Coordination of Benefits Agreement

IMPLEMENTATION USER GUIDE

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TABLE OF CONTENTS

Associated Documents Available for Download

Claims Dispute File Layout
COB Agreement (pdf 158KB)
COBA Attachment (pdf 479KB)
COBA Drug Coverage Eligibility (E02) Record Layout
COBA Drug Coverage Eligibility (E02) Response Record Layout
COBA Electronic Billing Introductory Package
COBA Eligibility (E01) Record Layout
COBA Eligibility File (E01) Acknowledgement Layout
COBA Eligibility Response File (ERF) Layout
COB COBA Problem Inquiry Request Form
Connectivity-HTTPS User Guide (pdf, 1.5M)
Connectivity-SFTP User Guide Section 1(pdf, 2.3MB)
Connectivity-SFTP User Guide Section 2(pdf, 747KB)
Connectivity-SFTP User Guide Section 3(pdf, 5.5MB)
Course Syllabus for COBA College
EDI Contact List
Electronic Transmission Form
HIPAA Closed Agree Issues Log (pdf 298KB)
HIPAA Closed Disagree Issues Log (pdf 157KB)
Medicare Contractor's and their Associated States
Medicare Gap Filling Instructions
Medigap Claim-based COBA IDs for Billing Purpose [pdf, 60KB]
Medigap-Insurer Letter [pdf, 64 Kb]
Medigap Questionnaire [pdf, 412 KB]
SFTP/HTTPS Information Form
Technical Readiness Survey (pdf 124KB)
Termination Procedures (pdf 61KB)
Test Sign Off Acceptance Form
Trading Partner Customer Service Point of Contact List
COBA National Crossover Process Supplemental Payers and Insurers in Current Production

Coordination of Benefits Agreement Implementation User Guide

Introduction

The purpose of the Coordination of Benefits Agreement Implementation User Guide is to communicate directly with staff affiliated with each trading partner about the administrative, technical, and financial requirements for implementing the Coordination of Benefits Agreement (COBA). Emphasis is given to preparing and testing data files to and from the Coordination of Benefits Contractor (COBC). This guide includes five sections. Referenced documents and forms are available for download at http://www.cms.hhs.gov/COBAgreement/01_overview.asp

SECTION 1: COBA PROGRAM HIGHLIGHTS
This section introduces the Coordination of Benefits program—its goals and expected benefits. A checklist is provided to guide the trading partner through the steps required to implement the COB Agreement and its Attachment. A timeline for the COBA program and the trading partner displays the current schedule for the COBA program implementation.

SECTION 2: COBA - CONTENTS OF AGREEMENT AND ATTACHMENT

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

SECTION 3: COBA TECHNICAL REFERENCE

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

SECTION 4: COBA FINANCIAL DETAILS

Trading partners under the COBA program may choose billing and payment remittance options. This section introduces the COBC's Electronic Invoice Presentment and Payment System (EIPP), and provides information on Crossover Fee Requirements.

SECTION 5: COBA CUSTOMER SERVICE

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

SECTION 1. COBA PROGRAM HIGHLIGHTS

1.0 Introduction to COBA

Overview

The Centers for Medicare & Medicaid Services (CMS) developed a model national contract, called the Coordination of Benefits Agreement (COBA), which standardizes the way that eligibility and Medicare claims payment information is exchanged. COBAs permit other insurers and benefit programs (also known as trading partners) to send eligibility information to CMS and receive Medicare paid claims data for processing supplemental insurance benefits for Medicare beneficiaries from CMS' national crossover contractor, the Coordination of Benefits Contractor (COBC).

Purpose

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

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

1.1 Implementation Checklist

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

1.1.1 Enrollment

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

1.1.1.2 *Execute COBA(s) Sign two original agreements.* Upon receipt, the COBC will sign both originals and return one original to the trading partner for their records.

1.1.1.3 *Complete the Attachment.* This form provides specific information to establish the trading partner's COBA such as the type of insurer or benefits program the trading partner represents, primary points of contact, and claims selection options. The COBA Attachment, although part of the formal agreement or contract, may be updated at the request of the trading partner or CMS as pertinent data or selections change.

1.1.1.4 *Complete Technical Readiness Survey.* The trading partner should use the Coordination of Benefits Agreement (COBA) Program Technical Readiness Assessment Survey to measure its current technical ability in relation to the COBA technical requirements as outlined in this guide. The survey is available for download at http://www.cms.hhs.gov/COBAgreement/01_overview.asp

1.1.1.5 *Mail completed documents.* The trading partner forwards each signed COBA and Attachment to the COBC at the mailing address specified in the COBA Attachment and the Customer Service section.

1.1.1.6 *Obtain COBA Identification Number(s) from the COBC.* Upon receipt and successful processing of the trading partner's COBA and Attachment, the COBC will generate a Profile Report assigning the trading partner's COBA ID(s), assigned according to the trading partner's line of business.

1.1.1.7 *Complete and return Profile Sheet.* This action notifies the COBC of the trading partner's approval of their Profile Report after reviewing it for accuracy. The trading partner must follow the notification instructions that accompany the Profile Report.

1.1.2 Testing

1.1.2.1. *Set up connectivity test.* Trading partners must coordinate testing of two-way transmission capability with the COBC, if applicable (i.e., electronic transmissions).

1.1.2.2 *Obtain a test date from the COBC.* Upon receipt of each signed COBA and Attachment, the COBC will provide the trading partner with the next available date to commence testing.

1.1.2.3. *Provide data transfer information.* Complete the appropriate Electronic Transmission Form available for download at http://www.cms.hhs.gov/COBAgreement/10_connectivity.asp Return the form to the COBC as indicated in the Customer Service section of this guide.

1.1.2.4 *Create test Eligibility File(s*). Trading partners must generate Eligibility Files in the required COBA Eligibility File Format using their assigned COBA ID(s) as furnished by the COBC. Claim tests will normally be done with a full size production Eligibility File; however, the initial test files should contain no more than 100 eligibility records. A syntax analyses will be performed on the initial mini test file. (Note: Does not apply to Medigap claim-based trading partners.) The first mini test file will be sent as all "add" transactions followed by a second mini test file that contains "change" records.

1.1.2.5 *Submit test Eligibility File(s) to the COBC.* Please refer to Section 3, Electronic Transmission, for data transmission options. (Note: The full eligibility test file will be loaded to the Beneficiary Other Insurance [BOI] file on CMS' Common Working File (CWF), and testing will occur based on the normal course of production.) (Note: Does not apply to Medigap claim-based trading partners.)

1.1.2.6 *Review test eligibility results.* The COBC will forward an Eligibility File Acknowledgement (EFA) that confirms receipt of an Eligibility File followed by an Eligibility Response File (ERF) after the file has completed processing at the CWF. The ERF provides a one-for-one disposition

response for each record in the Eligibility File. Refer to Section 3, COBA Eligibility Files, for more details on the EFA and ERF. (Note: Does not apply to Medigap claim-based trading partners.)

1.1.2.7 *Review test Claims File(s) from the COBC.* The COBC will create and forward Claims Files in the required formats for all claims matching eligibility information and claims selection criteria. For Medigap claim-based trading partners, please refer to Section 3, COBA Technical Reference for additional information on the testing procedures.

1.1.2.8 *Sign off on the test process with the COBC.* Once the trading partner is satisfied with the test results, they will submit a Test Sign-off Acceptance Form, which is available for download at http://www.cms.hhs.gov/COBAgreement/01_overview.asp/ and follow the instructions outlined on this form.

1.1.2.9 *Perform financial testing for billing and payment.* A summary of the COBC online payment system initiative db-eBills, how it works, and how to get started is provided in the Coordination of Benefits Agreement Electronic Billing Introductory Package, which is available for download at http://www.cms.hhs.gov/COBAgreement/30_New_COBA_Partner.asp

1.1.3 Final Implementation

1.1.3.1 *Obtain an implementation date from the COBC.* Upon receipt of the trading partner's Test Sign-off Form, the COBC, in coordination with CMS, will provide the trading partner with the next available date to move their COBA (s) into production/implementation. Note: The trading partner must confirm that the eligibility file that it intends to use to generate crossover claims for production has been submitted or updated to the COBC at least 14 days prior to the production date.

1.1.3.2 *Review invoices and Remit payment to the COBC.* The trading partner should review and follow instructions as provided in Section 4, COBA Financial Details, for billing and payment remittance.

1.2 Implementation Timeline

1.2.1 COBA Trading Partner Timeline

The following lists the major milestones and estimated durations in implementing the COBA program with the COBC noted in business days:

Task	Estimated Duration
Negotiate and execute COBA	15 days
Receive COBA ID(s), approve Profile Report, and begin data transfer setup.*	10 days
Generate mini and full test Eligibility File(s) (Note: Does not apply to Medigap claim-based trading partner.)	15 days
Review test claims files, complete financial testing, and provide test sign-off	25 - 40 days
Total Estimated Duration	65 - 80 days

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

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

1.3 Termination of a COBA

Overview

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

(1) The trading partner no longer wants to receive Medicare paid claims for supplemental payment or

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

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

1.3.1 Cessation of Crossover Activities in its Entirety

Through the COBA process, claims are crossed over to supplemental payers/insurers (trading partner) only after the claims have left the Medicare claims payment floor. This process usually occurs within 14 calendar days after Medicare receives the claim. To ensure that a significant percentage of crossover claims have been removed from the payment floor before the termination of the COBA ID, the Common Working File (CWF) will be advised to terminate the COBA 14 calendars prior to the actual termination date. It is possible that a small percentage of claims will be tagged and transmitted to the COBC for crossover to a supplemental insurer after the trading partner's connectivity to the COBC has been terminated. If this occurs, notification will be sent to the Medicare contractor that processed the claim(s) advising them that the "pipeline/run out" claim(s) did not crossover to the supplemental insurer. Providers are then informed that the claim(s) did not cross to the supplemental insurer. The notification to CWF of the COBA termination date 14 calendar days prior to the actual termination date should minimize this occurrence.

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

Below is an example timeline of a COBA termination.

COBA Termination Timeline	
Monday, 04/01/07	COBC receives notification to terminate COBA 99999. COBC sets the CWF termination date to 5/15/07 to allow for payment floor clearance. COBC sets the COBA claim transmission termination date to 6/1/07 (actual 60 days).
04/01/07 - 05/15/07	Claims continue to be tagged at CWF and transmitted to the trading partner as normal.
05/15/07	Invoice transmitted to COBA 99999 for April claim transmissions (04/01 - 04/30).
05/15/07	COIF file transmitted to CWF terminating COBA 99999
05/16/07	CWF applies COBA termination ceasing to tag claims to be crossed to COBA 99999.
05/16/07 - 06/01/07	Pipeline/run out claims continue to be transmitted from contractors as they come off the Medicare payment floor to COBC and crossed to COBA 99999.

06/01/07	COBC no longer accepts transmitted claims for COBA 99999. Claims received for COBA ID 99999 are returned to the submitting Medicare contractor.
06/15/07	Invoice transmitted to COBA 99999 for May claim transmissions (05/01 - 05/31).

1.3.2 Transitions Between the Trading Partner and a Clearinghouse

Neither the Centers for Medicare & Medicaid Services (CMS) nor the COBC solicit a move by a trading partner that receives crossover claims through a clearinghouse, to (1) receive claims directly from the COBC or (2) transition its crossover claim business activities to a different clearinghouse. However, CMS recognizes that all contractual situations are subject to change and is prepared to assist in the transition process when a trading partner has made a contractual decision. Therefore, the trading partner must notify CMS, in writing, of its' decision to transition to (1) receive claims directly from the COBC or (2) another clearinghouse. Notification may be forwarded to CMS via fax (410-786-7030) or by mail at:

CMS
COBA Crossover Team
7500 Security Blvd.
Mailstop: C3-14-16
Baltimore, MD 21244

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

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

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

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

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

(3) A copy of the Profile Report that was prepared by the COBC based on data submitted on the original Attachment should be used to determine if the claim selection criteria needs to change prior to transition – claim selection criteria should not change simultaneously with the transition date and/or revised attachment.

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

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

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

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

(7) Claims Testing: If claims are currently received directly from the COBC under another COBA ID, the trading partner or the incoming clearinghouse should be prepared to establish a test data set name in addition to the production COBA data set name for testing receipt of the transitioning claims. As a reminder, the test claims are the same production claims received by the outgoing clearinghouse or the trading partner through a separate transmission.

(8) The timeframe for claims testing will be dependent on whether or not the trading partner, which has decided to receive claims directly from the COBC, is currently receiving the 837 COB claim format from the clearinghouse.

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

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

(11) The trading partner should attend COBA College in order to process their invoices in db e-Bills. The COBC will provide a syllabus for all COBA College classes prior to the initial conversion meeting. The Course Syllabus for COBA College is available for download at http://www.cms.hhs.gov/COBAgreement/01_overview.asp/01_overview.asp/.

SECTION 2. COBA - CONTENTS OF AGREEMENT AND ATTACHMENT

2.0 COB Agreement and Attachment

The COB Agreement (COBA) is a contract between the Centers for Medicare & Medicaid Services' (CMS) contractor and other health insurers or benefit programs. The COBA specifies all of the essential functions to allow eligible insurers or benefit programs to receive Medicare paid claims automatically after Medicare releases claims from the payment floor. Only a trading partner can sign agreements. Refer to Section I of the COBA Attachment, which can be viewed at http://www.cms.hhs.gov/COBAgreement/01_overview.asp for the definition of who is defined as a trading partner. A third party is permitted to sign the standard COBA directly, but only if that third party adjudicates claims on behalf of an insurer or State Medicaid Agency.

Trading partners can designate Trading Partner contractors to perform and support the COBA.

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

2.1 Understanding Your Claims Selection Options Under the National COBA Crossover Program

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

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

Part I. General Claims Selection Options

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

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

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

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

- The trading partner has the opportunity to include **or** exclude all Part A claims for all providers and provider states.
- Trading partners have the option to include **or** exclude claims by provider identification number (Medicare Online Survey, Certification, and Reporting (OSCAR) legacy number) or by provider state (2-digit state code).

  Special Note: CMS anticipates that, with the full implementation of the National Provider Identifier (NPI) initiative, it will no longer be able to support inclusion or exclusion of Part A claims by provider identification number (ID). New trading partners are thereby **strongly cautioned against** making use of this inclusion or exclusion option.
- Exclusion by provider state means that CMS' CWF will exclude Part A claims based upon the first two (2) positions of the provider's OSCAR legacy number, which designate state in which services are provided, and not necessarily in accordance with the state in which the provider's claim is processed.
  - For example, if a COBA trading partner wishes to include only Maryland as a provider state, but the provider has nominated Trispan Medicare to be its processing intermediary for its claims[1], CMS' CWF would include claims where the first two (2) positions of the OSCAR number denote Maryland. Under the pre-Medicare Administrative Contractor (MAC) rules and regulations, governed by §1816 of Title XVIII of the Social Security Act, this means that a trading partner may well receive a Maryland provider claim that is processed by Trispan Medicare Services, which is corporately based in Jackson, Mississippi.
- Once MACs are fully operational by fiscal year (FY) 2009, providers may not be given the option to nominate their Part A claims intermediary. They will most likely be required to bill the designated MAC for their services. This means that, from that point onward, there will most likely be parity between provider state and assigned contractor for that jurisdiction across the board, with only the exception for regional home health intermediary (RHHI)-processed claims.

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

- The trading partner has the opportunity to globally include/receive all Part B (837 professional) claims[2] **or** to exclude such claims.

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[1] Under §1816 of Title XVIII of the Social Security Act, providers of Part A services have the legal right to nominate their claims processing intermediary if they elect not to utilize the intermediary that otherwise has jurisdiction within its state of registry.

[2] For COBA crossover purposes, 837 Professional claims encompass services provided by a non-institutional provider, such as a physician, practitioner, diagnostic specialist (e.g., radiologist or pathologist), other specialist (e.g., chiropractor, psychiatrist, surgeon, ophthalmologist, anesthesiologist) clinical lab, ambulance company. NOTE: Services billed to a Durable Medical Equipment Medicare Administrative Contractor (DMAC) are often billed on an 837 Professional claim. These kinds of services

- The trading partner may include **or** exclude specific states for crossover purposes.

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

  - If a COBA trading partner checks the "include" box and lists 10 specific states, CWF will include **only** those states for crossover purposes.
  - If a COBA trading partner checks the "exclude" box and lists 25 specific states, CWF will exclude only those states. The trading partner will receive the remaining states for crossover purposes.
  - COBA trading partners that wish to exclude all Part B claims should include a check in §IV.C.2 in lieu of populating the table in §IV.C.4 in its entirety.
  - COBA trading partners that wish to include **or** exclude Part B Railroad Retirement Board (RRB) claims should denote 'RR' within the table provided. Part A RRB claims are **not** billed centrally to one contractor but rather are billed in accordance with normal Medicare jurisdictional rules concerning the filing of Medicare Part A claims.

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

- The trading partner has the opportunity to include all DMAC claims—which encompasses those submitted as 837 Professional, as well as Part B NCPDP drug claims—to exclude certain DMAC jurisdictions/regions, **or** to exclude all DMAC claims by marking all jurisdictions/regions for exclusion.
- The trading partner also has the opportunity to exclude certain DMAC jurisdictions/regions and include others.
- The COBA trading partner may **not** uniquely include **or** exclude certain states within a DMAC jurisdiction/region but must include or exclude all states within a DMAC jurisdiction or region. Rather, the trading partner has the option of including or excluding all jurisdictions/regions, including all states therein, or subsets thereof.

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

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

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

- **Non-assigned claims**

are not included under the category of 'Carrier/MAC' (Professional) claims but rather are controlled for under the "DMERC/DME MAC Claims" section.

- **Description:** Refers to Part B claims and claims for durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) where the physician or supplier does not accept assignment on Medicare claims.
- **CWF logic:** Exclude the claim if the provider assignment indicator on the claim=N (non-assigned).
- **Reporting on 837 professional claims when these kinds of claims are included for crossover:** Loop 2300 CLM07 (value=C)

- **Original Medicare claims, fully paid, without deductible or co-insurance remaining (Applies to Part A and B claims)**
  - **Description:** Refers to original Part A and B claims on which all services or service lines are paid and there is no deductible or co-insurance remaining.
  - **CWF logic for Part A claims:** Exclude if the claim is determined to be original (action code=1); **all lines/services are fully paid**; and there is no deductible or co-insurance amount on the claim. NOTE: If one (1) of the services/line items is denied, the trading partner will receive the claim.
  - **CWF logic for Part B claims:** Exclude if the claim is determined to be original (entry code=1 or claim contains an 'N' non-adjustment claim header indicator); **all lines of the claim are fully paid,** with the allowed amount equal to the amount paid for all lines. NOTE: If one (1) of the services/line items is denied, the trading partner will receive the claim.
  - **Reporting on 837 claims if these claims are included for crossover:** There will be no CAS segments that include deductible (PR1) or co-insurance (PR2) amounts due. **NOTE:** If the trading partner receives the claim because it contains a denied service line, the CAS for the denied line may indicate beneficiary liability (PR) or provider obligation (CO).

- **Adjustment claims, fully paid, without deductible or co-insurance remaining**
  - **Description:** Refers to Part A and B "adjustment" claims on which all services or service lines are paid and there is no deductible or co-insurance remaining.
  - **CWF logic for Part A claims:** Exclude if the claim is determined to be adjustment (action code=3); all lines/services are fully paid; and there is no deductible or co-insurance amount on the claim.
  - **CWF logic for Part B claims:** Exclude if the claim is determined to be adjustment (entry code=5 or claim contains an 'A' adjustment claim header indicator); all lines of the claim are fully paid, with the allowed amount equal to the amount paid for all lines.
  - **Reporting on 837 claims if these claims are included:** The value in 2300 CLM05-3 is indicative of adjustment (value= 7 for either institutional or professional claims or additional possible alpha codes for 837 institutional claims) and there are no CAS*PR segments indicative of beneficiary liability. **NOTE:** If the trading partner receives the claim because it contains a denied service line, the CAS for the denied line may indicate beneficiary liability (PR) or provider obligation (CO).

- **Original Medicare claims paid at greater than 100% of the submitted charges without deductible or co-insurance remaining**
  - **Description:**
    (1) From a Part A context, this refers to situation where the amount paid on a Part A claim is within a range that is greater than 100% of the total submitted charges, as occurs under the Medicare prospective payment system (PPS), **and** the claim contains no deductible or co-insurance amounts.
    (2) From a Part B context, this refers **only** to ambulatory surgical center (ASC) claims for which the Medicare reimbursement is greater than the amount billed. These claims, which are always billed to Part B carriers/MACs, carry deductible and co-insurance amounts.
  - **CWF logic for Part A PPS claims:** Verify that the claim contains an action code 1; check that claim's reimbursement is greater than the submitted charges; and check that there are no deductible or co-insurance amounts on the claim.
  - **Reporting on 837 institutional claim if claim is included for crossover:** If the claim is PPS and there are no deductible or co-insurance amounts, there would be no CAS segments that would contain beneficiary liability (PR). If the claim is included because it contained deductible or co-insurance amounts, these amounts would appear in the appropriate CAS segment with PR*1 or PR*2.
  - **CWF logic for Part B—applies only to ASC claims:** Exclude the claim if the type of service equals 'F' and the place of service equals '24.' (**IMPORTANT:** Again, such claims **always** carry co-insurance responsibilities for the beneficiary and will carry deductible obligations as well.)
  - **Reporting of ASC services on 837 professional claims if included for crossover:** As noted above, despite the overarching label of this claim selection option, ASC claims are controlled by this exclusion. Therefore, amounts for beneficiary liability would be reflected as CAS*PR. The type of service 'F' would not be reflected; however, the place of service '24' would be reported in the 2300 loop CLM05-1, where value=24.

  Impact of Excluding This Claim Type:

  - The trading partner would **not** receive Part A PPS claims (situations where the Medicare diagnostic related groups (DRG) payment for the covered spell of illness or health care episode often exceeds the total charges billed) **for which there are no deductible or co-insurance amounts on the claim.**
  - Trading partners would still receive Part A PPS (DRG payment methodology) claims if they contain deductible or co-insurance amounts.
  - The trading partner would **not** receive Part B ambulatory surgical center (ASC) claims that are billed to carriers/MACs (type of service=F; place of service=24), even though co-insurance amounts will be present on the claim, as well as Part B deductible amounts, as applicable.

- **100% denied original claims, with no additional beneficiary liability**

- **Description:** Refers to fully denied claim situations where the beneficiary is determined to **not** have liability on any of the denied service lines (e.g., the beneficiary did **not** receive advanced notice that the service would not be covered or the provider is otherwise determined to be liable for all denied services/service lines).
- **Current CWF logic for Part A claims:** Exclude if the claim contains action code '1' and an 'R' non-payment indicator in association with the fully denied services or service lines.
- **Effective with October 1, 2007, the CWF logic for Part A claims:** Exclude if the claim contains action code '1' and an 'N' claim beneficiary liability indicator, which designates that the beneficiary has no liability on any of the fully denied services.
- **Reporting on the 837 institutional claim if claim is included for crossover:** Claim would be fully denied as CAS*CO*(followed by reason code) at the 2320 (claim) level.
- **CWF logic for Part B & DMEPOS claims:** Exclude if the claim contains entry code '1' and an 'N' claim beneficiary liability indicator, which designates that the beneficiary has no liability on any of the fully denied service lines.
- **Reporting on 837 professional claim if claim is included for crossover:** Claim is fully denied as CAS*CO* (followed by reason code) at the 2320 (claim) level.

- **100% denied adjustment claims, with no additional beneficiary liability**
  - **Description:** Refers to claims that are adjusted, possibly as the result of a post-payment claim review, to reflect fully denied where the beneficiary is determined to **not** have liability on any of the denied services or service lines.
  - **Current CWF logic for Part A claims:** Exclude if the claim contains action code '3' and an 'R' non-payment indicator in association with the fully denied service lines.
  - **Effective with October 1, 2007, the CWF logic for Part A claims:** Exclude if the claim contains action code '3' and an 'N' beneficiary liability indicator.
  - **Reporting on 837 institutional claim if claim is included for crossover:** Value in the 2300 CLM05-3 indicates adjustment claim. The claim is fully denied at the 2320 (claim) level with a CAS*CO* (followed by reason code).
  - **CWF logic for Part B & DMEPOS claims:** Exclude if the claim contains entry code '5' and an 'N' claim beneficiary liability indicator.
  - **Reporting on 837 professional claim if claim is included for crossover:** Value in the 2300 CLM05-3 indicates adjustment claim. The claim is fully denied at the 2320 (claim) level with a CAS*CO* (followed by reason code).
- **100% denied original claims, with additional beneficiary liability**
  - **Description:** Refers to claims that are fully denied and for which the beneficiary is determined to have liability on at least one of the fully denied services/service lines. ****IMPORTANT: The beneficiary's liability in such cases is not a deductible or co-insurance amount. Instead, the liability relates to the full amount of the denied service or service line item.****

- **Current CWF logic for Part A claims:** Exclude if the claim contains action code '1' and an 'N' or 'B' non-payment indicator in association with the fully denied services or service lines.
- **Effective with October 1, 2007, the CWF logic for Part A claims:** Exclude if the claim contains action code '1' and an 'L' beneficiary liability indicator, which signifies that the beneficiary has liability on at least one (1) of the fully denied services or service lines.
- **Reporting on 837 institutional claim if claim is included for crossover:** The value in the 2300 CLM05-3 indicates adjustment ('7' or possible other alpha code). The claim is fully denied at the 2320 (claim) level, and there is a CAS*PR* (followed by denial reason. services/service lines.
- **CWF logic for Part B & DMEPOS claims:** Exclude if the claim contains entry code '1' and an 'L' claim beneficiary liability indicator, which signifies that the beneficiary has liability on at least one (1) of the fully denied service lines.
- **Reporting on 837 professional claim if claim is included for crossover:** Value in the 2300 CLM05-3 indicates '7.' The claim is fully denied at the 2320 level, and there is a CAS*PR* (followed by reason code).

- **100% denied adjustment claims, with additional beneficiary liability**
  - **Description:** Refers to claims that are adjusted to reflect fully denied where the beneficiary is determined to have liability on at least one of the fully denied services or service lines. The beneficiary's liability in such cases is not a deductible or co-insurance amount.
  - **Current CWF logic for Part A claims:** Exclude if the claim contains action code '3'and an 'N' or 'B' non-payment indicator in association with the fully denied service lines.
  - **Effective with October 1, 2007, the CWF logic for Part A claims:** Exclude if the claim contains action code '3' and an 'L' beneficiary liability indicator (note: The 'L' beneficiary liability indicator signifies that the beneficiary has liability on at least one (1) of the fully denied services; claims reported with action code '3' will be stored on CWF as action code '5').
  - **CWF logic for Part B & DMEPOS claims:** Exclude if the claim contains entry code '5' and an 'L' claim beneficiary liability indicator (note: The 'L' beneficiary liability indicator signifies that the beneficiary has liability on at least one (1) of the fully denied service lines).
- **Adjustment claims, monetary**
  - **Description:** Refers to claims on which the original financial decision was monetarily changed. Not classified as "mass adjustment."
  - **Current CWF logic for Part A claims**: Exclude both the void/cancel and the replacement/adjustment (action code '3') if the amount on replacement/adjustment claims changes as compared to the original claims.

- **Current CWF logic for Part B & DMEPOS claims:** Exclude the replacement/adjustment claim (entry code '5') if the amount on the replacement/adjustment claim changes as compared to the original claim.

Special Notes:

a) Effective with October 2006, each COBA trading partner that wishes to receive adjustment claims, monetary will only receive these claims if CWF determines that the "original" claim was crossed over to the COBA trading partner.

b) Also, effective October 2006, CWF will exclude the Part A void/cancel claim (type of bill XX8 or other 3rd position alpha code) if the COBA trading partner wishes to exclude adjustments, monetary.

- **Adjustment claims, non-monetary/statistical**
  - **Description:** Refers to claims on which the original financial decision has **not** monetarily changed. Not classified as "mass adjustment."
  - **Current CWF logic for Part A claims**: Exclude both the void/cancel and the replacement/adjustment (action code '3') if CWF determines that the deductible, co-insurance, or other monetary amounts have remained unchanged from those on the "original" claim.
  - **Current CWF logic for Part B & DMEPOS claims:** Exclude the replacement/adjustment claim (entry code '5') if CWF determines that the deductible, co-insurance, or other monetary amounts have remained unchanged from those on the "original" claim.

  Special Notes:

  a) Effective with October 2006, each COBA trading partner that wishes to receive adjustment claims, non-monetary/statistical will only receive these claims if CWF determines that the "original" claim was crossed over to the COBA trading partner.

  b) Effective October 2006, CWF will exclude the Part A void/cancel claim (type of bill XX8 or other 3rd position alpha code) if the COBA trading partner wishes to exclude adjustments, non-monetary/statistical.

- **Mass Adjustment Claims Tied to the Medicare Physician Fee Schedule (MPFS) Updates (Effective July 2, 2007)**
  - **Description:** Refers to high volume adjustment actions taken to either increase or decrease the amounts allowed and reimbursed on services that are paid in accordance with the MPFS. Services excluded from payment under the MPFS include DMEPOS, ambulance, certain vaccinations, and most Part A services that are reimbursed under PPS/DRG, with limited exceptions.
  - **CWF logic for Part A & B claims:** CWF will verify that the incoming claim has an 'M' header value. If CWF determines that the trading partner wishes to exclude "mass adjustment claims-MPFS," CWF will exclude the claim from COBA crossover.
  - **Reporting on 837 institutional and professional claims if claims are included for crossover:** Value in the 2300 CLM05-3 indicates adjustment claim. The monetary amount tied to claim allowance (or total allowed billable charges in the case of institutional claims) and payment (B6, AAE, N1, D) within the 2320 loop will have changed.

- **Mass Adjustment Claims—Other (Effective July 2, 2007)**
  - **Description:** Refers to high volume adjustment actions taken independent of MPFS updates. These actions could be performed by CMS' Medicare contractors on all types of claims.
  - **CWF logic for Part A & B claims:** CWF will verify that the incoming claim has an 'O' header value. If CWF determines that the trading partner wishes to exclude "mass adjustment claims-other," CWF will exclude the claim from COBA crossover.
  - **Reporting on 837 institutional and professional claims if claims are included for crossover:** Value in the 2300 CLM05-3 indicates adjustment claim. The monetary amounts within the 2320 loop, not necessarily limited to claim allowance (or total allowed billable charges in the case of institutional claims, as applicable) and payment will have changed.
  - **Impact of Excluding This Claim Type:**

    While mass adjustments related to the MPFS are high in volume, "mass adjustments claims – other" are considered to be part of normal claims processing and the volume may be as few as 100 claims that are adjusted manually by Medicare contractors. By electing this exclusion, the trading partner may decrease the number of adjustment claims that it could easily handle in an electronic manner.
- **Medicare Secondary Payer (MSP) Claims**
  - **Description:** Globally refers to any claim, paid or denied, on which Medicare is the secondary payer.
  - **CWF logic for Part A claims:** Exclude if the claim contains a value code of 12, 13, 14, 15, 16, 41, 42, 43, 47.
  - **CWF logic for Part B & DMEPOS claims**: Exclude if the claim contains an MSP code equal to A, B, D, E, F, G, H, I, or L.

  Special Note:

  For all claim scenarios, CWF's exclusion logic is merely tied to the value code (or MSP code), not to whether the claim was paid or denied (cost-avoided) by Medicare.
- **MSP Cost-Avoided Claims**
  - **Description:** Refers to situations where Medicare fully denies a claim because it is aware that another payer/insurer should pay before Medicare. In such instances, Medicare is either not privy to the primary payer's payment decision **or** is privy to that information but determines that the primary payment exceeds what Medicare would have paid or allowed on the claim.
  - **CWF logic for Part A claims:** Exclude if the claim contains an MSP value code of 12, 13, 14, 15, 16, 41, 42, 43, or 47 along with one of the following MSP non-pay codes: E, F, G, H, J, K, Q, R, T, U, V, W, X, Y, Z, 00, 12, 13, 14, 15, 16, 17, 18, 25, and 26.

- **CWF logic for Part B & DMEPOS claims:** Exclude if the claim contains an MSP code that is equal to A, B, D, E, F, G, H, I, or L along with on e of the following MSP non-pay codes: E, F, G, H, J, K, Q, R, T, U, V, W, X, Y, Z, 00, 12, 13, 14, 25, and 26.
- **Reporting on 837 institutional and professional claims if claims are included for crossover:** Unfortunately, in MSP cost-avoid situations, the provider attempts to bill Medicare as if Medicare was primary. Therefore, the claim would most likely deny in its entirety at the 2320 (claim) level, with appropriate reason code designating MSP. No other indication of MSP will be present.

- **Claims if Other Insurance Exists for the Beneficiary (only available to State Medicaid Agencies)**
  - **Description:** Refers to situations where a beneficiary has other commercial insurance that may pay before his/her State medical assistance program (Title XIX Medicaid).
  - **CWF logic for all claims:** Verify that the beneficiary has an existing Beneficiary Other Insurance (BOI) record in which he/she is identified as having entitlement under Title XIX Medicaid, as evidenced by the COBA identification number [ID] (70000-77999 equals State Medicaid). If the beneficiary has at least one (1) additional BOI record whose COBA ID falls outside the Medicaid range, CWF will exclude the claim from crossing to the State Medicaid Agency.
  - **Reporting on the 837 institutional and professional claims if this option is not excluded:** The 2320 SBR portion of the claim would reflect all payers, inclusive of Medicare, that have a part to play in payment of the claim.
- **National Council for Prescription Drug Programs (NCPDP) Claims**
  - **Description:** Refers to the NCPDP version 5.1 batch standard 1.1 claims (or successor standard) that retail pharmacies transmit to DMERCs/DME MACs if they are billing national drug codes (NDCs) for certain Part B drugs. These claims are **always** assigned and carry co-insurance responsibilities for the beneficiary.
  - **CWF logic:** Exclude if the claim transaction contains a 'P' within its header in the predefined field.

Part III. Other Information Regarding COBA Claims Selection Options

- Adjustment claims will **only** be selected for crossover if the associated "original" claims were crossed over, with the exception of instances where the "original" claim has been archived (not on CWF's online history) but the trading partner has elected to receive adjustment claims, monetary **or** adjustment claims, non-monetary, **or both.**
- COBA trading partners do **not** have the option to exclude "true" voided/cancelled claims, which represent actions taken to wipe-out the original claim **without** also performing a replacement/adjustment action on the original claim.
- Effective with July 2007, CMS will have the ability to exclude "original" claims that are initially rejected by CWF and subsequently adjudicated as "adjustment" claims if the COBA trading partner

wishes to exclude **either** adjustment claims, monetary **or** adjustment claims, non-monetary **or both.**

- Claims for other services that **are** otherwise coverable and payable under Medicare and for which a provider is not enrolled, as evidenced by dummy Federal tax identification numbers (or EINs), such as '9999999999,' or gap-filled referring or ordering physician information (where the fields contain all 9s or Xs), are **not** excluded under the COBA crossover process.
- Home health care requests for anticipated payment (RAPs) are auto-excluded under COBA, since these do **not** represent claims but rather forecasts for resources to be expended.
- Final home health prospective payment (HHPPS) claims (type of bill 339 and 329) that contain no co-insurance responsibilities will **not** be excluded even if the COBA trading partner has elected to exclude either original claims fully paid, without deductible and co-insurance remaining or adjustment claims fully paid without deductible and co-insurance remaining.
- COBA trading partners do **not** have the option to exclude claims that are partially denied.
- Beneficiary liability on fully denied claims does **not** refer to any remaining co-insurance or deductible cost-sharing responsibilities. Rather, it refers to the full amount of the denied service/service line for which the supplemental payer may, depending upon its policy guidelines, make payment.
  - ❖ For example, an 837 professional claim contains four (4) service detail lines, all of which are denied. The beneficiary is determined to be responsible for 3 of the detail lines, while the provider is obligated to write-off the remaining denied line. This would be expressed as 3 detail lines that each contain a CAS*PR with an accompanying reason code, since the beneficiary is liable for each of the denied lines. The remaining line will contain a CAS*CO with an accompanying reason code, since the provider is liable for that denied line.

2.2 Profile Report

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

The trading partner must review the Profile Report for accuracy and notify the COBC of their approval. To provide approval, the trading partner signs the Profile Report and faxes the signed report to their EDI Representative.

2.2.1 COBA ID Assignment

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

(1) The trading partner submits separate Eligibility Files, as in the case of two distinct lines of business;

(2) The trading partner elects separate claims selection options within the same line of business or separate claims selection options per each line of business; or

(3) There are differences with respect to the COBA Attachment.

(4) The trading partner requests test COBA IDs for the purpose of testing additional claims selection options that are not included in their current agreement. These COBA IDs will remain in effect for 90 days, beginning from the activation date.

Trading Partner Profile Report

TP Contact ID: **Name:** **Company:** **TIN:**
COBA ID: **LOB:** **Contract Date:** **Date to Prod:** **Status:** **Status Date:**

Contact Information:

Administrative
Name:
Title/Position:
Company Name:
Address 1:
Address 2:
City/State/Zip:
Phone/Fax:
Email:
Contact ID:

Technical
Name:
Title/Position:
Company Name:
Address 1:
Address 2:
City/State/Zip:
Phone/Fax:
Email:
Contact ID:

Invoice
Name:
Title/Position:
Company Name:
Address 1:
Address 2:
City/State/Zip:
Phone/Fax:
Email:
Contact ID:

Medical Eligibility File Info
Frequency:
Type:
Media:

Claims File
Frequency:
Trans Day:
Media:
ISA Qualifier:
ISA Receiver:
NCP Receiver:

Print name on MSN?

Drug Coverage File Info
Frequency:
Type:
Media:

Customer Service
Name:
Title/Position:
Company Name:
Address 1:
Address 2:
City/State/Zip:
Phone/Fax:
Email:
Contact ID:

Part A Rate Code: **Rate:**
Part B Rate Code: **Rate:**
Contractor(s) Employed

Trading Partner Profile Report

TP Contact ID: **Name:** **Company:** **TIN:**
COBA ID: **LOB:** **Contract Date:** **Date to Prod:** **Status:** **Status Date:**

_____ **Check here if you wish to EXCLUDE ALL Part A Claims**

Part A Inclusion/Exclusion Criteria

Fiscal Intermediary TOB's

_____ **'X' Receive all types of bills**

'X' Exclude Description

_____ 11 Hospital: Inpatient Part A
_____ 12 Hospital: Inpatient Part B
_____ 13 Hospital: Outpatient
_____ 14 Hospital: Other Part B (Non-patient)
_____ 18 Hospital: Swing Bed
_____ 21 Skilled Nursing Facility: Inpatient Part
_____ 22 Skilled Nursing Facility: Inpatient Part
_____ 23 Skilled Nursing Facility: Outpatient
_____ 71 Clinic: Rural Health
_____ 72 Clinic: Freestanding Dialysis
_____ 74 Clinic: Outpatient Rehabilitation Facility
_____ 75 Clinic (CORF)
_____ 76 Clinic: Comprehensive Mental Health
_____ 83 Special Facility: Hospice Non-Hospital
_____ 85 Primary Care Hospital

Specialty Fiscal Intermediary TOB's

_____ 24 SNF: Other Part B (Non-patient)
_____ 28 SNF: Swing Bed
_____ 41 Christian Science/Religious Non-Medical (Hospital)
_____ 73 Clinic: Federally qualified Health
_____ 79 Clinic: Other

Fiscal Intermediary/RHHI TOBs

_____ 32 Home Health: Part B Trust Fund
_____ 33 Home Health: Part A Trust Fund
_____ 34 Home Health: Outpatient
_____ 81 Special Facility: Hospice Non-Hospital
_____ 82 Special Facility: Hospice Hospital

_____ **Check here if you wish to EXCLUDE ALL Part B Claims**

Part B Inclusion/Exclusion Criteria

_____ **Check here if you wish to receive claims for all provider states.**

'I' Include or 'E' Exclude:

List all provider states to be Included or Excluded as indicated above:

Print in this space the provider number or provider states: _____

_____ **Check here if you wish to EXCLUDE ALL DMERC Claims**

_____ **Check here if you wish to receive all DMERC type of claims**

Otherwise: 'X' Exclude the following:

_____ Jurisdiction A
_____ Jurisdiction B
_____ Jurisdiction C
_____ Jurisdiction D

Common Inclusion/Exclusion Criteria

_____ **Check here if you wish to receive all types of claims listed below:**

Otherwise: 'X' Exclude the following:

_____ Non-Assigned
_____ Original Medicare claims paid at 100%
_____ Original Medicare claims paid at greater than 100% of submitted charges
_____ 100% Denied Claims, with NO additional beneficiary liability.
_____ 100% Denied Claims, with additional beneficiary liability.
_____ Adjustment Claims, monetary.
_____ Adjustment Claims, non-monetary/statistical.
_____ Medicare Secondary Payer (MSP) claims.
_____ Claims if no other insurance exists for beneficiary
_____ NCPDP
_____ Adjustments Claims Paid at 100%
_____ Adjustment Claims, 100% Denied, No Add. Liability
_____ Adjustment Claims, 100% Denied, Add. Liability
_____ MSP Cost-Avoided Claims
_____ Mass Adjustments - MPFS
_____ Mass Adjustments - Other

Trading Partner Profile Report

TP Contact ID:	**Name:**		**Company:**		**TIN:**
COBA ID:	**LOB:**	**Contract Date:**	**Date to Prod:**	**Status:**	**Status Date:**

Part A Inclusion/Exclusion Criteria Continued...

_____ **Check here if you wish to receive claims for all providers and all states**

'I' Include or 'E' Exclude:

Provider Identification Number or Provider State:

Print in this space the provider number or provider states:

SECTION 3. COBA TECHNICAL REFERENCE

3.0 Test Procedures

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

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

3.1 Requirements

3.1.1 *Set up connectivity test.* The trading partner will coordinate testing two-way transmission capability with the COBC, if applicable (i.e., electronic transmissions).

3.1.2 *Obtain a test date from the COBC.* Upon receipt of the COBA and Attachments, the COBC will provide the trading partner with the next available date to commence testing.

3.1.3 *Provide data transfer information.* The trading partners will complete the appropriate Electronic Transmission Form (ETF), which is available for download at http://www.cms.hhs.gov/COBAgreement/10_connectivity.asp

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

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

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

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

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

over a 4-week period. If the Medigap claim-based trading partner continues to test for more than a 4-week period, the test bed of claims will be recycled.

It should be noted that each Medigap claim-based COBA ID will receive the same series of HICNs. It will not be possible for COBC to build claim files for each COBA with individual HICNs that they are accustomed to receiving (i.e. beneficiaries they insure).

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

(1) Medigap COBA 65001 requests a test.

(2) A copy of each test bed is created and the COBA ID is replaced with 65001.

(3) Test cycle 1 is executed on 6/7 and uses test bed A

(4) Test cycle 2 is executed on 6/14 and uses test bed B

(5) Test cycle 3 is executed on 6/21 and uses test bed C

(6) Test cycle 4 is executed on 6/28 and uses test bed D

(7) Test cycle 1 is executed on 7/5 and uses test bed A

(8) Test cycles continue rotating the test beds.

(9) COBA 65001 terminates testing.

(10)Replicated test decks A/B/C/D are pulled from the input cycle.

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

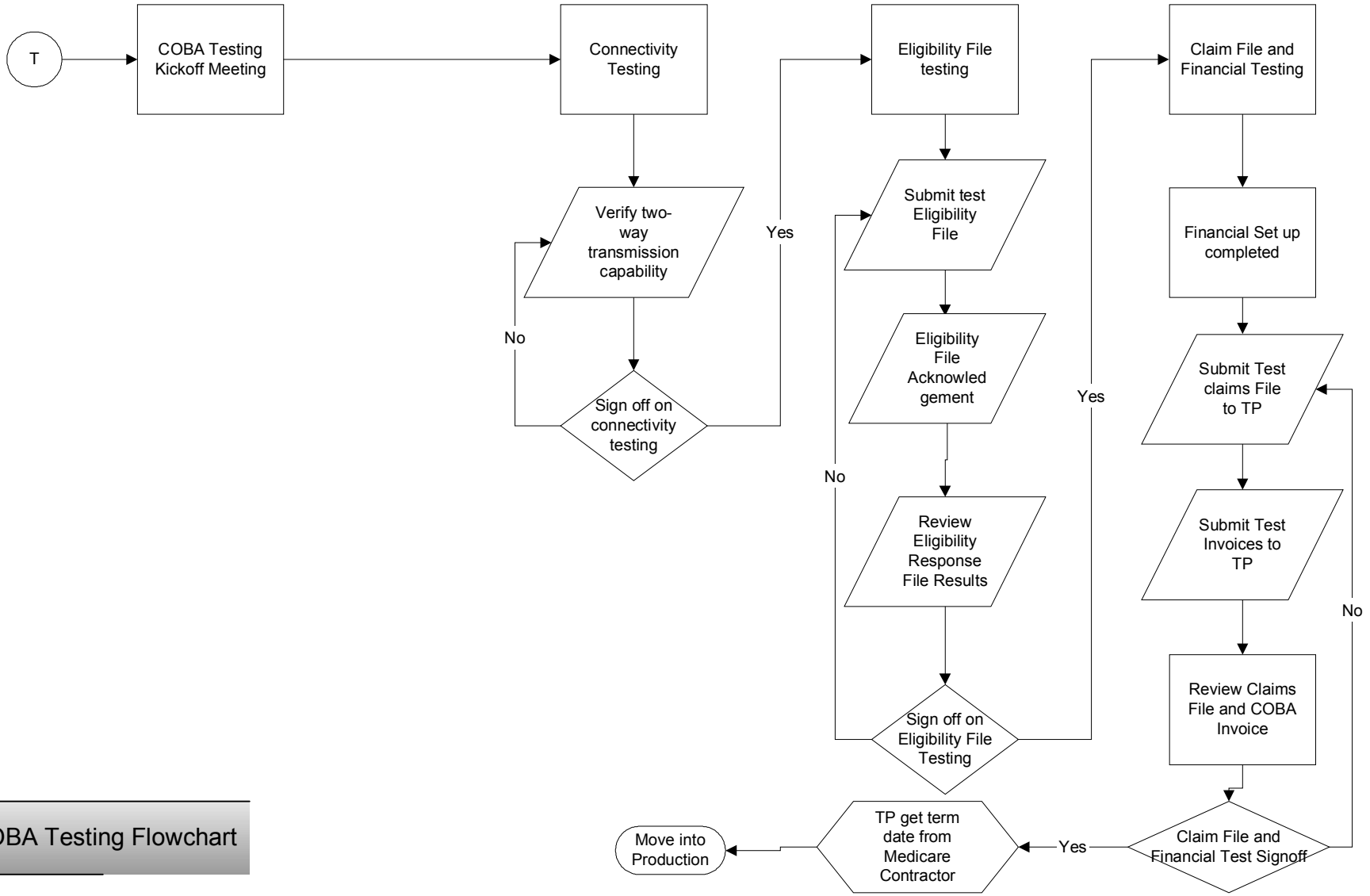
3.1.7 *Review test Claims File(s) from the COBC.* The COBC will create and forward Claims Files in the required formats for all claims matching eligibility information and claims selection criteria.

3.1.8 *Sign-off on the test process with the COBC.* Once the trading partner is satisfied with the test results, complete the Test Sign off Acceptance Form, which is available for download at http://www.cms.hhs.gov/COBAgreement/01_overview.asp and fax it to the COBC's EDI Department. Follow the instructions as outlined on the form.

3.1.9 *Perform financial testing for billing and payment.* A summary of the COBC's online payment system db-eBills, how it works, and how to get started is provided in the Financial section of this guide.

3.2 Test Process Flowchart

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



COBA Testing Flowchart

Note: Process steps referencing Eligibility files are not applicable to Medigap claim-based insurers.

3.3 Electronic Transmission

All methods of data transmission must meet CMS' standard. Currently, there are three (3) separate methods of data transmission that the trading partners may utilize. All three-transmission methods are via the AT&T Global Network System (AGNS). A brief synopsis of each is provided below. Detailed information on all three methods as well as AGNS is included in this section.

3.3.1 Transmission Types

3.3.1.1 *Secure File Transfer Protocol (SFTP)* Files sent via SFTP are actually sent to CMS and then, CMS sends the file to the COBC via Connect Direct. The trading partner's SFTP mailbox is located on a CMS server. Trading partners must complete the SFTP/HTTPS Information Form, and the Electronic Transmission Form and return both forms to the COBC. Both forms are available for download at http://www.cms.hhs.gov/COBAgreement/10_connectivity.asp For further information on SFTP/HTTPS, refer to the appropriate connectivity guide also available for download at http://www.cms.hhs.gov/COBAgreement/10_connectivity.asp

3.3.1.2 *Hypertext Transfer Protocol over Secure Socket Layer (HTTPS*) Files sent to the COBC via HTTPS are sent to CMS and then, CMS sends the file to GHI via Connect:Direct (NDM). The trading partner's HTTPS mailbox is located on a CMS server. Trading partners must complete the HTTPS Information Form and Electronic Transmission Form and return both forms to the COBC. Both forms are available for download at http://www.cms.hhs.gov/COBAgreement/10_connectivity.asp For further information on SFTP/HTTPS, refer to the appropriate connectivity guide also available for download at http://www.cms.hhs.gov/COBAgreement/10_connectivity.asp

3.3.1.3 *Connect Direct (NDM via the AT&T Global Network System (AGNS)* This process is similar to a private Internet. Files are sent via AGNS using Connect Direct. Subscribers to that network can participate in sessions with other subscribers' entities. The network uses an encryption scheme of triple DES as a default to keep the physical transport of the data source. Trading partners must complete the Connect Direct Information Form and the Electronic Transmission Form and return both forms to the COBC. Both forms are available for download at http://www.cms.hhs.gov/COBAgreement/10_connectivity.asp

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

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

send/receive files via one of these methods must complete and return the SFTP/HTTPS Information Form.

3.3.2.1 GENTRAN and SFTP/HTTPS GENTRAN Mailbox Access and System Requirements To access GENTRAN, please use your GUID that was provided by the IACS system. This should be your 7-character user ID. Plans may only have 4 submitters. Accounts are given to an individual and their SSN is a required field on the online application. Designated submitters are identified within the Plan organization and approved by the local EPOC. **Access will not be provided to unapproved individuals.**

Trading partners and/or those specifically identified will be using either HTTPS or the Sterling SFTP Client for file submission or file retrieval. FTP Installation and Configuration user guides are available on the CMS Web site under downloads:
This information is being updated and therefore is not avaliable please contact Sterling directly. Details for procuring the Sterling FTP
Client are available through the Sterling Commerce Web site: http://www.sterlingcommerce.com/.

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

The current CMS mailbox retention periods for all outgoing files are listed in the table below.

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

3.3.2.2 HTTPS GENTRAN Mailbox Access and System Requirements To configure your client, you will need the following information:

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

Extranet URL: https://gis.cmsnet:3443/mailbox

Note: remember to configure your network or node to use the CMS MDCN Domain Name Server (DNS) for name resolution

Port Number: 3443

Note: do not use the typical Port 80 for HTTP or Port 443 for HTTPS.

Browser Requirements: Internet Explorer 5.x or later

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

To eliminate the HTTPS Security Pop-up after you have downloaded the GENTRAN Certificate, the end user may need to update his/her VeriSign Class 3 Certificate. Instructions are available from the CSMM Helpdesk. Also, HTTP Screen Shot user guides are available under the download section at http://www.cms.hhs.gov/COBAgreement/01_overview.asp/.

3.3.2.2.1 *SFTP (SSH Client) GENTRAN Mailbox Access and System Requirements*

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

To configure your client you will need the following information:

Host Name/IP Address: GIS.CMS.HHS.GOV

Port Number: 10022

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

Sterling FTP Client Minimum Requirements (Sterling Commerce)

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

3.3.2.2.2 *GENTRAN Incoming File Naming Conventions (Trading Partner to GENTRAN)*

Trading partners can submit their Eligibility File, both test and production, to the COBC through the use of SFTP or HTTPS. Files sent to the Enterprise File Transfer Facility GENTRAN mailboxes should follow the naming convention below and be formatted in ALL CAPITAL LETTERS, e.g., GUID.RACFID.APPID.X.UNIQUEID.FUTURE.W.ZIP. Refer to COBA Eligibility (E01) Record Layout, which is available for download at http://www.cms.hhs.gov/COBAgreement/01_overview.asp/, for the format and content details for the COBA Eligibility File. (Does not apply to claim-based Medigap trading partners.)

SFTP or HTTPS Filename Convention Table

File Name Convention	Description
GUID	7 character Alphanumeric user ID generated by the Individuals Authorized Access to CMS Computer Services (IACS).
RACFID	4 character RACF user ID. **Note: If no RACF ID, insert NONE.**
APPID	**COB** Note: System that will process the inbound file.
X	D – DAILY W – WEEKLY M – MONTHLY Q – QUARTERLY Y – YEARLY A – AD HOC **Note:** This field indicates type of data, (e.g., Daily, Monthly). However, multiple file types may be transmitted on the same day, (e.g., 2 Daily submissions).
UNIQUEID	• **COBA ID w/ CB prefix (i.e. CB00000)**
FUTURE	Code exactly as shown for the applications listed below or code FUTURE. This field is reserved for future use. • DISPUTE – When sending a dispute file, replace FUTURE with DISPUTE.
W	Code T for Test Data Code P for Production Data
ZIP	Only used when file compression is used and automatically added to the file name by the ZIP application, e.g., WINZIP or PKZIP. Note: WINZIP version 9 or higher is required to support long file names.
. (Periods)	Delineators

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

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

Refer to the COBA Eligibility (E01) File Acknowledgement Layout and the COBA Eligibility Response File (ERF) Layout for further information. Both layouts are available for download at http://www.cms.hhs.gov/COBAgreement/01_overview.asp/.

Test Filenames

Description	Mailbox Filename
Eligibility File Acknowledgement Report	TCOB.BA.COBA.rrrrrrrr.EACK.REPORT.ssssss
Eligibility Response File	TCOB.BA.COBA.rrrrrrrr.BODET.REPORT.ssssss
Part A Claims	TCOB.BA.rrrrrrrr.PARTA.CLAIMS.ssssss
Part B Claims	TCOB.BA.rrrrrrrr.PARTB.CLAIMS.ssssss
NCPDP Claims	TCOB.BA.rrrrrrrr.NCPDP.CLAIMS.ssssss
Response file	TCOB.BA.PARTD.rrrrrrrr.RXRESP.ssssss
E02 Detail Report	TCOB.BA.PARTD.rrrrrrrr.RXDET.REPORT.ssssss
E02 Summary Report	TCOB.BA.PARTD.rrrrrrrr.RXSUM.REPORT.ssssss

Production Filenames

Description	Mailbox Filename
Eligibility File Acknowledgement Report.	PCOB.BA.COBA.rrrrrrrr.EACK.REPORT.ssssss
Eligibility Response File	PCOB.BA.COBA.rrrrrrrr.BODET.REPORT.ssssss
Part A Claims	PCOB.BA.rrrrrrrr.PARTA.CLAIMS.ssssss
Part B Claims	PCOB.BA.rrrrrrrr.PARTB.CLAIMS.ssssss
NCPDP Claims	PCOB.BA.rrrrrrrr.NCPDP.CLAIMS.ssssss
E02 Response file	PCOB.BA.PARTD.rrrrrrrr.RXRESP.ssssss
E02 Detail Report	PCOB.BA.PARTD.rrrrrrrr.RXDET.REPORT.ssssss
E02 Summary Report	PCOB.BA.PARTD.rrrrrrrr.RXSUM.REPORT.ssssss

Notes:

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

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

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

3.3.3 AT&T Global Network System (AGNS)

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

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

- When a trading partner comes in to COBC via the AT&T Global Network, that partner will be using a registered Internet address that belongs to AT&T to ensure customer routing via the AGNS network.
- The AT&T Global account ID for COBA will be BXGH that has a frame-relay connection via an AGNS managed router to the AT&T Cloud. The AT&T managed router at the COBC 441 9th Avenue site is called "BXGHNEWY." CMS has put in a connection from its site for NDM/IP to the 441 location.
- A trading partner will need a PVC for a private line to the AT&T network or a modem dial line to the AT&T network using appropriate AT&T software.
- If the trading partner will use a dial line, the AT&T software will assign to the user from a pool of 32 block addresses a specific 32.xxx.yyy.zzz address to use as its Source IP address.
- The user will need to have an AT&T account, Userid and Password to connect.
- The destination IP that the user will specify for COBC will depend on whether the user is using NDM/IP or FTP. It will probably be a 32.xxx.yyy.zzz address that will be passed from the COBC's AGNS router to the COBC's firewall.
- The COBC has a 32.xxx.yyy.zzz setup in its AGNS router currently for CMS' use of NDM/IP and probably can expand this for other users of this product.
- The COBC has a firewall that translates the user destination address (32.xxx.yyy.zzz) to a GHI network address that will route to the desired host and application.
- The COBC has also had to provide static routing in its core router to send the data back to the AGNS network so the user Source IP is also important. This will also apply to COBC's Firewall configuration. (Source IP addressing for dial will be assigned by the AT&T software via DHCP)
- For private line users connected to the AGNS network, the trading partner will have a site Source IP either directly out of AGNS or defined as a translated address in their Firewall (if any).
- Firewall and router modifications may be set up on an individual basis.

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

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

3.4 COBA Eligibility Files

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

The trading partner or the trading partner's contractor will transfer Eligibility Files to the COBC based on the terms defined within its COBA for all Medicare beneficiaries for whom it provides supplemental insurance coverage. The COBA Eligibility File is used by trading partners to identify their eligible beneficiaries to receive Medicare paid claims information for their supplemental payment processing and to submit drug coverage eligibility data. The COBC will process the Eligibility File, apply syntactical and data consistency edits, and transmit valid records daily to the Medicare Common Working File (CWF) and Medicare Beneficiary Database (MBD) for prescription drug records.

3.4.1 E01 Eligibility File Submission Process

The Coordination of Benefits Agreement (COBA) process only allows for one type of Eligibility File submission methodology: Adds, Changes (Updates), and Deletes. In this method, only beneficiary other insurance (BOI) eligibility records to be added, changed (updated), or deleted are submitted to the COBC for application to the CWF. Records that remain unchanged do not have to be included. Also, note that a separate COBA Eligibility E01 Record must be submitted for each coverage period reported for one Health Insurance Claim Number (HICN). BOI records are transmitted nightly to the CWF based on the Eligibility Files sent by the trading partner. If multiple BOI records exist, all payers will receive the claim. CWF maintains a history of up to 40 insurance periods. After 40 BOI records are received, the earliest record is deleted.

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

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

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

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

- *Change:* Updates to covered individual records that were previously provided through the COBA process.

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

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

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

Note: If the effective date is equal to the coverage termination date, CMS does not want to see these on the Eligibility File. If the intent of this record is to communicate that the coverage period is invalid or incorrect, a delete transaction should be sent in the Eligibility File.

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

- *Delete*: Removal of a record that was previously posted to the COBA eligibility database in error.

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

Example: Insurer Z via an "Add" action type previously posted Jane Doe to the COBA eligibility database as a covered individual with a coverage period of 01012006 through 00000000 (open-ended). However, Jane Doe's coverage effective date should have been 10012006. In order to apply the correct coverage period to the eligibility database, the initial record (01012006 through 00000000) must be deleted through a "Delete" action type, and an "Add" action type must be used to apply the correct coverage period (10012006 through 00000000).

3.4.1.2 *Multiple Eligibility Records or Insurers for a Single Beneficiary.* A trading partner can send multiple records for a beneficiary under two different Beneficiary Supplement ID Numbers if they are sent in two different Eligibility Files (e.g,. a beneficiary is covered as a spouse under one policy and covered as the contract holder under another policy, both having secondary coverage to Medicare). However, if both numbers are sent on the same Eligibility File, it will be treated as a duplicate and will not be accepted.

On the provider hard copy remit (for those that do not get an electronic remit) or the PC Print of the 835, you will see the MA18 on the 835 for eligibility-based crossover and the N89 will be used for multiple insurers.

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

If a beneficiary has two or more policies with a single insurance company, and the insurance company has requested that its name be placed on the Medicare Summary Notices (MSNs) and if the beneficiary eligibility records are attached to unique COBA IDs, the MSN would list multiple times that the claim had been crossed over to that particular trading partner.

The beneficiary could have policies with multiple insurers that could result in a trading partner receiving a Medigap claim from both the intermediary and COBC.

Note: The trading partner's Federal Employee Population (FEP) population can be isolated on a separate Eligibility File, and can be subject to its own selection criteria.

3.4.1.3 *Eligibility File Submission.* The trading partner or the trading partner's contractor will transfer Eligibility Files to the COBC based on the terms defined within its COBA for all Medicare beneficiaries for whom it provides supplemental insurance coverage. There is no limit to the number of COBA IDs that can be contained in one Eligibility File; however, multiple Eligibility Files per COBA ID are not acceptable. Trading partners with multiple COBA IDs have the option of submitting a separate Eligibility File for each COBA ID or combining all their eligibility records into a single file. In the combined file scenario, all beneficiary records must be sorted by COBA IDs and separated by a header and trailer. Note that a separate COBA Eligibility E01 Record must be submitted for each coverage period reported for one HICN. Trading partners will complete an Electronic Transmission Form (ETF) on which they designate their transmission method.

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

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

Header record contains COBA ID 000012345

Detail record contains COBA ID 000012345

Detail record contains COBA ID 000012345

Detail record contains COBA ID 000012345

Detail record contains COBA ID 000012345

Detail record contains COBA ID 000012345

Trailer record

Header record contains COBA ID 000067890

Detail record contains COBA ID 000067890

Detail record contains COBA ID 000067890

Detail record contains COBA ID 000067890

Detail record contains COBA ID 000067890

Detail record contains COBA ID 000067890

Trailer record

3.4.2 Frequency

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

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

Week 1

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

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

Week 2

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

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

3.4.3 Eligibility File Acknowledgment (EFA)

Syntactical data validation routines will be applied to all Eligibility Files. The COBC will initially edit the Eligibility File and transmit an EFA back to the trading partner containing a matching header record from the submitted file, a count of E01 records submitted, whether the Eligibility File was accepted (Status code = 'A') or had a fatal (severe) error (Status code = 'S'), and an error description. If a severe error occurs, it is the trading partner's responsibility to correct the error and retransmit the file to the COBC. The table below provides the error type and definition of Eligibility File fatal errors. The COBA Eligibility File (E01) Acknowledgement Layout is available for download at http://www.cms.hhs.gov/COBAgreement/01_overview.asp/.

Severe Error Types and Descriptions

Error Type	Description
INVALID COBA ID	The COBA ID on the file does not conform to the required specifications, i.e., 9 position, alphanumeric (no special characters), left justified, last four positions are spaces.
RECORD COUNT IN TRAILER DOES NOT MATCH ACTUAL RECORD COUNT	The record count denoted in the trailer record does not match the actual record count.
FILE REFLECTS 70% DECREASE IN ELIGIBILITY RECORDS	The file contains less than 70% of the records currently in the COBA eligibility database. For example, on November 1, the COBA eligibility database reflected 100 active records (non-deleted) for COBA ID 99999. On November 15, trading partner submits Eligibility File with 70 delete records.
FILE REFLECTS 70% INCREASE IN ELIGIBILITY	The file contains records that add at least 70% more to the records currently in the COBA eligibility database. For example, on November 1, the COBA eligibility database reflected 100 active records (non-deleted) for COBA ID 99999. On November 15, trading partner submits Eligibility File with 70 Add records.

FILE SENT OFF SCHEDULE	The file was submitted prior to the scheduled timeframe denoted in the COBA Attachment or less than 10 days after previous submission.
MISSING HEADER RECORD	File does not contain the required header record.
NO E01 RECORDS SUBMITTED	File received with header and/or trailer record with no detailed E01 records.
MISSING TRAILER RECORD	File does not contain the required header and/or trailer record
MULTIPLE FILES ENCOUNTERED WITH THE SAME COBA ID	More than one file has been submitted at the same time for a single COBA ID.
PREVIOUS ELIGIBILITY FILE IN SEVERE ERROR STATUS	Incoming Eligibility File cannot be processed because previously submitted file is in severe error status.

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

3.4.4 Eligibility Response File (ERF)

The COBC will also provide a detail-level report, ERF, back to the trading partner identifying eligibility records received, accepted, and denied when all CWF responses have been received or eight (8) business days after the initial Eligibility File is received (whichever comes first). Transmission of the ERF, at the time, will ensure that all records are applied to the CWF, or if not applied, the current status of each record will be known. The COBC will not be processing an incoming Eligibility File until the previous file has completed processing through the CWF and an ERF is returned to the trading partner. The COBA Eligibility Response File (ERF) Layout is available for download at http://www.cms.hhs.gov/COBAgreement/01_overview.asp/.

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

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

3.4.4.1 Disposition Codes and Descriptions

Disposition Codes and Descriptions

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

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

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

The primary match for records will be on the HICN. A secondary match will be on the first initial of the beneficiary's First Name, Date of Birth, Sex Code, and the first six characters of the beneficiary surname. In addition to the primary matching element, eligibility records that match on three out of the four matching criteria in the secondary match will pass.

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

Error Code	Description	Definition
BO01	INVALID HICN	Invalid HICN (Mandatory). Field must contain alpha and numeric characters. You received this error because: 1) either an invalid character was provided in this field, or 2) we were unable to match the HICN you supplied.

BO02	INVALID SURNAME	Invalid Beneficiary Surname (Mandatory). Field must contain alpha characters. Field cannot be blank or contain spaces or numeric characters. Note: Currently, if the first initial **and** the surname do not match, one BO02 error is returned and the record will not post to CWF. If only the first initial **or** the surname do not match and the HICN and all other matching criteria are accurate, one BO02 error is returned and the record will post to CWF (Disposition Code 01).
BO03	INVALID DATE OF BIRTH	Invalid Beneficiary Date of Birth (Mandatory). Field must contain numeric characters. Field cannot be blank or contain spaces or alpha characters. Format of this field must be CCYYMMDD. Day of the month must be correct. For example, if month = 02 and date = 30, the record will reject.
BO04	INVALID SEX CODE	Invalid Beneficiary Sex Code (Mandatory). Field must contain numeric characters. Field cannot be blank or contain spaces or alpha characters. Acceptable numeric characters include the following: M = Male F = Female If sex is unknown, default to M for male.
*BO05	INVALID CONTRACTOR NUMBER	Invalid Contractor Number (Mandatory). Non-blank, numeric. Must be valid, CMS-assigned Contractor Number. Internal CMS use only. Partner should not receive this error.
*BO08	INVALID DOCUMENT CONTROL NUMBER	Invalid Document Control Number (DCN). CMS replaces the Agreeing Partner's original DCN with CMS' DCN. CMS Automatically provides a DCN, so the partner should not receive this error. Blank for all others. (Valid Values: Alphabetic, Numeric, Space, Comma, & - '. @ # /; :)
BO09	INVALID ACTION TYPE	Invalid File Update Indicator (Mandatory). This error results from what is provided in the type of record transaction field. Field must contain alpha characters. Field cannot be blank or contain spaces. Acceptable alpha characters include the following: 'A' = Add 'C' = Change/Update 'D' = Delete

		Required as of March 1, 2007
*BO11	INVALID INSURANCE TYPE	Invalid Insurance Type. Field may contain alpha or numeric characters. Field cannot be blank. Valid values are: 'A' – Supplemental 'B' – Tricare 'C' – Medicaid
BO12	INVALID INSURANCE NAME OR ADDRESS	Invalid Insurer Name. Place the name of the insurer in this field. Spaces are allowed between words in an insurer plan name. Field may contain alpha and/or numeric characters, commas, & - ' . @ # / : ;. Field cannot be blank or contain numeric characters.
BO13	INVALID POLICY NUMBER	Invalid Policy Number. If field is not used, field must contain spaces. Field may contain alpha and/or numeric characters, commas, & - ' . @ # / : ;
BO14	INVALID EFFECTIVE DATE	Invalid Effective Date. Field must contain numeric characters. Field cannot be blank, or contain spaces, alpha characters, or all zeros. Number of days must correspond with the particular month. Valid format is CCYYMMDD.
BO15	INVALID TERMINATION DATE	Invalid Termination Date. Field must contain numeric characters. Date must correspond with the particular month – CCYYMMDD. For example, 19970228 is acceptable but not 19970230. If there is no termination date (coverage is still active), must use zeros (not spaces) in this field. Termination date cannot be less than the effective date.
BO16	INVALID SUPPLEMENTAL ID	Field may contain alpha and/or numeric characters, spaces, commas, & - ' . @ # / : ; If field is not used, field must contain spaces.
BO17	INVALID COBA NUMBER	Field may contain numeric characters only. Spaces, commas, & - ' . @ # / : ; are invalid. Field is 9 position, alphanumeric (no special characters), left justified, last four positions are spaces. Mandatory.
BO18	INVALID PLAN ID NUMBER	Field may contain alpha and/or numeric characters, spaces, commas, & - ' . @ # / : ; If field is not used, field must contain spaces.
BO19	INVALID OTHER INS NUMBER	Field may contain alpha and/or numeric characters, spaces, commas, & - ' . @ # / : ; If field is not used, field must contain spaces.
BO20	NO MATCH FOUND FOR DELETE	Beneficiary other insurance (BOI) occurrences not found for delete transaction. Where there is an existing period of coverage, the incoming record must match on

		certain criteria so the system can differentiate among various periods of coverage on the beneficiary's Medicare file. These criteria are: COBA ID/ HICN/ Effective Date
BO22	RECORD ALREADY DELETED	Beneficiary other insurance (BOI) record not found for delete data transaction. This edit occurs when an attempt is made to delete a non-existent BOI record.
BO99	DUPLICATE RECORD	This record is a duplicate of a record in the incoming Eligibility File. A match is performed on COBA, HICN, and Effective Date to determine duplicates. Note: This is a COBC generated error. Record will not be sent to the CWF.

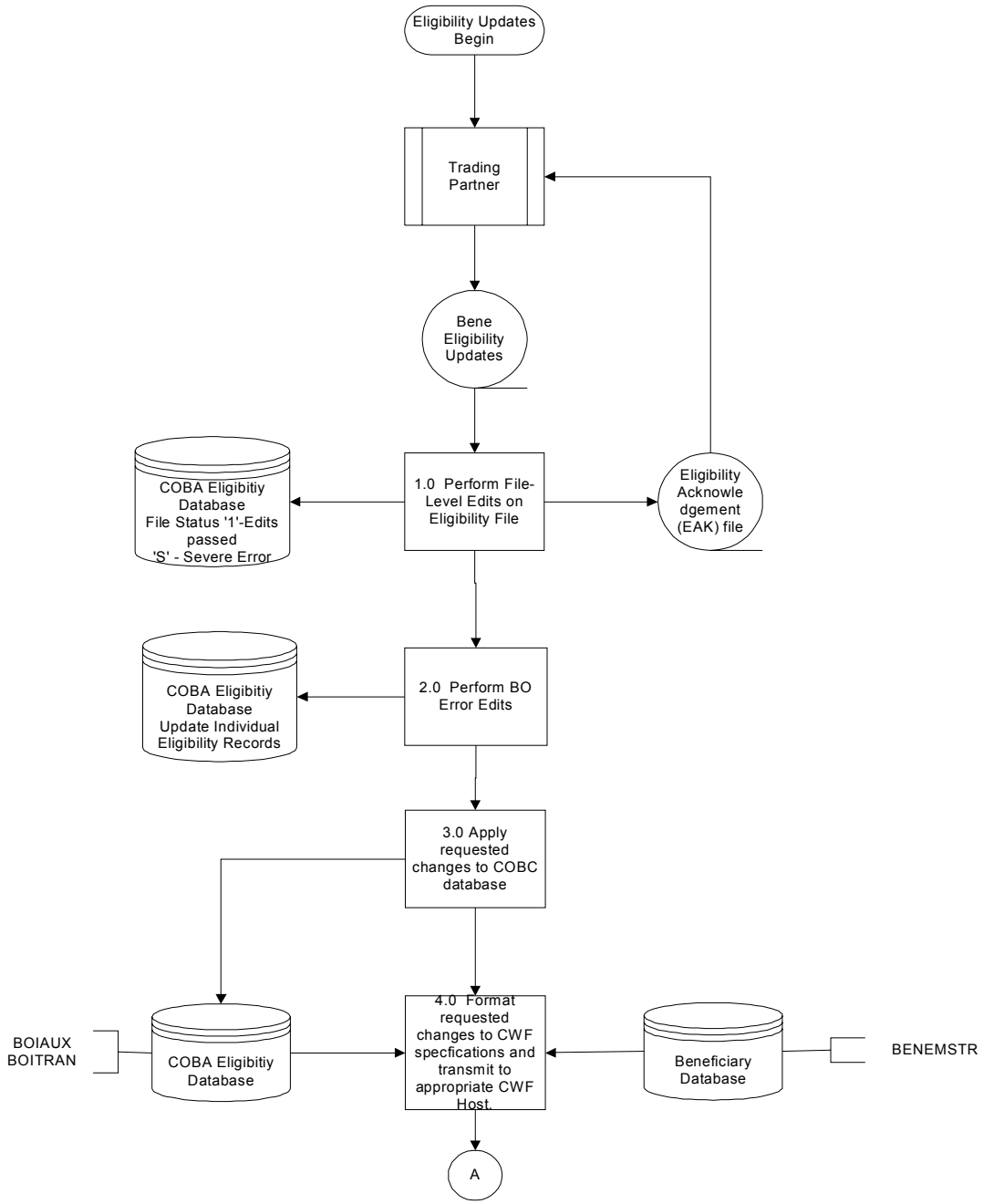
*The trading partner should not receive these errors in the ERF. However, if received, the records should be resubmitted in next Eligibility File for a final disposition.

**For future updates to this list, please refer to the Eligibility Response File Layout.

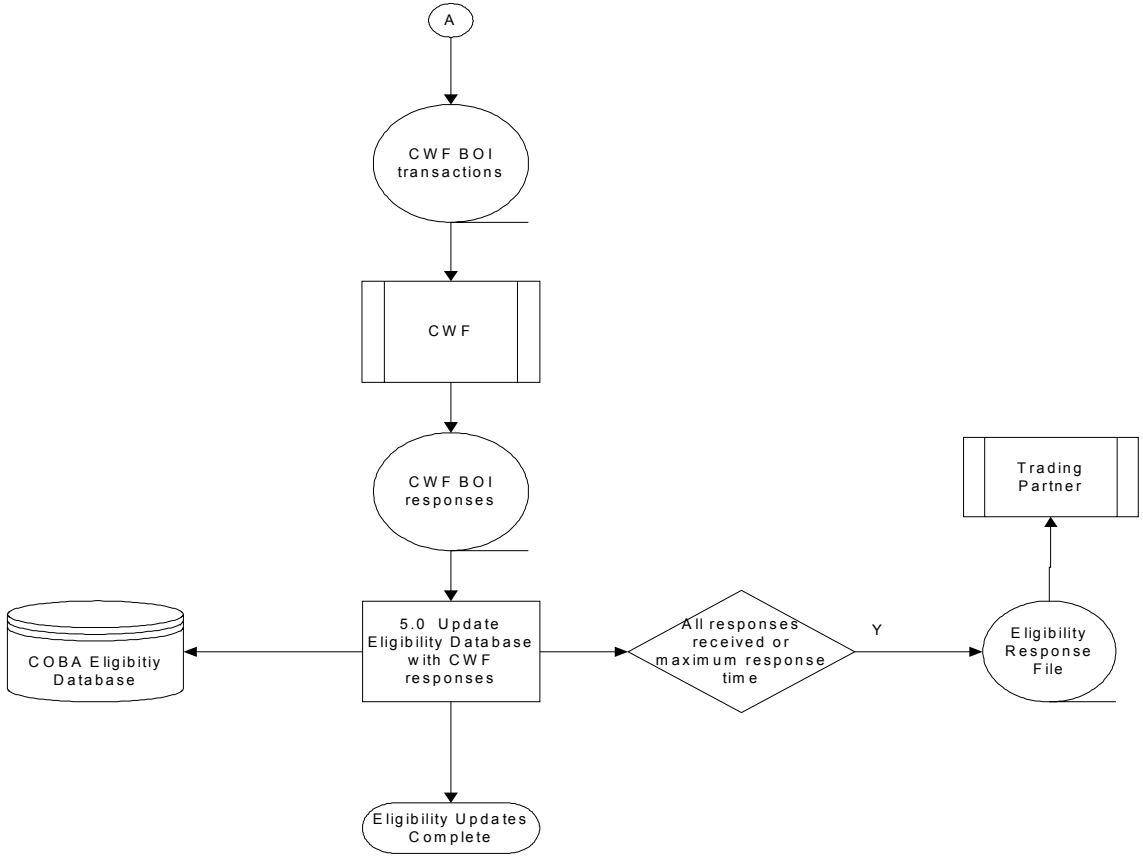
3.4.5 Flowchart

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

Beneficiary Eligibility Processing
Wednesday, November 01, 2006



Beneficiary Eligibility Processing
Wednesday, November 01, 2006



3.4.5.1 Flowchart Narrative

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

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

3.0 Eligibility records with requested changes that passed COBC BO edits are applied to the COBC database.

4.0 COBC formats the requested changes to CWF specifications and transmits the records to the appropriate CWF host site.

5.0 COBC receives and processes CWF responses. All '01' (accepted at CWF) responses are applied to the COBC database. COBC will continue to recycle response not received and update the database on a daily basis. Once all of the CWF Response files are received or 9 business days has elapsed since the transmission of the Eligibility File, the Eligibility Response File (ERF) will be returned to the trading partner. If a record is still recycling when the ERF is created, the record will have a disposition code of '50', '52', 60, AB, or CI. (Record still being processed by CMS). Trading partners should resubmit the record with their next file.

3.4.6 Sample Eligibility Acknowledgement and Response File

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

SAMPLE ELIGIBILITY ACKNOWLEDGEMENT FILE

EFA99999 20070206 0000034A

SAMPLE ELIGIBILITY RESPONSE FILE

XXXXXXXXXA	TEST12	RITA	19230129F1988010319880103R08062187	5220070206		D
XXXXXXXXXA	TEST12	RITA	19230129F2004010800000000R08062187	0120070206	XXXXXXXXXA	A
XXXXXXXXXA	TEST13	ALICE	19191130F1978093000000000R01583874	5120070206	XXXXXXXXXA	A
XXXXXXXXXA	TEST13	ALICE	19191130F1978093019780930R01583874	BO20070206BO99		D
XXXXXXXXXA	TEST14	IRENE	19210819F1987010119870101R17832422	5220070206		D
XXXXXXXXXA	TEST14	IRENE	19210228F1987010100000000R17832422	BO20070206BO99		A
XXXXXXXXXA	TEST15	ROBERT	19170326M1989010120041031R18428615	5520070206	XXXXXXXXXA	C
XXXXXXXXXA	TEST16	CHRISTINE	19320603F1997060119970601R50508471	5120070207	XXXXXXXXXA	D
XXXXXXXXXA	TEST16	CHRISTINE	19320603F1998060100000000R50508471	5220070206		A
XXXXXXXXXA	TEST17	LEO	19280105M1999010119990101R58301791	5520070207	XXXXXXXXXA	D
XXXXXXXXXA	TEST17	LEO	19280105M2001010100000000R58301791	0120070206	XXXXXXXXXA	A
XXXXXXXXXA	TEST18	DOLORES	19320209F1997020100000000R03423388	0120070206	XXXXXXXXXA	A
XXXXXXXXXA	TEST19	CATHERINE	19411125F2006110100000000R58856079	0120070206	XXXXXXXXXA	A
XXXXXXXXXA	TEST20	JEAN	19130917F1990010100000000R50712903	0120070206	XXXXXXXXXA	A
XXXXXXXXXA	TEST20	JEAN	19110917F1990010119900101R50712903	BO20070206BO99		D
XXXXXXXXXA	TEST21	KENNETH	19170627M1989010119890101R00926906	0120070206	XXXXXXXXXA	D
XXXXXXXXXA	TEST21	KENNETH	19160228M1989010100000000R00926906	BO20070206BO99		A
XXXXXXXXXA	TEST22	RUTH	19190427F1992010100000000R61044706	0120070206	XXXXXXXXXA	A
XXXXXXXXXA	TEST22	RUTH	19190427F1992010119920101R51044706	BO20070206BO99		D
XXXXXXXXXD	TEST23	KATHRYN	19200825F1989010119890101R07898715	0120070206	XXXXXXXXXD	D
XXXXXXXXXD	TEST23	KATHRYN	19200825F1989010100000000R07898715	BO20070206BO99		A
XXXXXXXXXD	TEST24	KELLY	19170413F1992010100000000R03837919	0120070206	XXXXXXXXXD	A
XXXXXXXXXD	TEST24	EVA	19170413F1992010119920101R03837919	BO20070206BO99		D
XXXXXXXXXA	TEST25	RUTH	19130821F1989010119890101R11771137	0120070206	XXXXXXXXXA	D
XXXXXXXXXA	TEST25	RUTH	19230821F1989010100000000R11771137	BO20070206BO99		A
XXXXXXXXXA	TEST26	BUSTER	19150726M1980070119800701R00927432	0120070206	XXXXXXXXXA	D
XXXXXXXXXA	TEST26	BUSTER	19150726M1990070100000000R00927432	0120070206	XXXXXXXXXA	A
XXXXXXXXXA	TEST27	GLADYS	19131030F1989010120070101R26841594	0120070206	XXXXXXXXXA	C
XXXXXXXXXA	TEST28	LENNA	19150707F1989010120061029R02264594	0120070206	XXXXXXXXXA	C
XXXXXXXXXA	TEST29	MAXINE	19210903F1988010100000000R00926766	BO20070206BO01		A
XXXXXXXXXA	TEST30	MICHAEL	19411117M2006110100000000R58075546	0120070206	XXXXXXXXXA	A
XXXXXXXXXA	TEST31	LARRY	19411109M2006110100000000R58328084	0120070206	XXXXXXXXXA	A
XXXXXXXXXB	TEST32	LARUE	19340321F2000090100000000R23677760	0120070206	XXXXXXXXXB	A
XXXXXXXXXA	TEST33	DENNIS	19411108M2006110100000000R14806983	0120070206	XXXXXXXXXA	A

3.5 E02 Eligibility (Drug) File Submission Process

Overview

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

Purpose

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

3.5.1 Drug Coverage and the COBA Program

Because the COBA program is designed to coordinate benefits with supplemental payers/insurers, prescription drug benefit information must be incorporated into the Eligibility Files exchanged between trading partners and the COBC. Trading partners should submit drug coverage eligibility information through one of two channels: (1) an eligibility record, known as the ***E02 record***, through the COBA program or (2) the Voluntary Data Sharing Agreement (VDSA) program.

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

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

Medigap plans will receive Part D eligibility response files containing Part D Medicare entitlement information to prevent Medigap plans from providing drug coverage to beneficiaries who have enrolled in Part D.

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

The E02 record also allows trading partners the flexibility of submitting the SSN in place of the Medicare HICN. Another advantage is that trading partners are able to submit E02 records more frequently—biweekly and monthly—whereas, the VDSA restricts submissions to a quarterly basis.

3.5.2 COBA Drug Coverage Record Layouts

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

- Trading partners can combine the E01 and E02 input files in the same file. However, the header record E00 must be specified followed by the E01 and E02 records with the E99 trailer record at the end of the file.
- The E02 record is **not** used in the COBA process to cross-supplemental Part D claims over to supplemental insurers after Medicare has made payment.
- E02 submissions should be submitted for your members who have supplemental drug coverage. If you are a Prescription Drug Plan (PDP), do not submit the Part D coverage that falls under the PDP plan.
- It is possible that a member can appear on an E02 record for supplemental drug coverage and not on the E01 record for supplemental hospital and medical coverage in the following cases:
  - The member only carries supplemental drug coverage. Since no COB Agreement exists, a privacy agreement must be signed and a unique COBA ID will be assigned.
  - The insurer is supplying the drug coverage but does not want to receive claims for the member via the E01, although the member has supplemental hospital and medical coverage. If the insurer has signed a COB Agreement and has a COBA ID, there is no need to have a unique COBA ID for the E02 drug coverage, unless requested.
- The submitter of the E02 must have signed a COB Agreement (except in the situation above where the member only carries supplemental drug coverage) or must administer drug coverage benefits for the trading partner that has signed the COB Agreement. In this situation, those administering the drug coverage must be listed in Section V of the COBA Attachment.
- Insurers who do not know if their members with drug coverage are "active" (working aged, according to the Medicare Secondary Payer rules) or "inactive" (retired) must obtain that information prior to including the member on the E02 file. Only "inactive" members may be included on the E02 record. The "active" members are reported through the Voluntary Data Sharing Agreement (VDSA) process, and are **not** to be included on the E02 file.
- In all situations listed above, the E02 record can be used for exchange of data purposes.
- Note: The COBA ID is a 10 position numeric field, which must be prefixed with leading zeroes, e.g., 0000012345.
- Insurers in COBA production may **Query** using the E02 record to receive a response file identifying the member as having Part D coverage. A supplemental drug coverage COB record will not be created when the Transaction Type is 'Q' Query Only.

3.5.2.1 Query Matching Criteria

- When only the Social Security number (SSN) is known and at least three of the four personal identifiers* match, the HICN will be returned.

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

- Submitters will submit an E02 record in the prescribed format for COB record creation, which is **Add/Update/Delete.**
- **Add/Update/Delete Matching Criteria**
  - When the HICN and three of the four personal identifiers match, CMS will create a COB record.
  - When one of the personal identifiers does not match, the corrected personal identifier will be returned on the response file.
- Submitters will submit an E02 record in the prescribed format for COB record creation, which is **Full File Replacement**.
- **Full File Replacement Matching Criteria**
  - Compares existing eligibility information against incoming eligibility information and converts the incoming data into add, change, or delete actions. Any record on the existing file that does not match three of the four personal identifiers in the incoming file will be deleted.
- When populating the BIN/PCN fields, the partner should only use their Part D specific BIN and/or PCN, or the BIN/PCN that the Pharmacy Benefit Manager (PBM) has acquired for coverage that is supplemental to Part D. The partner should populate the BIN/PCN fields with the Part D specific BIN/PCN despite whether or not it knows that the individual is enrolled in Part D. If the individual is enrolled in Part D, a COB record will be created using the Part D specific BIN/PCN record, which designates coverage supplemental to Part D. Otherwise, when the individual is not Part D enrolled, the COB Contractor will reject the E02 and no COB record will be created.
- **Medicaid Only -** Medicaid agencies can submit, at their discretion, an E02 record to obtain Part D enrollment information. Medicaid cannot provide supplemental benefits to Part D, but can help beneficiaries pay for drugs not covered by Medicare Part D using federal funds. A Medicaid agency can provide supplemental benefits to Part D, as long as the funds used to provide such benefit are 100% **state funded**. The distinction is between "Medicaid," which is a mix of federal and state funding and the Medicaid agency, which using state-only dollars may provide benefits exceeding those defined as "Medicaid." In these situations, CMS views the supplemental drug benefit administered by the Medicaid agency as a State Pharmaceutical Assistance Program (SPAP). CMS has rules governing whether a SPAP is "qualified" as a CMS defined SPAP and may count towards the TrOOP calculation. If it does not meet these rules, the SPAP is a non-qualified state program whose payments do not count towards the TrOOP level of the beneficiary.
- **Definition – Part D Enrollment/Termination**
  - Current Part D Plan Enrollment Date: Refers to a Medicare beneficiary that is eligible, has applied for and has coverage through a Part D Plan.

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

- ***Personal Identifiers**

  Surname

  First Name

  Date of Birth

  Beneficiary Sex Code

Refer to the COBA Drug Coverage Eligibility (E02) Record Layout and the COBA Drug Coverage Eligibility Response (E02) Record Layout, which are available for download at http://www.cms.hhs.gov/COBAgreement/01_overview.asp/.

3.5.2.2 Conventions for Describing Data Values

The following Data Type Key table defines the data types used by COB for their external interfaces (inbound and outbound). The formatting standard defined for each data type corresponds to the data type identified for each field within the interface layout.

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

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

DATA TYPE KEY TABLE

Data Type /		
Numeric	• Zero through 9 (0 → 9) • Padded with leading zeroes • opulate empty fields with spaces	• Numeric (5): "12345" • Numeric (5): "00045" • Numeric (5): " "
Alpha	• A through Z • Left justified • Non-populated bytes padded with spaces	• Alpha (12): "TEST EXAMPLE" • Alpha (12): "EXAMPLE "
Alpha-Numeric	• A through Z (all alpha) + 0 through 9 (all numeric) • Left justified • Non-populated bytes padded with spaces	• Alphnum (8): "AB55823D" • Alphanum (8): "MM221 "

Text	• A through Z (all alpha) + 0 through 9 (all numeric) + special characters:
	  • Comma (,)
	  • Ampersand (&)
	  • Space ( )
	  • Dash (-)
	  • Period (.)
	  • Single quote (')
	  • Colon (:)
	  • Semicolon (;)
	  • Number (#)
	  • Forward slash (/)
	  • At sign (@)
	• Left justified
	• Non-populated bytes padded with spaces
		• Text (8): "AB55823D"
		• Text (8): "XX299Y "
		• Text (18): "ADDRESS@DOMAIN.COM"
		• Text (12): " 800-555-1234"
		• Text (12): "#34 "

Date	• Format is field specific • Fill with all zeroes if empty (no spaces are permitted)	• CCYYMMDD (e.g. "19991022") • Open ended date: "00000000"
Filler	• Populate with spaces	
Internal Use	• Populate with spaces	

3.5.3 E02 Edit Error Listing

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

E02 EDIT ERROR LISTING

SP CODE	DESCRIPTION
SP 12	Invalid HIC Number. Field must contain alpha or numeric characters. Field cannot be blank or contain spaces.
SP 13	Invalid Beneficiary Surname. Field must contain alpha characters. Field cannot be blank, contain spaces or numeric characters.
SP 14	Invalid Beneficiary First Name Initial. Field must contain alpha characters. Field cannot be blanks, contain spaces, numeric characters or punctuation marks.
SP 15	Invalid Beneficiary Date of Birth. Field must contain numeric characters. Field cannot be blanks, contain spaces or alpha characters. Day of the month must be correct. For example, if month = 02 and date = 30, the record will reject.
SP 16	Invalid Beneficiary Sex Code. Field must contain numeric characters. Field cannot be blank, contain spaces or alpha characters. Acceptable numeric characters include the following: 1 = Male 2 = Female
SP 19	Invalid Transaction Type. Field must contain numeric characters. Field cannot be blank, contain alpha characters or spaces. Acceptable numeric characters must include the following: 0 = Add Record 1 = Delete Record 2 = Update Record
SP 31	Invalid Effective Date. Field must contain numeric characters. Field cannot be blank, contain spaces, alpha characters or all zeros. Number of days must correspond with the particular month.
SP 47	No valid record exists for delete request. Attempt to delete a nonexistent MSP will cause a reject.
SP 62	Incoming termination date is less that effective date. MSP termination date must be greater than the effective date.

Additionally, the COBC will provide RX specific errors:

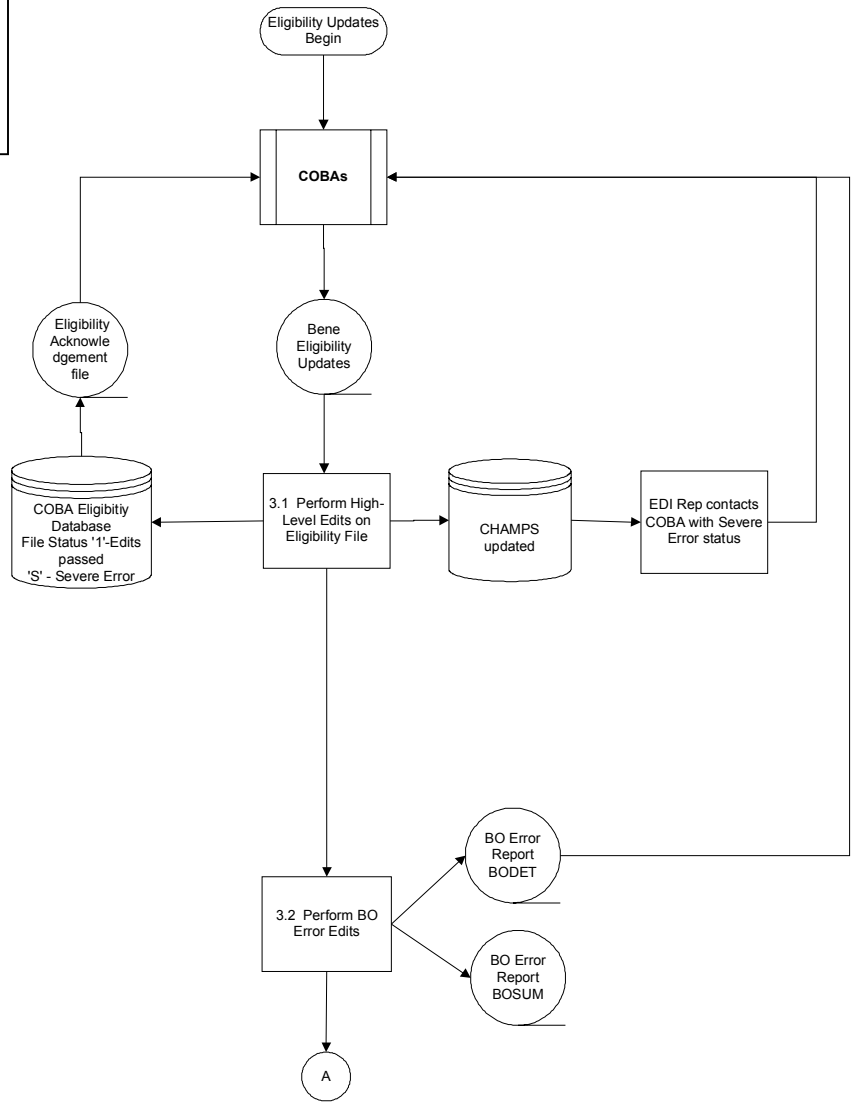
RX CODE	DESCRIPTION
RX 01	Missing RX ID
RX 02	Missing RX BIN
RX 03	Missing RX Group Number
RX 04	Missing Group Policy Number
RX 05	Missing Individual Policy Number
RX 07	No Part D Dates Found

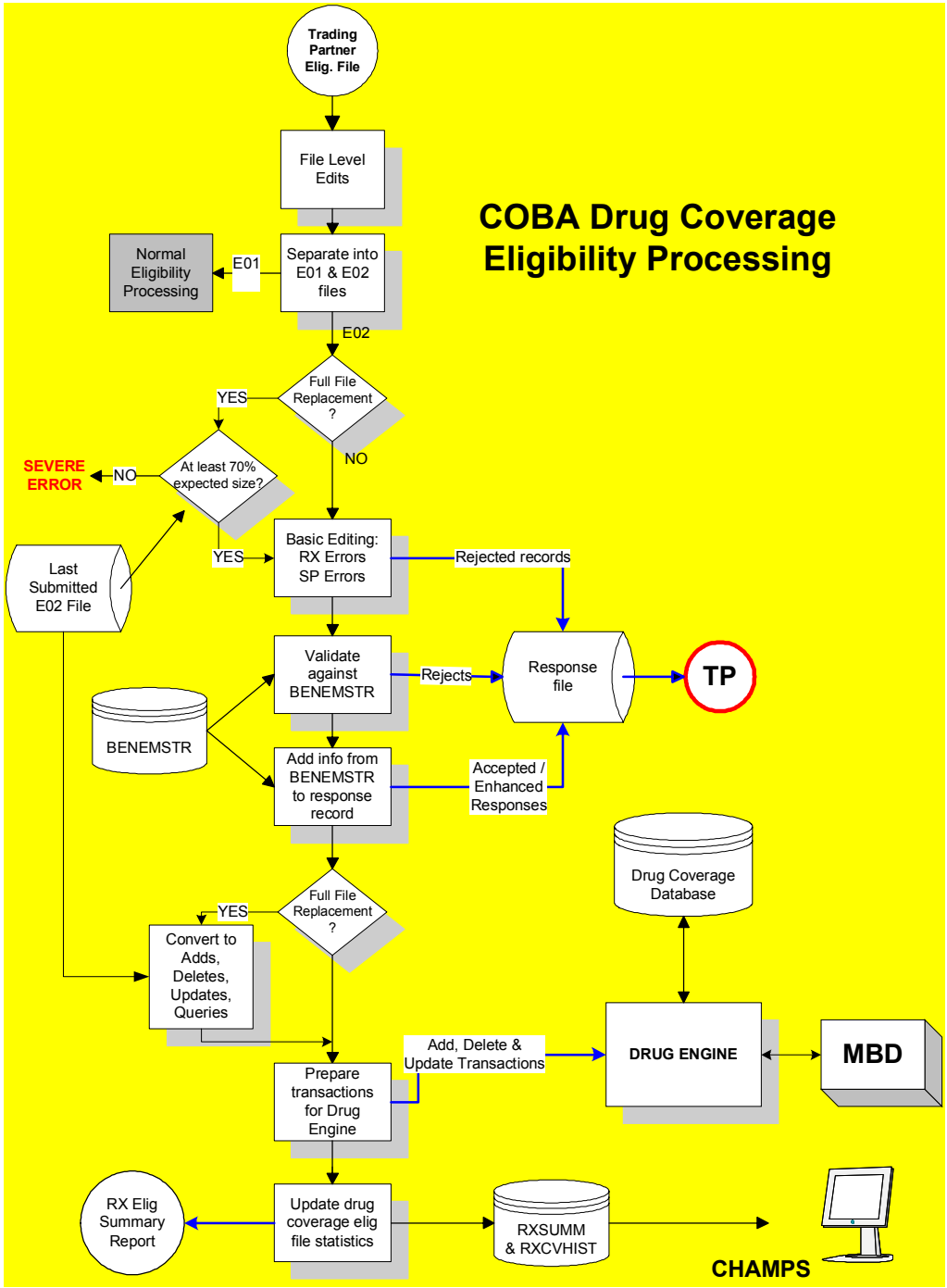
3.5.4 Flowchart

The first following flowchart displays how the COBC's COBA Eligibility File process will edit, validate, and process trading partner's Eligibility Files. The second flowchart displays the process flow of receiving, editing, and validating trading partner's drug records.

COBA Eligibility File Processing

Beneficiary Eligibility Processing
Thursday, September 21, 2006




COBA Drug Coverage Eligibility Processing
Trading Partner Elig. File
File Level Edits
Separate into E01 & E02 files
E01
Normal Eligibility Processing
E02
Full File Replacement ?
YES
NO
At least 70% expected size?
NO
SEVERE ERROR
YES
Last Submitted E02 File
Basic Editing: RX Errors SP Errors
Rejected records
Validate against BENEMSTR
Rejects
Response file
TP
BENEMSTR
Add info from BENEMSTR to response record
Accepted / Enhanced Responses
Drug Coverage Database
Full File Replacement ?
YES
Convert to Adds, Deletes, Updates, Queries
Add, Delete & Update Transactions
DRUG ENGINE
MBD
Prepare transactions for Drug Engine
RX Elig Summary Report
Update drug coverage elig file statistics
RXSUMM & RXCVHIST
CHAMPS

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

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

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

3.6 Claims File Process

Overview

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

Process

Medicare contractors submit all claims for crossover to the COBC nightly via 837 flat file formats and/or NCPDP. The COBC will edit claims for required elements. Any files that fail business edits will not be processed. Instead, the COBC will ask the contractors to re-transmit the entire file. Upon acceptance of the file, the COBC will run the file through its customized claims translator to convert the file to an outbound HIPAA ANSI X12N (version 40101) and perform HIPAA validation. Then, after referencing the frequency and media type specifications established in the COBA database for the trading partner, the COBC will sort the claims by COBA IDs for transmission to the trading partners.

The COBC's translator will edit to the level of compliance mandated by the HIPAA 837 Implementation Guide. "Gap filling" will always occur when mandatory fields do not contain values. The Medicare contractors' system will be responsible for producing "gap filling" on the 837 flat files for crossover. Medicare Gap Filling Instructions is available for download at http://www.cms.hhs.gov/COBAgreement/01_overview.asp/

3.6.1 File Structure

A COBA trading partner will receive up to three claims files (Institutional, Professional, and NCPDP) per COBA ID (1 per format) or three per all COBA IDs, based upon the exclusion criteria selected in the COB Agreement. All electronic claims, with the exception of NCPDP transfer claims, must be received in ANSI 837 Version 4010A1 (Institutional/Professional). NCPDP transfer claims will be sent in the NCPDP version 5.1 batch standard 1.1 format. (Note: Data validation routines will be applied to all outbound files.)

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

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

Each claim for service submission request may contain up to four occurrences of claims/service data. The Medicare contractor will enter on the COB file for each line item- the Medicare paid amount, any deductible and coinsurance amount applied to the item. Medicare processes claims at the line level.

A HIPAA Crosswalk document is provided below:

Medicare Part A & B 837 HIPAA Claims from COBA

	ISA INTERCHANGE CONTROL HEADER	
ISA06	Interchange Sender ID	**Literal "COBA" without quotes.**
ISA08	Interchange Receiver ID	**PAYER SUPPLIED ID (specified in the COBA contract)**
ISA13	Interchange Control Number	EDI 837 FileID (Unique ID for each ISA transmitted)
	GS FUNCTIONAL GROUP HEADER	
GS02	Application Sender's Code	**Literal "COBA" without quotes.**
GS03	Application Receiver's Code	**PAYER SUPPLIED ID (specified in the COBA contract)**
ST	*Transaction Set Header*	
	LOOP ID - 1000A SUBMITTER NAME	
NM1	Submitter Name (NM101 = 41)	**NM109 WILL CONTAIN THE CONTRACTOR'S MEDICARE ID. (See CMS List)**
	LOOP ID - 1000B RECEIVER NAME	
NM1	Receiver Name (NM101 = 40)	**NM109 WILL CONTAIN THE Payer's COBA ID**
	LOOP ID - 2010BA SUBSCRIBER NAME	
NM1	Subscriber Name (NM101 = IL)	**NM109 CONTAINS THE SUPPLEMENT INSURANCE ID IF THE ELIGIBILITY FILE CONTAINS THE SUBSCRIBER ID. OTHERWISE, MEDICARE HIC# OF THE INSURED**
	LOOP ID - 2010BB (837P) 2010BC (837I) PAYER NAME	
NM1	Payer Name (NM101 = PR)	**NM109 WILL CONTAIN THE Payer's COBA ID**
	LOOP ID - 2330A OTHER SUBSCRIBER NAME	
NM1	Other Subscriber Name (NM101 = IL)	**NM109 CONTAINS MEDICARE HIC# OF THE INSURED**

- **Data Elements**

The following information will be reported in the data elements:

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

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

- **Adjusted claims**

Adjusted claims can be identified in the Claims Adjustment segment (CAS), as found in the 2320 loop (claim level) and in the 2430 loop (line level), for both the 837 Institutional and Professional claim.

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

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

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

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

- **EIN**

The EIN number cannot be reported for a billing provider in an 837 file (loop 2010AA, NM109) with a leading zero followed by the nine-byte EIN.

The 837P COB files will contain the Medicare contractor's proprietary provider ID for the billing provider in loops 2010AA (billing provider), 2310B (claim level rendering) and 2420A (line level rendering) in REF02 field with a qualifier of 1C.

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

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

- **State Licensee Number**

The state licensee number will be reported in the 2310A loop and will not be moved to the 2330D loop. The 0B qualified REF segment in the 2310A will not be moved.

- **REF Segment**

Medicare will pass along all iterations of the secondary identifier REF segment whether contained in the claim level loops or the COB 2320/2330/2430 loops. If the information comes in on a claim, it will be passed to the trading partner. The 0B qualified REF segment in the 2310A will not be moved to the 2330 loop.

3.6.2 Test Claims

CMS and the COBC tested with all Medicare contractors to validate their ability to produce COB flat files from which the COBC can then produce HIPAA-compliant 837 COB files. Testing confirmed that Medicare contractors are able to successfully produce 837 COB flat files.

Parallel test claim files will be provided to the payers by the COBC. During the testing phase, the COBC will populate 'P' for production to the ISA-15. Extensive parallel production testing would mitigate the potential for any problems during implementation.

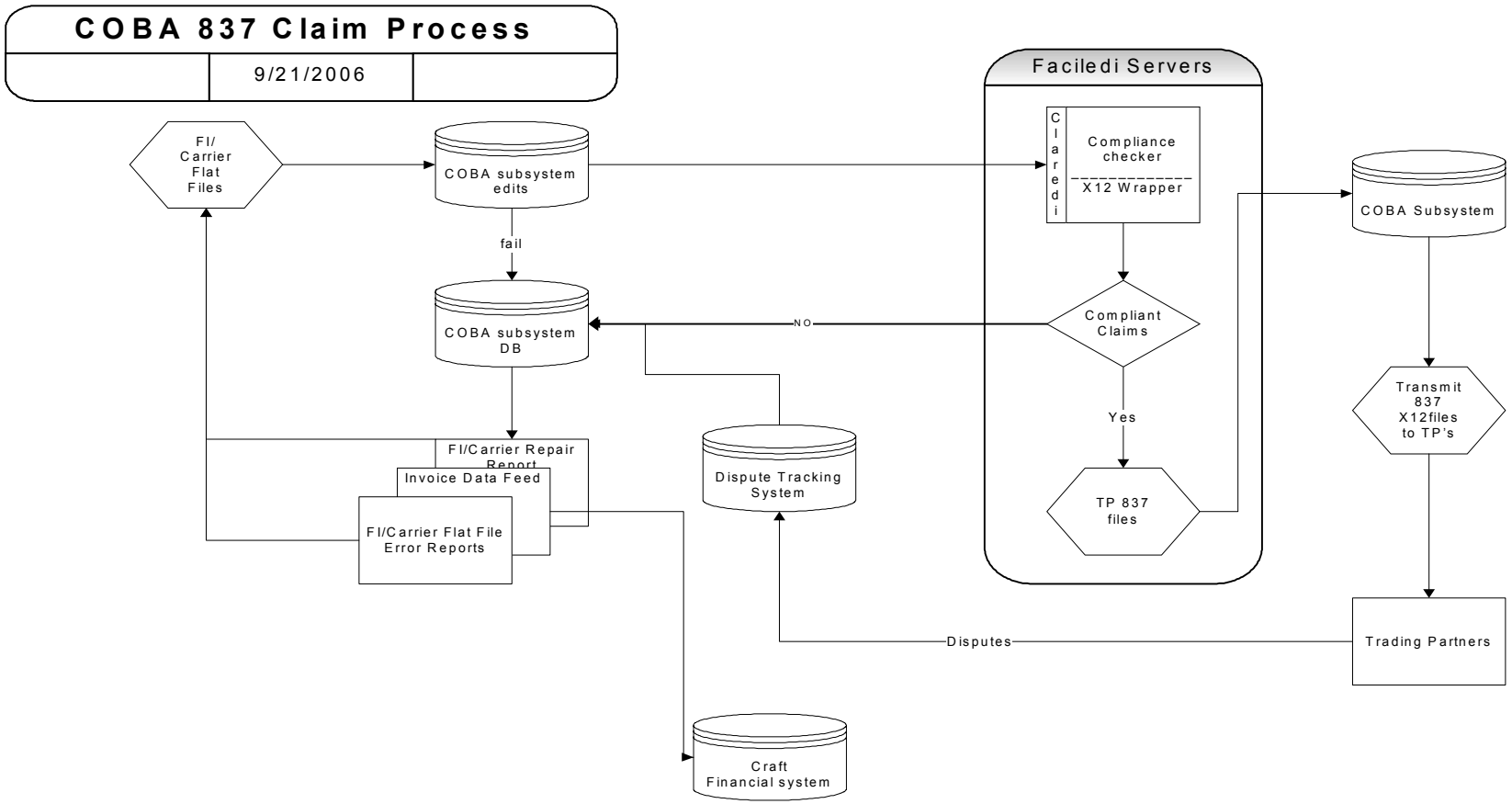
3.6.3 NCPDP

NCPDP claims will be assigned. NCPDP claims do not provide a Medicare Assignment Indicator or Benefits Assignment Indicator. CMS is currently working on a Data Element Request Form (DERF) within the NCPDP to add these data elements. Depending upon the type of transmission, the trading partner may receive only 1 service line per NCPDP claim.

For questions regarding examples of claims that would fall within #10 (National Council for Prescription Drug Programs claims), refer to the NCPDP Web site at http://www.ncpdp.org.

3.6.4 Flowchart

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


COBA 837 Claim Process
9/21/2006
Faciledi Servers
FI/ Carrier Flat Files
COBA subsystem edits
fail
COBA subsystem DB
NO
Compliance checker
X12 Wrapper
Compliant Claims
Yes
TP 837 files
COBA Subsystem
Transmit 837 X12files to TP's
Trading Partners
Disputes
Dispute Tracking System
FI/Carrier Repair Report
Invoice Data Feed
FI/Carrier Flat File Error Reports
Craft Financial system

3.6.5 Formats

The COBC will forward all COBA claims in the following American National Standards Institute (ANSI) X12N file formats—ANSI 837 Version 4010A1 (Institutional) and ANSI 837 4010A1 (Professional)—and the National Council for Prescription Drug Programs (NCPDP) version 5.1 batch standard 1.1 format for drug claim transactions.

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

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

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

3.6.6 Frequency

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

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

3.6.7 Companion Guides

The standard Institutional, Professional, and NCPDP Coordination of Benefits (COB) Companion Documents are available on the Internet at http://www.cms.hhs.gov/manuals/pm_trans/R83OTN.pdf.

3.6.8 Claims Adjustment Reason Codes and Remittance Advice Remark Codes

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

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

3.6.9 HIPAA Issues Logs (Agree/Disagree)

CMS tracks all HIPAA-related Medicare crossover claim issues in a HIPAA Issues Log that is posted to the CMS Web site at http://www.cms.hhs.gov/COBAgreement/01_overview.asp/. The log is used by CMS' Medicare contractors to schedule HIPAA claim-related fixes to their shared systems; by the trading partners to identify and schedule HIPAA claim-related fixes; and by CMS and the COBC to monitor HIPAA claim-related fixes that impact COBA production. Regular updates to the HIPAA Issues Log are posted to the Web site along with the date the issue is closed.

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

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

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

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

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

3.7 Dispute File Process

Overview

In a continuous effort to improve the COBA (Coordination of Benefits Agreement) Dispute Process, the following information has been developed to provide our COBA trading partners with a basic outline of the COBA dispute process. The Claims Dispute File Layout and Specifications, which is available for download at http://www.cms.hhs.gov/COBAgreement/01_overview.asp/, must be referenced when you are filing a dispute. The file layout contains important information, including the technical requirements of a dispute file, necessary for resolution. For all three levels of dispute, it is required that a COBA Problem Inquiry Request Form is completed and submitted to cobva@ghimedicare.com. The COBA Problem Inquiry Request Form is also available for download at http://www.cms.hhs.gov/COBAgreement/01_overview.asp/.

Please note that prior to filing a dispute, COBA trading partners should review the COBC/HIPAA Issues Logs at the same CMS Web site listed above. If the issue associated to a potential dispute is listed under the Agree tab, the

Medicare contractor(s) should have a fix scheduled to correct the issue, avoiding future disputes. If the issue is listed under the Disagree tab, CMS has ruled that the issue is HIPAA compliant and a dispute will not be accepted.
Dispute Submission Process

ANSI 837 Processing Errors – Some claims may be flagged as errors when a trading partner processes the ANSI 837 claims received from the COBC, through their pre-editor/translator. A trading partner should identify to the COBC ANSI 837 or NCPDP claims that they should not have received or which contain invalid data or values. Following are three possible levels of claims dispute for the ANSI 837 files, and the appropriate reporting method for each. Note that a COBA Problem Inquiry Request Form (COBAF020) must be completed for all three levels of claim disputes. All COBAF020 forms must be sent to the general EDI Representative e-mail address, cobva@ghimedicare.com. An EDI Contact List, which contains all EDI contact information, is available for download at http://www.cms.hhs.gov/COBAgreement/01_overview.asp/.

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

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

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

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

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

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

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

Step 2. The trading partner transmits the dispute file to the COBC to the following filename: 'PCOB.BA.NDM.COBA.CBXXXXX.DISPUTE(+1) XXXXX = TP assigned COBA ID.

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

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

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

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

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

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

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

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

- **Duplicate Claim**

The COBC front-end edits and HIPAA validation software are designed to capture duplicate files sent by Medicare contractors. Within the COBC HIPAA validation software, a signature value is created of each ST-SE transaction set, which is calculated based on the position and value of each byte of data within the transaction set. For each ST-SE transaction set a comparison of the signature value is performed against those received over the past six (6) months. If all bytes of data in the incoming ST-SE transaction set matches a previously submitted ST-SE transaction set, the signature values will be the same and the transaction set is rejected as a duplicate. However, if one byte of data differs, the incoming file is considered to be unique and will crossover to trading partners. Following are two possible levels of claims dispute for the ANSI 837 files, and the appropriate reporting method for each. Note that a COBA Problem Inquiry Request Form (COBAF020), must be completed for all three levels of claim disputes. All COBAF020 forms must be sent to the general EDI Representative e-mail address. Please see EDI Contact List, for this address and other contact information.

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

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

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

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

Report disputed duplicate claims at the claim level and claims within an ST-SE envelope to the COBC through the Dispute Flat File and e-mail the completed COBA Problem Inquiry Request Form (COBAF020) to cobva@ghimedicare.com.

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

Step 2. The trading partner transmits the dispute file to the COBC to the following filename: 'PCOB.BA.NDM.COBA.CBXXXXX.DISPUTE(+1) XXXXX = TP assigned COBA ID.

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

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

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

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

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

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

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

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

Escalation Process

The COBC places great importance in providing exceptional service to our customers. To that end, we have developed the following escalation process to assist us with bringing your disputed claims issue to resolution within five (5) business days from the date your COBA Inquiry Request Form (COBAF020) is assigned a ticket number.

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

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

Please refer to the EDI Contact List when contacting the COBC EDI Department.

SECTION 4. COBA FINANCIAL DETAILS

4.0 COBA Financial Process Overview

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

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

4.1 db-eBills

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

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

db-eBills provides access to timely invoice information and the ability to authorize payment electronically, and it is a multi-user system with flexible access rights that can be adapted to the trading partner's existing invoice approval and payment process. A detailed description of db-eBills, and its many available features is provided in the Electronic Billing Introductory Package, which is available for download at http://www.cms.hhs.gov/COBAgreement/01_overview.asp/.

4.2 Crossover Fee Requirements

Fees established in the trading partner's Agreement under Section III.D.1a and 1b and the provisions under Payment Terms apply when a trading partner moves from a test environment to the production environment. These fees do not apply to State Medicaid Agencies and are subject to change with notice from CMS.

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

- The Trading partner will be invoiced for claims for those Medicare beneficiaries provided on an Eligibility File and/or meet the claims selection criteria denoted on the COBA Attachment that are transferred to the trading partner in the formats described in Section III.B of the COBA Attachment.

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

SECTION 5. CUSTOMER SERVICE

5.0 General Overview

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

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

5.1 COBC - COBA Problem Inquiry Request Form Submission

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

Inquiries submitted on a COBA Problem Inquiry Request Form (COBAF020), available for download at http://www.cms.hhs.gov/COBAgreement/01_overview.asp/, are logged into a centralized database and tracked to ensure each submitted request is addressed timely. Additionally, this process provides the COBC with a resource through which we can identify commonly reported issues and the impact of these issues on our trading partners and the COBA program.

5.1.2 Form Submission and Processing

Submit all problem inquiries on the COBA Problem Inquiry Request Form

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

- Within 48 hours from ticket number notification, the COBC will send a follow-up e-mail to you indicating the status of your request and when applicable, the corrective action taken.

5.1.3 Escalation Process

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

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

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

5.2 Quick Reference: COBC Contact Information

Below is the COBC's mailing address and general contact information referenced in this guide. The EDI Contact List, available for download at http://www.cms.hhs.gov/COBAgreement/01_overview.asp/, should be used when following the escalation processes listed in the Dispute Process and COBA Problem Inquiry Request Submission, or to report unsatisfactory service levels.

COBC Mailing Address
Medicare Coordination of Benefits Contractor
25 Broadway 12th Floor
New York, New York 10004
Attention: COBC EDI Department

EDI Department General Contact #
(646) 458-6740

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

E-mail
cobva@ghimedicare.com

Additional Contact References

The following references are available for download at http://www.cms.hhs.gov/COBAgreement/01_overview.asp/:

Trading Partner Customer Service Point of Contact List

Medicare Contractor's and their Associated States

5.4 Other Useful Technical Guides And Web Sites

837 Implementation Guides

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

NCPDP Implementation Guides

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

CMS' COB Web Site

For more information regarding the COBA program and to stay connected on any updates/changes, visit http://www.cms.hhs.gov/medicare/cob. The COBA, Attachment and COBA Implementation User Guide can be downloaded from the COBC's Web site at http://www.cms.hhs.gov/COBAgreement/01_overview.asp/.