CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 4243	**Date: February 15, 2019**
	Change Request 10961

Transmittal 4160, dated November 2, 2018, is being rescinded and replaced by Transmittal 4243, dated, February 15, 2019 to modify the wording in the NOTE included in 10961.8.1 from "which were 6 digits in length" to "which included an alpha prefix and 6 digits" and to change the numeric example to reflect A000000. Additionally, CMS is clarifying that the Multi-Carrier System (MCS) is waived from implementing the requirement specified in the NOTE associated with requirement 10961.8.1. All other information remains the same.

SUBJECT: Modifications to the National Coordination of Benefits Agreement (COBA) Crossover Process

I. SUMMARY OF CHANGES: Through this change request, the Centers for Medicare & Medicaid Services (CMS) is introducing process efficiencies within its COBA claims recovery process. The CMS is also undertaking changes to ensure that outbound Benefits Coordination & Recovery Center (BCRC) Detailed Error Report provider notification letters now will include masked Health Insurance Claim Numbers (HICNs). Additionally, CMS is implementing a change to ensure that the Part A shared system discontinues a default process of including a Present on Admission (POA) indicator of "U" on COBA non-inpatient hospital crossover claims.

EFFECTIVE DATE: April 1, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 1, 2019

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	28/70/70.6.1 - Coordination of Benefits Agreement (COBA) Detailed Error Report Notification Process
R	28/70/70.6.3 - Coordination of Benefits Agreement (COBA) Eligibility File Claims Recovery Process

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: 4243	Date: February 15, 2019	Change Request: 10961

Transmittal 4160, dated November 2, 2018, is being rescinded and replaced by Transmittal 4243, dated, February 15, 2019 to modify the wording in the NOTE included in 10961.8.1 from "which were 6 digits in length" to "which included an alpha prefix and 6 digits" and to change the numeric example to reflect A000000. Additionally, CMS is clarifying that the Multi-Carrier System (MCS) is waived from implementing the requirement specified in the NOTE associated with requirement 10961.8.1. All other information remains the same.

SUBJECT: Modifications to the National Coordination of Benefits Agreement (COBA) Crossover Process

EFFECTIVE DATE: April 1, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 1, 2019

I. GENERAL INFORMATION

A. Background: Through this instruction, the Centers for Medicare & Medicaid Services (CMS) is implementing the following three (3) changes: 1) modernizing its COBA claims recovery process to realize operational efficiencies; 2) ensuring that the Benefits Coordination & Recovery Center (BCRC) Detailed Error Report provider notification letters/reports will reflect masked Health Insurance Claim Numbers (HICNs); and 3) modifying the Part A system default logic used in producing Present on Admission (POA) indicators on COBA non-inpatient hospital claims that providers originally submitted either as hard copy (UB-04) or via Direct Data Entry (DDE) submission.

Through the implementation of Transmittal 1038, Change Request (CR) 5250, CMS developed a COBA claims recovery process to address situations where: 1) a COBA trading partner failed to include all of its members on the Beneficiary Other Insurance auxiliary file sent to the Common Working File (CWF) for a defined period of time; or 2) a COBA trading partner made an error with its claims selection criteria that were, in turn, loaded within CWF. **Note:** All Durable Medical Equipment Medicare Administrative Contractors (DME MACs) remain exempt from the COBA claims recovery process.

The CMS and the BCRC launched a first-time national COBA claims recovery process during May 2018. That experience brought to light the need for a few operational efficiencies and clarifications. The CMS is remedying these issues through this instruction.

To ensure compliance with the Social Security Number (SSN) Fraud Prevention Act of 2017, CMS is requiring that the shared systems produce BCRC Detailed Error Report notification letters or reports that include a masked HICN. The shared systems create these letters/reports on a daily basis when the BCRC is unable to cross over specific claims due to Health Insurance Portability and Accountability Act (HIPAA) Accredited Standard Committee (ASC) 837 X12N claims compliance errors or other claim data errors.

Since the inception of version 5010A1 of the HIPAA ASC X12N 837 institutional claims transactions, the Part A shared system has always defaulted to a value of "U" for the POA indicator for all non-inpatient hospital claims if a Store and Forward Repository is not available. This means that all incoming hard copy and DDE-submitted claims currently are affected by this logic. Because of the HIPAA 837 claims compliance concerns around inclusion of POA indicators on non-inpatient hospital claims (Type of Bill (TOB) other than 11x, 18x, 21x, and 41x), CMS will be changing this practice through this instruction.

B. Policy: Unless otherwise noted, all pre-existing operational requirements specified in CR 5250 and found in Pub.100-04, chapter 28, section 70.6.3 are unchanged and shall be followed.

As part of an active COBA claims recovery, the two Virtual Data Centers (VDCs) that support the A/B MACs shall complete an Electronic Transmittal Form on behalf of their associated MACs that are participating in a COBA claims recovery process. (**Note:** The Electronic Transmittal Form specifies the file dataset names to which the BCRC will transmit a COBA E01 eligibility file. The COBA E01 eligibility file contains the specifications on the COBA trading partner and the individuals whose claims need to be recovered).

When CMS sends a 'COBAProcess' e-mail to a MAC and its associated VDC to initiate a COBA claims recovery, the MAC and VDC shall submit the names of at least two (2) crossover points of contact (POC) to CMS for purposes of fulfilling the COBA claims recovery process. Each MAC and associated Data Center shall send POC information to Brian Pabst (brian.pabst@cms.hhs.gov), copying COBAProcess@cms.hhs.gov, within 3 days following receipt of the COBAProcess e-mail.

As was previously stated in CR 5250, as part of its COBAProcess notification e-mail to a MAC, CMS will specify whether the claims recovery is specific to CWF date span (i.e., process date), specified dates of service, or both. Additionally, CMS will specify which specific MAC(s), by state, will be involved in the COBA claims recovery activity. CMS will communicate further with the MACs' crossover staff and the VDCs involved in the COBA recovery process either via phone or e-mail.

The Part B shared system shall accept either a Health Insurance Claim Number (HICN) or Medicare Beneficiary Identifier (MBI) as reported via the COBA E01 eligibility file in the field defined as "Beneficiary Medicare ID" (see file displacement 64--75 in attachment B). (**Note:** The Part A shared system made a change to accept either the HICN or MBI on the incoming COBA E01 eligibility file through the implementation of FS0694.)

The Part A shared system and the VDCs shall send no more than 100,000 recovered claims (which equates to 20 ST-SE envelopes per MAC with 5,000 claims per envelope) to the BCRC per transmission. (**Note:** The Part B shared system is already following this requirement.) The VDCs shall: 1) review the COBA claims recovery cycle queue daily; and 2) send all COBA recovery claims to the BCRC continuously until no additional recovery claims are in queue. Additionally, the Part A and B shared systems and VDCs shall send the recovered claims files to the BCRC via a separate 837 flat file submission. The VDCs shall transmit the separate 837 flat file submission to the BCRC using the specified dataset included in the business requirements below.

The CMS will charge the COBA trading partner the customary per-claim crossover fee for each recovered claim, unless CMS specifies otherwise through an officially recognized communication.

Effective April 1, 2019, the Part A and B shared systems and Durable Medical Equipment Medicare Administrative Contractors (DME MACs) shall issue BCRC Detailed Error Report notification letters/reports that contain a masked HICN (e.g., xxxxx7777A**)**. Additionally, the Part A and B shared systems and DME MACs shall mask Railroad Retirement Board (RRB)-HICNs on their outbound provider notification letters/reports in the manner specified in the business requirements below. **Important:** If the claim at issue contains an MBI, the shared systems shall include the MBI on the outbound provider notification letter/report, in accordance with current procedures. (**Note:** As of October 1, 2018, all DME MACs are fully responsible for all outgoing correspondence, including any changes/ upgrades that may be needed.)

Effective April 1, 2019, the Part A shared system shall discontinue the practice of defaulting to a POA indicator on outbound COBA non-inpatient hospital claims (TOB other than 11x, 18x, 21x, and 41x).

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	
10961.1	A/B MACs shall note that unless otherwise indicated, all pre-existing operational requirements specified in CR 5250 and found in Pub.100-04, chapter 28, section 70.6.3 are unchanged and shall be followed.	X	X	X						RRB-SMAC
10961.2	As part of an active COBA claims recovery, the two VDCs that support the A/B MACs shall complete an Electronic Transmittal Form (see Attachment A) on behalf of their associated MACs that are participating in a COBA claims recovery process. (**Note:** The Electronic Transmittal Form specifies the file dataset names to which the BCRC will transmit a COBA E01 eligibility file. The COBA E01 eligibility file contains the specifications on the COBA trading partner and the individuals whose claims need to be recovered.)									VDC
10961.3	When CMS sends a 'COBAProcess' email to a MAC and its associated VDC to initiate a COBA claims recovery, the MAC and VDC shall submit the names of at least two (2) crossover points of contact (POC) to CMS for purposes of fulfilling the COBA claims recovery process.	X	X	X						RRB-SMAC, VDC
10961.3.1	Each MAC and associated Data Center shall send POC information to Brian Pabst (brian.pabst@cms.hhs.gov), copying COBAProcess@cms.hhs.gov, within 3 days following receipt of the CMS COBAProcess e-mail.	X	X	X						RRB-SMAC, VDC
10961.4	As part of its COBAProcess notification e-mail to a MAC, CMS shall specify whether the recovery is specific to CWF date span (i.e., process date), specified dates of service, or both. Additionally, CMS will specify which specific MAC(s), by state, will be involved in the COBA claims recovery activity.									CMS
10961.4.1	CMS shall communicate further with the MACs' crossover staff and VDCs involved in the COBA recovery process either via phone or e-mail.									CMS
10961.5	The Part B shared system shall accept either a HICN or MBI as reported via the COBA E01 eligibility file in the field defined as "Beneficiary Medicare ID" (see						X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	file displacement 64--75 in attachment B). (**Note:** The Part A shared system made a change to accept either the HICN or MBI on the incoming COBA E01 eligibility file through the implementation of FS0694.)									
10961.6	The Part A shared system and the VDCs shall send no more than 100,000 recovered claims (which equates to 20 ST-SE envelopes per MAC with 5,000 claims per envelope) to the BCRC per transmission. (**Note:** The Part B shared system is already following this requirement.)					X				VDC
10961.6.1	The VDCs shall take the following additional actions on behalf of MACs that have initiated a COBA claims recovery: • Monitor the COBA claims recovery cycle queue daily; and • Send all COBA recovery claims to the BCRC until no additional recovery claims are in queue.									VDC
10961.6.2	The indicated shared systems and VDCs shall send the recovered claim files to the BCRC via a separate 837 flat file submission.					X	X			VDC
10961.6.3	The VDCs shall transmit the separate 837 flat file submission to the BCRC using the following file dataset name: PCOB.BA.NDM.COBA.Cxxxxx.PARTA.RECV(+1) [for 837 institutional recovered claims] (**Note:** The 'xxxxx' value in the dataset name above represents the MAC contractor number. The VDCs for Part B MACs are already fulfilling this requirement for 837 professional recovery claims.)									VDC
10961.6.4	The Part B shared system shall produce a report for its MACs that contains a count of recovered claims per cycle.						X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	(**Note:** The Part A shared system already produces such a report for its MACs.)									
10961.7	The CMS shall charge the COBA trading partner the customary per-claim crossover fee for each recovered claim, unless CMS specifies otherwise through an officially recognized communication.									CMS
10961.8	Effective April 1, 2019, the indicated shared systems and DME MACs shall issue BCRC Detailed Error Report notification letters/reports that contain a masked HICN (e.g., xxxxx7777A). (**Important:** If the claim at issue contains an MBI, the shared systems shall, of course, include the MBI on the outbound letter/report, in accordance with current procedures.) (**Note:** As of October 1, 2018, all DME MACs are fully responsible for all outgoing correspondence, including any changes/upgrades that may be needed.)				X	X	X			
10961.8.1	Additionally, the Part A and B shared systems and DME MACs shall mask RRB-HICNs on their outbound provider notification letters/reports as follows, depending upon the RRB-HICN's composition: • Axxxxx1370 • WCAxxxxx2388 • CAxxxxx1 (**Note:** This masking requirement does not apply to RRB numbers issued before March 1964, which included an alpha prefix and 6 digits; e.g., A000000. **Important:** MCS shall continue to mask all RRB numbers regardless of the year issued.)				X	X	X			
10961.9	Effective April 1, 2019, the Part A shared system shall discontinue the practice of defaulting to a POA indicator on outbound COBA non-inpatient hospital claims (TOB other than 11x, 18x, 21x, and 41x).					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: 2

70.6.1 - Coordination of Benefits Agreement (COBA) Detailed Error Report Notification Process

(Rev. 4243, Issued: 02-15-19, Effective: 04-01-19, Implementation: 04-01-19)

Effective with the July 2005 release, CMS implemented an automated process to notify physicians/ practitioners, suppliers, and providers that specific claims that were previously tagged by the Common Working File (CWF) for crossover will not be crossed over due to claim data errors. Claims transmitted via ASC X12 837 flat file by the A/B MAC and DME MAC shared systems to the Benefits Coordination & Recovery Center (BCRC) may be rejected at the flat file level, at a HIPAA ASC X12 pre-edit validation level, or by trading partners as part of a financial dispute arising from an invoice received.

Effective with the April 2005 release, the A/B MAC and DME MAC shared systems began to populate the BHT 03 (Beginning of Hierarchical Reference Identification) portion of their ASC X12 837 COB flat file submissions to the BCRC with a unique 22-digit identifier. This unique identifier will enable the BCRC to successfully tie a claim that is rejected by the BCRC at the flat file or HIPAA ASC X12 pre-edit validation levels as well as claims disputed by trading partners back to the original ASC X12 837 flat file submissions.

Effective October 4, 2005, A/ B MACs and DME MACs and their shared systems began to receive notification via the BCRC Detailed Error Reports, whose file layout structures appear below, that a COBA trading partner is in test or production mode via the BHT 03 identifier that is returned from the BCRC.

Effective April 3, 2011, all A/B MACs and DME MACs shall include an extra 1-byte "Original versus Adjustment Claim Indicator" value within the BHT03 identifier on all ASC X12 837 institutional and professional claims they transmit to the BCRC for crossover purposes. The BCRC shall, in turn, return this value to the appropriate A/B MAC and DME MAC via the BCRC Detailed Error Report process. In addition, the DME MAC shared system shall send an additional 1-byte value (defined as "reserved for future use") as spaces in field 504-F4 (Message) of the NCPDP flat file sent to the BCRC. The BCRC shall, in turn, also return this value to the appropriate DME MAC via the BCRC Detailed Error Report process.

Effective April 1, 2013, CMS added a new 1-byte Original versus Adjustment indicator to the suite of possible 1-byte options for position 23 of the BHT03 identifier, as reflected below.

Effective with April 7, 2014, CMS has added 2 new 1-byte Original versus Adjustment indicators to the suite of possible options for position 23 of the BHT03 identifier, as reflected below.

A. Inclusion of the Unique 23-Digit Identifier on the ASC X12 837 Flat File and NCPDP File

1. Populating the BHT 03 Portion of the ASC X12 837 Flat File

The A/B MAC and DME MAC shared systems shall populate the BHT 03 (Beginning of Hierarchical Transaction Reference Identification; **field length=30 bytes**) portion of their ASC X12 837 flat files that are sent to the BCRC for crossover with a 23-digit Contractor Reference Identifier (CRI). The identifier shall be formatted as follows:

a. A/B MAC or DME MAC number (9-bytes; until the 9-digit MAC number is used, report the 5-digit MAC number, left-justified, with spaces for the remaining 4 positions);

b. Julian date as YYDDD (5 bytes);

c. Sequence number (5 bytes; this number begins with "00001," so the sequence number should increment for each ST-SE envelope, which is specific to a trading partner, on a given Julian date);

d. Claim version indicator (2 bytes, numeric, to denote claim version)
**Acceptable values = 50 (for ASC X12 claims), and 20 (for NCPDP D.0 claims);

e. COBA Test/Production Indicator (1-byte alpha indicator; acceptable values = “T” [test] and “P” [production]) or “R” if the claims were recovered for a “production” COBA trading partner (see §70.6.3 of this chapter for more details;

f. Original versus Adjustment Claim Indicator (1-byte alpha indicator); acceptable values are defined as the following:

E - for reprocessed claims that formerly included an electronic prescribing (e-RX) negative adjustment amount;

O - for original claims;

P - for Affordable Care Act or other congressional imperative mass adjustments;

M - for non-Affordable Care Act mass adjustments tied to Medicare Physician Fee Schedule (MPFS);

S - for mass adjustment claims—all others;

R - for RAC adjustment claims;

A - for routine adjustment claims, not previously classified; and
C – for CMS-directed mass adjustment action (use specified by CMS).

The following indicator is only applicable to FISS-generated claims:
V - Void/cancel only claim.

The 23-digit CRI shall be left-justified in the BHT 03 segment of the 837 flat file, with spaces used for the remaining 8 positions. (**NOTE:** The CRI is unique inasmuch as no two files should ever contain the same combination of numbers.)

2. NCPDP 23-Digit Unique Identifier

Effective April 3, 2011, the DME MAC shared system shall also adopt a unique 23-digit format, referenced directly above under “Populating the BHT 03 Portion of the ASC X12 837 Flat File.” However, prior to April 7, 2014, the system shall populate the unique 23-digit identifier (defined as “future use”) with spaces in field 504-F4 (Message) within the NCPDP file (field length=35 bytes). The DME MAC shared system shall populate the unique identifier, left justified, in the field. Spaces shall be used for the remaining bytes in the field.

Effective April 7, 2014, the DME MAC shared system shall ensure that its DME MACs have the ability to 1) execute actions that will result in the transmission of their HUDC claims to CWF with Mass Adjustment Indicator set to “O”; and 2) transmit mass adjusted NCPDP D.0 COB claims to the BCRC under a 504-F04 (Message) field identifier of "C" (CMS-directed mass adjustment action) or "P" (mass adjustments tied to Affordable Care Act or Congressional/legislative mandate) as appropriate to the situation.

In addition, the DME MAC shared system shall ensure that all NCPDP D.0 crossover claims will now be sent to the BCRC with the 23rd byte 504-F04 (Message) field indicator completed, when appropriate, as indicated below.

O -- for all "original" NCPDP D.0 claims transmitted;

A-- for "routine adjustment claims" transmitted; and

R-- for recovery audit claims (RAC) adjustment claims transmitted.

B. BCRC Institutional, Professional, and NCPDP Detailed Error Reports

The A/B MAC and DME MAC shared systems shall accept the BCRC Institutional, Professional, and NCPDP Detailed Error Reports received from the BCRC. The formats for each of the Detailed Error Reports appear below.

Beginning with July 2007, all A/B MAC and DME MAC systems shall no longer interpret the percentage values received for ASC X12 837 institutional and professional claim "222" and "333" errors via the BCRC Detailed Error Reports as if the values contained a 1-position implied decimal (e.g., "038"=3.8 percent). DME MACs shall also no longer interpret the percentage values received for NCPDP claims for "333" errors via the BCRC Detailed Error Report for such claims as if the values should contain a 1-position implied decimal.

In addition, A/B 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 otherwise described within this section.

Effective with July 2009, the A/B MAC and DME MAC shared systems shall accept the modified versions of the BCRC Detailed Error Reports for institutional and professional claims as reflected below. As part of the July 2009 changes, the BCRC will, at CMS's direction, expand the length of the "error description" field. (**NOTE:** This means that the shared systems shall therefore include the expanded error description code as part of their special provider notification letters.)

The Institutional Error File Layout, including summary portion, will be used for Part A claim files.

BCRC Detailed Error Report

Institutional Error File Layout - (Detail Record)

Field	Description	Field Size	Record Location
1	Date	8	1-8
2	Control Number	9	9-17
3	COBA ID	10	18-27
4	Subscriber ID/Medicare ID	12	28-39
5	Claim DCN/ICN	14	40-53
6	Record Number	9	54-62
7	Record/Loop Identifier	6	63-68
8	Segment	3	69-71
9	Element	2	72-73
10	Error Source Code	3	74-76 ('111', '222', or '333')
11	Error/Trading Partner Dispute Code	6	77-82
12	Filler	100	83-182
13	Field Contents	50	183-232
14	BHT 03 Identifier	30	233-262 (23 bytes used)
15	Claim DCN/ICN	23	263-285
16	Error Description	300	286-585
17	Filler	15	586-600

Institutional Error File Layout - (Summary Record)

Field	Description	Field Size	Record Location
1	Date	8	1-8
2	Total Number of Claims for Processing Date	10	9-18
3	Number of '111' Errors	10	19-28
4	Number of '222' Errors	10	29-38
5	Percentage of '222' Errors	3	39-41
6	Number of '333' Errors	10	42-51
7	Percentage of '333' Errors	3	52-54
8	Filler	19	55-73

Field	Description	Field Size	Record Location
9	Summary Record ID Error Source Code	3	74-76 ('999')
10	Filler	524	77-600

The Professional Error File Layout, including summary portion, will be used for Part B and DME MAC claim files.

BCRC Detailed Error Report

Professional Error File Layout - (Detail Record)

Field	Description	Field Size	Record Location
1	Date	8	1-8
2	Control Number	9	9-17
3	COBA ID	10	18-27
4	Subscriber ID/Medicare ID	12	28-39
5	Claim DCN/ICN	14	40-53
6	Record Number	9	54-62
7	Record/Loop Identifier	6	63-68
8	Segment	3	69-71
9	Element	2	72-73
10	Error Source Code	3	74-76 ('111', '222', '333')
11	Error/Trading Partner Dispute Code	6	77-82
12	Filler	100	83-182
13	Field Contents	50	183-232
14	BHT 03 Identifier	30	233-262 (23 bytes used)
15	Claims DCN/ICN	23	263-285
16	Error Description	300	286-858
17	Filler	15	586-600

Professional Error File Layout – (Summary Record)

Field	Description	Field Size	Record Location
1	Date	8	1-8
2	Total Number of Claims for Processing Date	10	9-18
3	Number of '111' Errors	10	19-28
4	Number of '222' Errors	10	29-38
5	Percentage of '222' Errors	3	39-41
6	Number of '333' Errors	10	42-51
7	Percentage of '333' Errors	3	52-54
8	Filler	19	55-73
9	Summary Record ID Error Source Code	3	74-76 ('999')
10	Filler	524	77-600

The NCPDP Error File Layout, including summary portion, will be used by DME MACs for Prescription Drug Claims

BCRC Detailed Error Report

NCPDP Error File Layout - (Detail Record)

Field	Description	Field Size	Record Location
1	Date	8	1-8
2	Batch Number	7	9-15
3	COBA ID	5	16-20
4	Medicare ID	12	21-32
5	CCN	14	33-46
6	Record Number	9	47-55
7	Batch Record Type	2	56-57
8	Segment ID	2	58-59
9	Error Source Code	3	60-62 ('111', or '333')
10	Error/Trading Partner Dispute Code	6	63-68
11	Error Description	100	69-168
12	Field Contents	50	169-218

Field	Description	Field Size	Record Location
13	Unique File Identifier	30	219-248 (23 bytes used)
14	CCN	23	249-271
15	Filler	18	272-289

NCPDP Error File Layout - (Summary Record)

Field	Description	Field Size	Record Location
1	Date	8	1-8
2	Total Number of Claims for Processing Date	10	9-18
3	Number of '111' Errors	10	19-28
4	Number of '333' Errors	10	29-38
5	Percentage of '333' Errors	3	39-41
6	Filler	18	42-59
7	Summary Record ID Error Source Code	3	60-62 ('999')
10	Filler	524	63-289

If the BCRC has rejected back to the A/B MAC and DME MAC shared system for 2 or more COBA Identification Numbers (IDs), the shared system shall receive a separate error record for each COBA ID. Also, if a file submission from a shared system to the BCRC contains multiple provider, subscriber, or patient level errors for one COBA ID, the shared system will receive a separate error record for each provider, subscriber, or patient portion of the file on which errors were found.

C. Further Requirements of the COBA Detailed Error Report Notification Process

1. Error Source Code

A/B MACs and DME MACs, or their shared systems, shall use all information supplied in the BCRC Detailed Error Report (particularly error source codes provided in Field 10 of Attachment B) to (1) identify shared system changes necessary to prevent future errors in test mode or production mode (Test/Production Indicator= T or P) and (2) to notify physicians, suppliers, and providers that claims with the error source codes “111,” “222,” and “333” will not be crossed over to the COBA trading partner.

2. Time Frames for Notification of All MACs Financial Management Staff and Providers

A/B MACs and DME MACs, or their shared systems, shall provide notification to MAC financial management staff for purposes of maintaining an effective reconciliation of crossover fee/ complementary credits received within five (5) business days of receipt of the BCRC Detailed Error Report.

Effective with the October 2005 release, A/B MACs and DME MACs and their shared systems shall receive BCRC Detailed Error Reports that contain BHT03 identifiers that indicate “T” (test) or “P” (production) status for purposes of fulfilling the provider notification requirements. (**Note:** The “T” or the P” portion of the BHT03 indicator will be identical to the Test/Production indicator originally returned from CWF on the processed claim.)

a) Special Automated Provider Correspondence

A/B MACs and DME MACs, or their shared systems, shall also take the following actions indicated below only when they determine via the Beneficiary Other Insurance (BOI) reply trailer (29) that a COBA trading partner is in crossover production mode with the BCRC (Test/Production Indicator=P). After an A/B MAC or DME MAC, or its shared system, has received a BCRC Detailed Error Report that contains claims with error source codes of “111” (flat file error) “222” (HIPAA ASC X12 error), or “333” (trading partner dispute), it shall take the following two specified actions within five (5) business days:

1. Notify the physician/practitioner, supplier, or provider via automated letter from your internal correspondence system that the claim did not cross over. The letter shall include specific claim information, not limited to, Internal Control Number (ICN)/Document Control Number (DCN), *a*

masked Health Insurance Claim *Number (HICN) [e.g., xxxxx7777A] or Railroad Board (RRB) HICN [e.g., WCAxxxxx2388], as applicable if included on the claim, or a non-masked Medicare Beneficiary Identifier (MBI)*, Medical Record Number (applies only to Part A), Patient Control Number (only if it is contained in the claim), beneficiary name, date of service, and the date claim was processed.

Effective with July 2007, A/B MACs and DME MACs and their systems shall ensure that, in addition to the standard letter language (the claim(s) was/were not crossed over due to claim data errors and was/were rejected by the supplemental insurer), their A/B MACs' and DME MACs' special provider letters/reports, which are generated for '222' and '333' error rejections in accordance with CR 4277, now include the following additional elements, as derived from the BCRC Detailed Error Report: 1) HIPAA H-series rejection code or other rejection code, and 2) the rejection code's accompanying description.

NOTE: A/B MACs or DME MACs, or their shared systems, are **not** required to reference the COBA trading partner's name on the above described automated letter, since the original remittance advice (RA)/electronic remittance advice (ERA) would have listed that information, if appropriate.

2. Update its claims history to reflect that the claim(s) did not cross over as a result of the generation of the automated letter.

   Effective with October 1, 2007, all A/B MACs and DME MACs shall modify their special provider notification letters that are generated for "111," "222," and "333" error situations to include the following standard language within the opening paragraph of their letters: "This claim(s) was/were not crossed over due to claim data errors or was/were rejected by the supplemental insurer."

   A/B MACs and DME MACs shall reformat their provider notification letters to ensure that, in addition to the new standard letter language, they continue to include the rejection code and accompanying description, as derived from the BCRC Detailed Error Report, for "222" or "'333" errors in association with each errored claim.

   Effective with the July 7, 2009, release, upon receipt of the BCRC Detailed Error Report (DER), the A/B MAC (A) and A/B MAC (HH) shared system shall configure the existing 114 report, as derived from the BCRC DER, so that it 1) continues to display in landscape format; and 2) includes a cover page that contains the provider's correspondence mailing address.

b) ***Special Exemption from Generating Provider Notification Letters***

Effective July 7, 2008, upon their receipt of BCRC Detailed Error Reports that contain "222" error codes 000100 ("Claim is contained within a BHT envelope previously crossed; claim rejected") and 00010 ("Duplicate claim; duplicate ST-SE detected"), all shared systems shall automatically suppress generation of the special provider notification letters that they would normally generate for their associated A/B MACs and DME MACs in accordance with the requirements of this section as well as §70.6.3 of this chapter. In addition, upon receipt of BCRC Detailed Error Reports that contain "333" (trading partner dispute) error code 000100 (duplicate claim) or 000110 (duplicate ISA-IEA) or 000120 (duplicate ST-SE), all shared systems shall automatically suppress generation of the special provider notification letters, as would normally be required in accordance with this section as well as §70.6.3 of this chapter.

NOTE: When suppressing their provider notification letters for the foregoing qualified situations, the A/B MACs and DME MACs shall also not update their claims histories to reflect the non-crossing over of the associated claims. A/B MACs and DME MACs should, however, continue to take into account the volume of claims that they are suppressing for financial reconciliation purposes.

Effective with October 6, 2008, when the BCRC returns the "222" error code "N22225" to A/B MACs and DME MACs via the BCRC Detailed Error Report, the A/B MACs and DME MACs' shared systems shall suppress generation of the special provider notification letters that they would normally issue in accordance with CRs 3709 and 5472.

When suppressing their provider notification letters following their receipt of a "N22225" error code, the A/B MACs' and DME MACs' shared systems shall also not update their claims histories to reflect the non-crossing over of the associated claims. A/B MACs and DME MACs should, however, continue to take into account the volume of claims that they are suppressing for financial reconciliation purposes.

Effective with January 5, 2009, when the BCRC returns claims on the BCRC Detailed Error Report whose COBA ID falls in the range 89000 through 89999 (range designates "Other-Health Care Pre-payment Plan [HCPP] and HMO Cost Plan"), the A/B MACs' and DME MACs' systems shall take the following actions:

1) Suppress generation of the special provider letters; and

2) Not update their affiliated A/B MACs and DME MACs' claims histories to indicate that the BCRC will **not** be crossing the affected claims over.

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

(Rev. 4243, Issued: 02-15-19, Effective: 04-01-19, Implementation: 04-01-19)

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) and associated Virtual Data Center (VDC) a 'COBAProcess' e-mail communication. When the CMS sends a "COBAProcess" e-mail communication to an A/B MAC to 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 *and associated VDC either* via phone *or e-mail* to discuss the specific Common Working File (CWF) date span *(i.e., process date)* or claim date of service parameters, or both, for the claims recovery process. *Additionally, CMS will specify which specific MAC(s), by state, will be involved in the COBA claims recovery activity.* **(NOTE:** DME MACs and their shared system may *be required to* implement the COBA eligibility file claims recovery process as part of a future *instruction*.)

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

*As part of an active COBA claims recovery, the two VDCs that support the A/B MACs shall complete an Electronic Transmittal Form on behalf of their associated MACs that are participating in a COBA claims recovery process. (**Note:** The Electronic Transmittal Form specifies the file dataset names to which the BCRC will transmit a COBA E01 eligibility file. The COBA E01 eligibility file contains specifications on the COBA trading partner and the individuals whose claims need to be recovered.)*

Following the completion of the Electronic Transmittal Form, the BCRC sends the *appropriate VDC a copy* of the trading partner's COBA eligibility file(s), which will be prepared in accordance with the CMS

proprietary format. *(**Note:** The BCRC will transmit the COBA eligibility file to the VDC through its existing Connect: Direct connection.)* The VDC then notifies the affected A/B MAC*(s)* that the COBA recovery eligibility file is available so that the A/B MAC*(s)* may initiate a claims recovery.

Effective April 1, 2019, the shared systems supporting the A/B MACs shall accept either a Health Insurance Claim Number (HICN) or Medicare Beneficiary Identifier (MBI), as reported via the COBA E01 eligibility file, in the field defined as "Beneficiary Medicare ID" (file displacement 64—75).
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 *(i.e., process date)* or date of service parameters, or both, that CMS has provided to the A/B MAC.

In performing the COBA claims recovery, MACs shall not attempt to recover claims that were previously transmitted to the BCRC. *"Previously transmitted claims" may be identified by the claims' crossover location status or the presence of the COBA ID being used for the recovery process along with a "P" (production) indicator in association with the processed claims.*
Additionally, the MAC shall not apply the COBA trading partner's selection criteria, as found on the Health Insurance Master Record (HIMR) COBS, when recovering claims.

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 (*file displacement 121—128* for beneficiary supplemental eligibility-from date and *file displacement 129—136* 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 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 *and their associated shared systems* 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 *VDCs* 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. *The shared systems shall create reports that will provide MACs with the count of recovered claims per cycle.*

Attachment A

ELECTRONIC TRANSMITTAL FORM

Project: Coordination of Benefits Agreement (COBA)

Task: COBA Claims Recovery Process

Contact Information

Company Name: _____

Contact Name: _____Phone# _____ ext. _

Contact Email Address: _____

CMSNet Information

Account ID: _____ Node ID: _____

IP Address: _____ Port: _____

Production Requirements

Filename(s): _____

Special Instructions (e.g., file triggers):

Test Requirements

Filename(s):

Special Instructions (e.g., file triggers):

Attachment B

COBA Eligibility File

Table 1: COBA Eligibility E01 Record Layout Header – E00

Data Element	Description	Field Length	MO	Field Location
HEADER RECORD TYPE	**Value -E00**	3X	O	E00.001
HEADER COBA ID	COBA ID assigned by the COBC Field is 9 position, alphanumeric (no special characters), left justified, last four positions are spaces. **Mandatory.**	9X	O	E00.002
HEADER CREATION DATE	Date the record was created; format: (CCYYMMDD), with no special characters	8X	O	E00.003
HEADER BENEFICIARY STATE CODE	Beneficiary State of residence **NOTE: This field will not be used by the COBA Process.**	2X	O	E00.004
FILLER	Blank Field. Value is spaces.	178X	O	E00.005

Table 2: COBA Eligibility E01 Record Layout

File attributes:
Format: Fixed block
Length: 200 bytes

Data Field	Length	Type	Displacement	Description
Record type	3	Alpha-Numeric	1–3	Type of Record Set to ‘E01’. Mandatory
COBA ID	9	Alpha-Numeric	4-12	Coordination of Benefits Agreement Identification Number Field is 9 position, alphanumeric (no special characters), left justified, last four positions are spaces. Mandatory
File Effective Date	8	Alpha-Numeric	13-20	Effective date of file in CCYYMMDD format with no special characters. Mandatory

Data Field	Length	Type	Displacement	Description
File Update Indicator	1	Alpha-Numeric	21	Type of update values: 'A' = Add 'C' = Change/Update 'D' = Delete Required as of March 1, 2007
*Beneficiary Surname	20	Alpha-Numeric	22-41	Beneficiary last name Mandatory Uppercase characters only
*Beneficiary First	12	Alpha-Numeric	42-53	Beneficiary first name. Mandatory Uppercase characters only
Beneficiary Middle Initial	1	Alpha-Numeric	54	Beneficiary middle initial. Optional Uppercase characters only
*Beneficiary Birth Date	8	Alpha-Numeric	55-62	Beneficiary date of birth in CCYYMMDD format with no special characters. Mandatory
*Beneficiary Sex Code	1	Alpha-Numeric	63	Beneficiary sex code values are: 'M' = Male 'F' = Female NOTE: If unknown, default to 'M' Mandatory Uppercase characters only
Beneficiary Medicare ID	12	Alpha-Numeric	64-75	Beneficiary Medicare ID (Medicare Health Insurance Claim Number [HICN] or Medicare Beneficiary Identifier [MBI]). Mandatory
Beneficiary Supplemental ID Number	25	Alpha-Numeric	76-100	Supplemental ID on file with sender. Should be the same as what is submitted on the claim. Optional
Beneficiary Group Policy Number	20	Alpha-Numeric	101-120	Supplemental policy number on file. Should be the same as what is submitted on the claim. Optional
Beneficiary Supplemental Eligibility From Date-1	8	Alpha-Numeric	121-128	Medicare supplemental "from" date in CCYYMMDD format with no special characters. Mandatory

Data Field	Length	Type	Displacement	Description
Beneficiary Supplemental Eligibility To Date-1	8	Alpha-Numeric	129-136	Medicare supplemental “to” date in CCYYMMDD format with no special characters **NOTE: This is the coverage through date. Indicate zeros for open-ended dates.** Mandatory
Filler	64	Alpha- Numeric	137-200	Unused Field – Populate with spaces

Table 3: COBA Eligibility E01 Record Layout Trailer Record – E99

Data Element	Description	Field Length	MO	Field Location
Record Type	**Value is 'E99'.**	3X	M	E99.001
E01 Record Count	Total number of E01 records in this file.	7N	M	E99.002
Filler	Blank Field – Value is spaces	190X	M	E99.003