and chapter 28 §70.6.5 of Pub.100-04 when repairing their originally transmitted prior format errored crossover claims in the HIPAA current ASC X12 837 claim format on and after January 1, 2012. In addition, the shared systems shall apply current non-SFR "skinny" logic to claim repair situations where they originally transmitted claims to the *BCRC* prior to January 1, 2012 in the prior claim format.

**IMPORTANT:** A/B MACs and DME MACs shall **not** repair errored claims in a prior format that they transmitted to the *BCRC* just prior to January 1, 2012 if the errors returned via the *BCRC* Detailed Error Report relate to a field or segment that no longer exists in the current claim format. Instead, A/B MACs and DME MACs shall issue provider notification letters for those errored claims to the affected providers.

## 70.6.3 - Coordination of Benefits Agreement (COBA) Eligibility File Claims Recovery Process

***(Rev.4069, Issued: 06-08-18, Effective: 07- 09-18, Implementation: 07- 09-18)***

Effective January 2, 2007, when the CMS or the *BCRC* determines that 1) certain members on a COBA production trading partner's eligibility file were **not** properly loaded to the Common Working File (CWF) Beneficiary Other Insurance (BOI) auxiliary file (see §70.6 of this chapter for more details regarding this file) **or** 2) a COBA production trading partner's claims selections, as conveyed via the COBA Insurance File (COIF), were **not** properly loaded to the CWF, the CMS shall send the A/B MAC crossover contact(s) a 'COBAProcess' e-mail communication. When the CMS sends a "COBAProcess" e-mail communication to an A/B MAC Hto initiate a COBA eligibility file claims recovery process, the A/ B MAC shall acknowledge receipt of the communication via return e-mail within 1 business day. The CMS will then contact the A/B MAC's crossover staff via phone to discuss the specific Common Working File (CWF) date span or claim date of service parameters, or both, for the claims recovery process. **(NOTE:** DME MACs and their shared system may implement the COBA eligibility file claims recovery process as part of a future systems release.)

Following the telephone discussion between the CMS and the A/B MAC crossover staff, the COBA eligibility file recovery process will further unfold as detailed below.

### 1. Receipt and Processing of the *BCRC* COBA Eligibility File and Searching Claims History for the Needed Claims

The *BCRC* sends the virtual data center (VDC) copies of the trading partner's COBA eligibility file(s), which will be prepared in accordance with the CMS proprietary format. The VDC then notifies the affected A/B MAC that the COBA recovery eligibility file is available so that the A/B MAC may initiate a claims recovery. The A/B MAC shall initiate recovery of the processed claims by systematically going against its online claims history that meet the beneficiaries' eligibility dates, as provided on the *BCRC* eligibility file(s), and that fall within the specified CWF date span or date of service parameters, or both, that CMS has provided to the A/B MAC. (**NOTE**: The *BCRC* will transmit the COBA eligibility file to the VDC through its existing Connect: Direct connection.

### 2. Time Frames for Recovery

The A/B MAC shall complete its claims recovery process, culminating with transmission of the recovered claims to the *BCRC*, within eight (8) work days following the date that it receives the *BCRC* COBA eligibility file or as soon as possible thereafter as CMS directs.

### 3. Using Data Elements from the COBA Eligibility File For the Claims Recovery Process and Copying Elements from That File to the Recovered Claims Flat File

A/ B MACs shall perform the following activities related to the COBA eligibility file:

a) Utilize each beneficiary's coverage dates from the COBA eligibility files (field E01.13 for beneficiary supplemental eligibility-from date and field E01.14 for beneficiary supplemental-to date and successive eligibility-from and eligibility-to dates if provided);

b) Apply the specified CWF date span; or

c) Apply the date of service parameters; or

d) Both items b and c above.

Once the A/B MAC, working with the VDC as necessary, has recovered the specified claims, it shall copy the COBA ID from the *BCRC* COBA eligibility file (field E01.002) and place it within the NM109 segment of the 1000B loop of the flat file containing the recovered Part A and B claims.

**4. Scope of the Claims Recovery Effort**

Neither the A/B MAC nor its VDC shall be required to search archived claims history while fulfilling the COBA eligibility file claims recovery process.

The A/ B MAC and its VDC shall not be required to apply the COBA production trading partner's selection criteria before transmitting the recovered claims to the *BCRC*.

The A/B MAC or its VDC shall not transmit claims that had previously been sent to the *BCRC* as part of the COBA eligibility file claims recovery process, as demonstrated by the claims' crossover location status or the presence of a COBA identification (ID) number accompanied by a 'P' (production) indicator in relation to the processed claims.

**5. Populating a Unique BHT-03 Identifier to Designate Recovered Claims**

The A/ B MAC shared systems shall be required to populate an 'R' indicator in the 22nd position of the Beginning of the Hierarchical Transaction (BHT)-03 segment of the ASC X12 837 flat file when transmitting recovered claims for COBA production trading partners to the *BCRC*. (**NOTE**: The CMS would only consider invoking the COBA eligibility file recovery process for trading partners that are in production mode. Therefore, this practice does not conflict with previous guidance issued by the CMS, which may be referenced in §70.6.1 of this chapter.)

**6. Preparation and Transmission Requirements**

The recovered claim files shall be prepared in the same ASC X12 837 flat file format used for normal, daily transmissions to the *BCRC*, as discussed in §70.6 of this chapter.

The VDC shall transmit the recovered claims to the *BCRC* via a separate ASC X12 837 flat file transmission. A/B MACs shall transmit the recovered claims to the *BCRC* using the following dataset names:

For Part A recovered files: PCOB.BA.NDM.COBA.Cxxxxx.PARTA.RECV(+1)

For Part B recovered files: PCOB.BA.NDM.COBA.Cxxxxx.PARTB.RECV(+1)

(**NOTE:** Datasets that begin with 'TCOB,' with all else remaining constant, would be used as part of systems release testing. The 'xxxxx' in the dataset names above represents the A/B MAC number.)

The VDC shall send no more than 100,000 recovered claims (which equates to 20 ST-SE envelopes per A/B MAC with 5,000 claims per envelope) to the *BCRC* per transmission.

The VDC shall transmit recovered claims files to the *BCRC* via the existing Connect: Direct connectivity that it has with that entity.

**7. Marking Claims History To Assist Customer Service Efforts**

When the VDC transmits the recovered claims to the *BCRC*, the A/B MAC shall mark its claims history to indicate that each claim was recovered and transmitted to the *BCRC* to be crossed over to the COBA trading partner.

A/B MACs shall notify their customer service representatives that they will be able to determine that recovered claims were sent to the *BCRC* by referencing claims history.

### 8. *BCRC* Detailed Error Report Processes In Relation to the Claims Recovery Process

If A/B MACs receive *BCRC* Detailed Error Reports that contain a 22-byte BHT-03 identifier that ends with an 'R,' they shall suppress generation of provider letters, regardless of the error source code indicated ('111,' '222,' or '333').

When the A/B MAC, or its shared system, receives *BCRC* Detailed Error Reports for recovered *BCRC* Detailed Error Reports for recovered claims that contain '111,' '222,' or '333' errors, it shall mark its claims history to indicate that the recovered claims will not be crossed over.

### 9. The Possibility of Repairing COBA Recovery Claims

A/B MACs, and their shared systems, shall assume that recovered claims for COBA production trading partners that exceed established percentage parameters for '111,' '222,' and '333' errors are potential candidates for the COBA repair process, as provided in §70.6.2 of this chapter.

In accordance with the full claim file repair process discussed in 70.6.2 of this chapter, A/B MACs and their shared systems shall populate an '18' Beginning of the Hierarchical Transmission (BHT)-02 transaction set purpose code at the ST-SE envelope level when transmitting the 'repaired' COBA recovery claims.

Unlike the process documented in §70.6.2 of this chapter, A/B MACs shall transmit 'repaired' COBA recovery claims to the *BCRC* via the separate ASC X12 837 flat file transmission for recovery claims, as described within "Preparation and Transmission Requirements" above.

In addition, unlike the existing full claim file recovery process documented in §70.6. 2 of this chapter, A/B MACs and their shared systems shall include an 'R' in the 22nd position of the BHT-03 identifier when transmitting the 'repaired' COBA recovery claims to the *BCRC*.

A/B MACs, or their shared systems, shall also **not** generate provider notification letters if they, in conjunction with CMS, determine that the recovered claims that contained severe errors cannot be repaired.

### 10. COBA Claims Recovery Financial Management Processes

The CMS will reimburse the A/B MAC for individual claims accepted by the trading partner at the current per claim rate.

The A/B MACs' shared systems shall develop a separate report for their associated A/B MACs to enable them to fulfill the foregoing requirements.

As directed by their CMS Contracting Officer Representative, A/B MACs shall include their costs for each individual COBA recovery within any other cost reporting mechanism needed to capture costs incurred in support of the national COBA crossover process.

## 70.6.4 - Coordination of Benefits Agreement (COBA) Medigap Claim-Based Crossover Process

***(Rev.4069, Issued: 06-08 -18, Effective: 07- 09- 18, Implementation: 07- 09-18)***

Effective with claims filed to Medicare on October 1, 2007, all participating physicians/ practitioners and suppliers that have been granted a billing exception under the Administrative Simplification Compliance Act (ASCA) shall be required to enter CMS's newly assigned Coordination of Benefits Agreement (COBA) Medigap claim-based identifier (ID) within block 9-D of the incoming CMS-1500 claim for purposes of triggering Medigap claim-based crossovers. All other participating physicians/practitioners and suppliers

shall enter the newly assigned COBA Medigap claim-based ID within the NM109 portion of the 2330B loop of the incoming HIPAA ASC X12 837 professional claim and within field 301-C1 of the T04 segment on incoming National Council for Prescription Drug Programs (NCPDP) claims for purposes of triggering Medigap claim-based crossovers.

Effective October 1, 2007, Medigap claim-based crossovers will occur exclusively through the *BCRC* in the Health Insurance Portability and Accountability Act (HIPAA) ASC X12 837 professional claim format (current standard).

**A. Changes to A/B MAC (*Part* B) and DME MAC Up-Front Screening Processes for COBA Claim-based Medigap Crossovers**

The affected A/B MACs (*Part* B) and DME MACs' processes for screening incoming claims for Medigap claim-based crossovers shall feature a syntactic editing of the incoming COBA claim-based Medigap ID to ensure that the identifier begins with a "5" and contains 5 numeric digits. Additionally, for incoming ASC X12 837 or NCPDP claims, A/B MACs (*Part* B) and DME MACs shall ensure that the Medigap claim-based COBA ID is included within the appropriate designated fields, as indicated above.

If the claim fails the syntactic verification, the A/B MAC (*Part* B) and DME MAC shall not copy the identifier from the incoming claim and populate it within field 34 ("Crossover ID") of the HUBC or HUDC claim transaction that is sent to the Common Working File (CWF) for verification and validation. Instead, the A/B MAC (*Part* B) or DME MAC shall continue to follow its pre-existing processes for notifying the provider via the ASC X12 835 or other remittance advice and the beneficiary via the MSN that the information reported did not result in the claim being crossed over. The affected A/B MACs (*Part* B) and DME MACs' screening processes for Medigap claim-based crossovers shall also continue to include verification that the provider participates with Medicare and that the beneficiary has assigned benefits to the provider.

If the physician/practitioner or supplier-populated value for the claim-based Medigap ID passes the A/B MAC (*Part* B) or DME MAC's syntactic editing process, the affected shared systems shall copy the claim-based Medigap COBA ID value from the incoming claim to the first 10-byte iteration of field 34 of the HUBC or HUDC claims transactions that are sent to CWF for verification and validation.

**B. Use of Field 34 Within the HUBC and HUDC Claims Transactions and CWF Validity Check**

Following successful completion of the A/B MACs (*Part* B) or DME MACs' internal screening processes, including the up-front syntactical check, the A/B MACs (*Part* B) and DME MACs' system shall copy the COBA Medigap claim-based ID from the incoming Medicare claim and populate it within the field 34 (header portion, defined as "Crossover ID") of the HUBC and HUDC claims transactions that the A/B MACs (*Part* B) and DME MACs send to CWF for verification and validation purposes. The associated shared systems shall populate the value right-justified and prefixed with 5 zeroes (e.g., 0000056000) within field 34 of the HUBC or HUDC claims transaction.

**NOTE:** Effective October 1, 2007, the CWF maintainer has deactivated the second and third 10-byte iterations that have heretofore been included as part of field 34 of the HUBC or HUDC claim (header) transaction.

Upon receipt of HUBC and HUDC claims that contain a value within field 34, the CWF shall read the value that is present within the field for purposes of conducting a validity check. The CWF shall accept the following values as valid for field 34: a value within the range 0000055000 to 0000059999, or spaces. If the A/B MAC (*Part* B) or DME MAC has sent an inappropriate value within field 34 of the HUBC and HUDC claims transaction, CWF shall return an alert code 7704 on the "01" disposition response via the claim-based alert trailer 21.

**Use of Standard Medicare Summary Notice (MSN) and ASC X12 835 Remittance Advice (ERA) Messages When the Identifier in Field 34 Is Invalid**

Upon receipt of the alert code 7704, the affected A/B MAC (*Part* B) and DME MAC shall include the following standard message on the provider's ASC X12 835 ERA or other production remittance advice in association with the claim: (MA19) 6- "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." In addition, the affected A/B MAC (*Part* B) and DME MAC shall include a **revised** message on the beneficiary's MSN in association with the claim: (MSN #35.3) - "A copy of this notice will not be forwarded to your Medigap insurer because the Medigap information **submitted on the claim** was incomplete or invalid. Please submit a copy of this notice to your Medigap insurer." (See §40 and 50 of chapter 28 for more information regarding MSN and ERA messages.)

**Special Note Regarding Information to Print on the MSN and ERA**

If the affected A/B MAC (*Part* B) or DME MAC receives an alert code 7704 for an invalid Medigap claim-based COBA ID (outside the range 0000055000 to 0000059999 or space), and also receives a BOI reply trailer (29) that contains a "production" eligibility file-based Medigap COBA ID (30000-54999), the A/B MAC or DME MAC shall print the MSN 35.2 and ASC X12 835 ERA MA18 messages that are tied to receipt of the "production" eligibility file-based Medigap COBA ID.

**C. CWF Processing for COBA Claim-based Medigap Crossovers**

Following receipt of an HUBC and HUDC claims transaction that contains a valid value within field 34 (a value within range of 0000055000 to 0000059999 or spaces), CWF shall check for the presence of a Beneficiary Other Insurance (BOI) auxiliary record for the purpose of triggering crossovers for all other eligibility file-based COBA IDs. Then CWF shall read the COBA Insurance File (COIF) to determine the claims selection criteria for any eligibility file-based trading partners as well as for the claim-based Medigap insurer. If CWF does not locate a corresponding COIF for the valid COBA Medigap claim-based ID, it shall **not return** a BOI reply 29. In addition, since the valid value was part of the incoming HUBC or HUDC claim, the CWF shall post the valid COBA Medigap claim-based ID without an accompanying crossover disposition indicator in association with the claim within the "claim-based crossover" segment of the appropriate HIMR claim detailed history screen.

The CWF shall then perform a duplicate check to determine if the beneficiary is identified for crossover to a **"production"** Medigap eligibility file-based insurer (COBA ID 30000-54999) and to a claim-based Medigap insurer (COBA ID 0000055000 to 0000059999). If CWF determines that the beneficiary is identified for crossover to both a **"production"** Medigap eligibility file-based insurer and a claim-based Medigap insurer, it shall suppress the BOI reply trailer (29) for the claim-based Medigap insurer (COBA ID range 0000055000 to 0000059999). After CWF has determined that beneficiary has already been identified for Medigap eligibility file-based crossover, it shall 1) mark the associated claim with indicator "AA" and, 2) display this indicator, together with the affected claim-based Medigap COBA ID, in association with the claim on the appropriate HIMR detailed history screen in the "claim-based crossover" segment. (See Pub. 100-04, chapter 27 §80.*7* for more information regarding this process.)

If CWF determines that the claim meets the trading partner's claims selection criteria, it shall select the claim and return a BOI reply trailer (29) for the claim to the affected A/B MAC *(Part B)* or DME MAC. The CWF shall display the "A" crossover disposition indicator for the claim-based crossover claim within the "claim-based crossover" segment of the Health Insurance Master Record (HIMR) claim detailed history screens. As with the COBA eligibility file-based crossover process, CWF shall display the COBA ID and accompanying crossover disposition indicator on claim detailed history screens, with the exception of circumstances where there the valid ID cannot be located on the COIF, as discussed above, or the Medigap claim-based insurer is in "test" mode with the *BCRC*. In these situations, only the COBA Medigap claim-based ID shall be displayed.

**D. Modification of the CWF Sort Routine For Multiple COBA IDs and Accompanying A/B MAC and DME MAC Actions Following Receipt of the BOI Reply Trailer (29)**

In light of the COBA Medigap claim-based crossover process, the CWF sort routine for COBA IDs to be returned via the BOI reply (29) trailer shall be modified as follows:

1) Medigap eligibility file-based (30000-54999);
2) Claim-based Medigap (55000-59999);
3) Supplemental (00000-29999);
4) Other Insurer (80000-80213);
5) Other Insurer (80215-88999);
6) CHAMPVA (80214);
7) TRICARE for Life (60000-69999);
8) Medicaid (70000-79999); and
9) Other—Health Care Pre-Payment Plan [HCPP] and HMO Cost Plan (89000-89999).

Upon receipt of the BOI reply trailer (29), the affected A/B MACs (*Part* B) and DME MACs shall continue to utilize information from this source to populate the beneficiary's MSN and provider ASC X12 835 remittance advice (or other provider remittance advice in production). The affected A/B MACs (*Part* B) and DME MACs shall continue to report the name of **only** the first listed entity returned via the BOI reply trailer 29 on the provider ASC X12 835 ERA or remittance advice if they receive multiple COBA IDs and accompanying insurer names via the BOI reply trailer 29. (Refer to chapter 27 §80.*4* for additional details.)

**E. Impact Upon Flat File Creation Processes**

Following their receipt of a BOI reply trailer (29) that contains a Medigap claim-based COBA ID (range 55000-59999), A/B MACs (*Part* B) and DME MACs shall populate a "Y" within the REF02 segment of the 2300 ("Mandatory Medicare Section 4081 Crossover Indicator") loop of the affected HIPAA ASC X12 837 adjudicated claims for transmission to the *BCRC*. The affected A/B MACs (*Part* B) and DME MACs shall include a 4081 indicator value of "N" in the 2300 loop REF02 of their adjudicated HIPAA ASC X12 837 claims for transmission to the *BCRC* for all other COBA IDs included as part of the BOI reply trailer (29).

## 80 - Electronic Transmission - General Requirements

***(Rev.4069, Issued: 06-08 -18, Effective: 07- 09- 18, Implementation: 07- 09-18)***

The outbound COB transaction is a post-adjudicative transaction. This transaction includes the incoming claim data as well as the COB data. A/B MACs or DME MACs 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 store-and-forward repository (SFR). This repository file is designed and maintained by the shared system. This data must be re-associated 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 re-associate all data required to map to the COB transaction.

Data on claims that the A/B MAC or DME MAC receives from its keyshop or image processing systems may not be included on the SFR, depending on the shared system design. The A/B MAC and DME MAC 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” dataset. It will contain all “required” COB transactions segments and post-adjudicative Medicare data.

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

- A/B MACs and DME MACs’ translators perform syntax edits and map incoming claim data to the ASC X12 flat file;
- Standard system creates any Medicare edits for the flat file data;
- Medicare data on ASC X12 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 are combined with repository data to create the outbound COB. Under the COBA process, the *BCRC* will receive flat files containing processed Medicare claims. The *BCRC* will then convert the flat files into the appropriate HIPAA outbound COB format and transmit the claims to the COBA trading partner.