Medicare Claims Processing Manual
Chapter 28 - Coordination With Medigap, Medicaid, and Other Complementary Insurers

Table of Contents
(Rev. 2215, 05-13-11)

10 - Medigap - Definition and Scope

(Rev. 1, 10-01-03)

B3-4700

The Omnibus Budget Reconciliation Act of 1990 (OBRA 1990, Public Law 101-508) requires all Medicare supplemental (Medigap) insurance policies to conform to minimum standards including loss ratio requirements, standardized benefit packages and consumer protection requirements.

The procedures described in §§20 through 110 apply to all policies meeting the definition of Medicare supplemental insurance policies ("Medigap") in §1882(g)(1) of the Social Security Act (the Act.)

A Medigap policy is: A group or individual policy of accident and sickness insurance, or a subscriber contract of hospital and medical service associations or health maintenance organizations, other than a policy issued pursuant to a contract under §1876 or §1833 of the Act, or a policy issued under a demonstration project.

A Medigap policy is offered by a private company to those entitled to Medicare benefits and provides payment for Medicare charges not payable because of the applicability of deductibles, coinsurance amounts or other Medicare imposed limitations. Typically, a Medigap policy does not include limited benefit coverage areas available to Medicare beneficiaries, such as "specified disease" or "hospital indemnity" coverage. By law, the definition explicitly excludes a policy or plan offered by an employer to employees, or former employees, as well as policies offered by a labor organization to members or former members.

The National Association of Insurance Commissioners has developed model regulatory language for State insurance commissions to apply to Medigap insurance offerings. This model regulatory language is located at: http://www.carfra.com/products/medsupappendixb.pdf. It recommends the requirements that states should consider for approving proposed Medigap insurance plans.

The following procedures for furnishing information are mandatory for Medigap plans. Contractors may enter similar arrangements with other insurers or State Medicaid plans for furnishing claims information. Medicaid agencies are furnished information in the standard format free of charge. Other payers must pay the Medicare costs for providing information.

20 - Assignment of Claims and Transfer Policy

(Rev. 138, 04-09-04)

B3-4702, B3-3047

A Medicare beneficiary who has a Medigap policy may authorize the participating physician, provider, or supplier of services to file a claim on his or her behalf and to receive payment directly from the insurer instead of through the beneficiary. In such cases, the intermediary or

carrier must transfer Medicare claims information to the Medigap insurer. The Medigap insurer pays the physician/provider/supplier, and must pay the intermediary or carrier for their costs in supplying the information subject to limitations.

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

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

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

20.1 - Beneficiary Insurance Assignment Selection

(Rev. 138, 04-09-04)

B3-4702.1, B3-3047, B4-2110.1

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

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

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

HICN

NAME OF BENEFICIARY MEDIGAP POLICY NUMBER

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

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

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

30 - Completion of the Claim Form

(Rev. 1332, Issued: 08-31-07, Effective: 10-01-07, Implementation: 10-01-07)

As part of the national Coordination of Benefits Agreement (COBA) claim-based Medigap crossover process, participating physicians and providers/suppliers that are attempting to trigger mandatory Medigap ("claim-based") crossovers must include the CMS-assigned 5-digit Medigap COBA claim-based ID within designated areas on the appropriate claims forms as follows:

- Item 9-D of the incoming paper CMS-1500 claim form (**NOTE:** the PAYERID or the Medigap company or plan name within this field will **not** trigger a Medigap claim-based crossover); and

- Within field NM109 of the NM1 segment within the 2330B loop of the incoming Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X12-N 837 professional claim (version 4010-A1 or more current format).

In addition, retail chain pharmacies that are attempting to trigger crossovers to their clients' Medigap insurers should enter the Medigap COBA claim-based within field 301-C1 of the T04 segment on the incoming National Council for Prescription Drug Programs (NCPDP) batch claims (version 5.1 batch standard 1.1 or more current format).

For more information regarding the COBA Medigap claim-based crossover process, refer to §70.6.4 of this chapter.

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

(Rev. 1332, Issued: 08-31-07, Effective: 10-01-07, Implementation: 10-01-07)

Participating physicians and suppliers must enter information required in item 9 and its subdivisions if requested by the beneficiary. Participating physicians/suppliers sign an agreement with Medicare to accept assignment of Medicare benefits for all Medicare patients. A claim for which a beneficiary elects to assign his/her benefits under a Medigap policy to a participating

physician/supplier is called a “mandated Medigap transfer.” Medigap information is entered on the CMS Form 1500 as follows:

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

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

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

1257 Anywhere Street
Baltimore, Md. 21204
Is shown as
1257 Anywhere St. MD 21204

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

All the information in items 9, 9a, 9 b, and 9d must be complete and accurate. Otherwise, the Medicare contractor cannot forward the claim information.

Under CMS’s national COBA claim-based Medigap process, participating Part B and DME providers and suppliers that are exempted under the Administrative Simplification Compliance Act (ASCA) from having to bill electronically will be required to enter the CMS-assigned 5-digit claim-based Medigap COBA ID in item 9-D of Form CMS-1500.

Those participating providers and suppliers that must bill electronically shall enter the 5-digit claim-based Medigap COBA ID in field NM109 of the NM1 segment in loop 2330B of the Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X12-N 837 professional claim for purposes of triggering Medigap claim-based crossovers. If a participating Part B provider or supplier of durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) fails to include this identifier in the field just described, the claim will not be transferred to the Medigap insurer via the COBA claim-based Medigap crossover process.

Retail pharmacies that wish to trigger claim-based crossovers to Medigap insurers shall enter the Medigap claim-based COBA ID within field 301-C1 of the T04 segment of the NCPDP claim.

30.2 - UB-92 (Form CMS-1450)

(Rev. 1332, Issued: 08-31-07, Effective: 10-01-07, Implementation: 10-01-07)

Under CMS direction, claim-based Medigap crossovers have been limited to claims processing situations involving Part B contractors, including carriers and Medicare Administrative

Contractors (MACs), and to Durable Medical Equipment Regional Carriers (DMERCs)/DME Medicare Administrative Contractors (DMACs) since 1994.

In accordance with the language provided within §1842(h)(3)(B) of the Social Security Act, no information entered on an incoming UB-92 claim (or UB-04 or successor claim form) or incoming Health Insurance Portability Act (HIPAA) American National Standards Institute (ANSI) X12-N 837 institutional claim (4010-A1 or more current format) shall result in a process whereby CMS transfers the claim to a Medigap insurer.

40 - MSN Messages

(Rev. 1420; Issued: 01-25-08; Effective: 10-01-07; Implementation: 02-01-08)

FI/Carriers should use the following messages, as appropriate, on the beneficiary's MSN for each approved claim for which they have sent or will send a transaction to a Medigap insurer:

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

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

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

Effective with October 1, 2007, contractors shall ensure that MSN #35.3 reads as follows:

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

Spanish translation of MSN # 35.3:

"No se enviará copia de esta notificación a su asegurador de Medigap debido a que la información estaba incompleta o era inválida. Favor de someter una copia de esta notificación a su asegurador Medigap."

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

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

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

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

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

50 - Remittance Notice Messages

(Rev. 138, 04-09-04)

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

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

MA 18 – “The claim information is also being forwarded to the patient’s supplemental insurer. Send any questions regarding supplemental benefits to them.”

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

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

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

60 - Returned Medigap Notices

(Rev. 98, 2-06-04)

B3-4705, AB-99-3

Notices sent to Medigap insurers may be returned to the intermediary or carrier by the post office or other mail carrier as undeliverable. FIs and carriers consider returned notices as a source of information for detecting processing problems that merit additional analysis or investigation. They use findings to improve the transmittal process with respect to proper identification of the insurer or to update their Medigap insurer files. The intermediary or carrier should develop

procedures to advise beneficiaries, physicians and suppliers of their responsibility for filing Medigap claims when a notice is returned but not re-transmitted. They should re-transmit notices that are returned due to their error.

If an insurer refuses to accept valid notices, FIs and carriers follow the procedures detailed in §70.4.

Intermediaries and carriers shall cease this responsibility after CMS' Coordination of Benefits Contractor (COBC) has assumed full responsibility for claim-based Medigap process.

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

(Rev. 1332, Issued: 08-31-07, Effective: 10-01-07, Implementation: 10-01-07)

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

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

Cost Calculation Process Leading Up to the Coordination of Benefit Contractor's (COBC's) Assumption of Claim-Based Medigap Crossovers

Up to and including the final claims transferred under their pre-existing mandatory Medigap (claim-based) crossover processes (note: the "final" claims should be those processed by the contractor just before the October 2007 release is installed), Part B contractors, including Medicare Administrative Contractors (MACs), as well as DME Medicare Administrative Contractors (DMACs) should determine the frequency at which they routinely transmit notices to all Medigap insurers but must transmit not less often than monthly. (See §70.4)

During fiscal year 2006, the CMS consolidated the eligibility file-based claims crossover process, as it relates to Medigap insurers and other commercial payers, under the Coordination of Benefits Contractor (COBC). Refer to §70.6 and succeeding sub-sections for Medicare contractor requirements and responsibilities relating to the national Coordination of Benefits Agreement (COBA) consolidated crossover process. Refer to §70.6.4 for all contractor requirements relating to the COBA Medigap claim-based crossover process, which shall be inaugurated on October 1, 2007. (See also Pub.100-04 chapter 27 §80.17.)

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

Suppression of Sanctioned Provider Claims from Claim-Based Medigap Crossovers

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

NOTE: All such contractors shall continue to suppress 100 percent paid and 100 percent denied claims from their mandatory Medigap crossovers, per previous CMS guidance.

70.1 - Authorization for Release of Information

(Rev. 1, 10-01-03)

B1-4600-4602.5, B3-10010, A1-1600 - 1602.5, A3-3768, A3-3769

See Pub 100-01, the Medicare General Information, Eligibility, and Entitlement Manual, Chapter 6.

70.1.1 - Requests for Additional Information

(Rev. 1, 10-01-03)

Normally the standard EDI Coordination of Benefits formats are used to convey Medigap or other complementary insurance information. Where the Medigap or other complementary insurer requests title XVIII information for certain claims only, FIs and carriers treat the situation as a special request and determine the cost for providing it as described in Chapter 1 of Pub. 100-06, the Medicare Financial Management Manual.

If the request is for duplicate MSNs, the FI or carrier first informs the requestor that remittance remarks are included in the COB outbound claim records, and that there is a crosswalk from remittance remarks to MSN messages on the CMS Web site.

In the absence of a standing arrangement, the mere presence of an “authorization” to release and the identification of a complementary insurer on a title XVIII billing form does not constitute a request for the “release” of information. The request for the information must be specific.

70.1.2 - Release of Title XVIII Claims Information for Medigap Insurance Purposes by Providers

(Rev. 1, 10-01-03)

HO-91.3

Subject to specific written beneficiary authorization, providers are permitted to furnish certain limited information about Medicare eligibility status and related claims information to third part payers for complementary insurance purposes. (See Chapter 6 of Pub 100-01, the Medicare General Information, Eligibility, and Entitlement Manual.)

70.2 - Integration of Title XVIII Claims Processing With Complementary Insurance Claims Processing

(Rev. 1, 10-01-03)

A3-3769

General

See Chapter 6 of Pub 100-01, the Medicare General Information, Eligibility, and Entitlement Manual for instructions about disclosure of information.

See Chapter 1 of Pub. 100-06, the Medicare Financial Management Manual, for requirements for determining costs.

70.2.1 - Program Recognition

(Rev. 1, 10-01-03)

Since title XVIII program identity must be maintained, notices and forms for title XVIII purposes must clearly identify their title XVIII origin. The complementary insurance notices and forms must be free of implication that the coordination of benefits constitutes an official endorsement by CMS of the complementary insurance plan. Also, they must not imply that title XVIII entitlement or enrollment is dependent upon the individual's retention of his/her complementary insurance policy.

70.2.2 - Records and Information

(Rev. 1, 10-01-03)

A3-3769.C

See chapter 6, of Pub 100-01, the Medicare General Information, Eligibility, and Entitlement Manual.

70.2.3 - Matching Files Against Medicare Claims Files

(Rev. 1, 10-01-03)

A3-3769.D

See Chapter 6 of Pub 100-01, the Medicare General Information, Eligibility, and Entitlement Manual.

70.3 - Standard Medicare Charges for COB Records

(Rev. 138, 04-09-04)

A1-1600, B1-4601

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

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

70.4 - General Guidelines for Intermediary or Carrier Transfer of Claims Information to Medigap Insurers

(Rev. 1, 10-01-03)

B1-4607

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

70.5 - Audits

(Rev. 1, 10-01-03)

B1-4601, A1-1601.C

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

70.6 - Consolidation of the Claims Crossover Process

(Rev. 2215, Issued: 05-13-11, Effective: 10-01-11, Implementation: 10-03-11)

Background – Medicare Claims Crossover Process--General

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

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

As a rule, the shared system maintainers shall populate an outbound COB/Medigap file as an 837 flat file with the Employer Identification Number (EIN)/Tax ID or SSN (for a sole practitioner) present in the provider's file, unless otherwise specified within §70.6.5 or §70.6.6 of this chapter. With the adoption of the National Provider Identifier (NPI), the shared system shall report qualifier XX in NM108 and the NPI value in NM109. The shared system shall report the provider's EIN/TAX ID within the REF segment of the billing provider loop, as appropriate. In addition, unless otherwise stated within §70.6.5 or §70.6.6 of this chapter, the shared systems shall populate the provider loops on outbound 837 claims with the provider's first name, last name, middle initial, address, city, state and zip code as contained in the Medicare provider files, the information for which is derived from the Provider Enrollment Chain and Ownership System (or PECOS)

Background—Specific COBA Crossover Process

The CMS has now streamlined the claims crossover process to better serve its customers. Under the new consolidated claims crossover process, trading partners execute national agreements called Coordination of Benefits Agreements (COBAs) with CMS' Coordination of Benefits Contractor. Through the COBA process, each COBA trading partner will send one national eligibility file that includes eligibility information for each Medicare beneficiary that it insures to the COBC. The COBC will transmit the beneficiary eligibility file(s) to the Common Working File (CWF) via the HUBO maintenance transaction. The transaction is also termed the "Beneficiary Other Insurance (BOI)" auxiliary file. (See Pub.100-4, chapter 27, §80.14 for more details about the contents of the BOI auxiliary file.)

During August 2003, the CMS modified CWF to accept both the HUBO (BOI) transaction on a regular basis and COBA Insurance File (COIF) as a weekly file replacement. Upon reading both the BOI and the COIF, CWF applies each COBA trading partner's claims selection criteria against processed claims with service dates that fall between the effective and termination date of one or more BOI records.

Upon receipt of a BOI reply trailer (29) that contains (a) COBA ID (s) and other crossover information required on the Health Insurance Portability and Accountability Act (HIPAA) 835 Electronic Remittance Advice (ERA), Medicare contractors will send processed claims via an 837 COB flat file or National Council for Prescription Drug Programs (NCPDP) file to the COBC.

The COBC, in turn, will cross the claims to the COBA trading partner in the HIPAA American National Standards Institute (ANSI) X12-N 837 or NCPDP formats, following its validation that the incoming Medicare claims are formatted correctly and pass HIPAA or NCPDP compliance editing.

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

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

I. Contractor Actions Relating to CWF Claims Crossover Exclusion Logic

A. Determination of Beneficiary Liability for Claims with Denied Services

Effective with the January 2005 release, the Part B and Durable Medical Equipment Regional Carrier (DMERC)/DME Medicare Administrative Contractor (DME MAC) contractor shared systems will be required to include an indicator "L" (beneficiary is liable for the denied service[s]) or "N" (beneficiary is not liable for the denied service[s]) in an available field on the HUBC and HUDC queries to CWF for claims on which all line items are denied. The liability indicators (L or N) will be at the header or claim level rather than at the line level.

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

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

- The "L" indicator is applied at the header/claim level if the beneficiary is liable for any of the denied services on a fully denied claim; and

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

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

As Part A contractors adjudicate claims and determine that the beneficiary has payment liability for any part of the fully denied services or service lines, they shall set an "L" indicator within the newly created beneficiary liability field in the header of their HUIP, HUOP, HUHH, and HUHC claims that they transmit to CWF. In addition, as Part A contractors adjudicate claims and determine that the beneficiary has no payment liability for any of the fully denied services or service lines—that is, the provider must absorb all costs for the fully denied claims—they shall include an "N" beneficiary indicator within the designated field in the header of their HUIP,

HUOP, HUHH, and HUHC claims that they transmit to CWF. **NOTE:** Part A contractors shall not set the "L" or "N" indicator on partially denied/partially paid claims.

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

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

CWF shall post the appropriate crossover disposition indicator in association with the adjudicated claim on the HIMR detailed history screen (see §80.15 of this chapter).

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

CWF Editing for Incorrect Values

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

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

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

Upon receipt of a claim that contains entry code "5" or action code "3" with a non-adjustment claim header value of "N," the CWF shall treat the claim as if it were an "original" claim (i.e., as entry code "1" or action code "1") for crossover inclusion or exclusion determinations. If CWF subsequently determines that the claim meets all other inclusion criteria, it shall mark the claim with an "A" ("claim was selected to be crossed over") crossover disposition indicator.

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

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

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

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

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

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

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

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

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

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

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

If contractors send a value other than "A," "N," or spaces within the newly designated header field within their HUBC, HUDC, HUIP, HUOP, HUHH, and HUHC claims, CWF shall apply an

edit to reject the claim back to the contractor. Upon receipt of the CWF rejection edit, the contractors' systems shall correct the invalid value and retransmit the claim to CWF for verification and validation.

D. CWF Identification of National Council for Prescription Drug Claims

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

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

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

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

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

In addition, CWF shall create a 2-byte field on page 2 of the HIMR claim detail in association with the new category "COBA Bypass" for the value "BQ," which shall designate that CWF auto-excluded the claim because it contained only PQRI codes (see §80.15 of this chapter for more details regarding the bypass indicator).

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

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

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

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

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

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

In addition, the CWF maintainer shall create space within page two (2) of the HIMR detail of the claim screen for 1) a new category "COBA Bypass"; and 2) a 2-byte field for the indicator "BN." (See Pub. 100-04, chapter 27, §80.15 for more details regarding the "BN" bypass indicator.)

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

As contractors, including Medicare Administrative Contractors (MACs) and Durable Medical Equipment Medicare Administrative Contractors (DME MACs), adjudicate **non VA MRA** claims that fall within any of the NPI placeholder requirements, their shared system shall take the following combined actions:

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

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

Upon receipt of claims where the NPI Placeholder field contains the value "Y," CWF shall auto-exclude the claim from the national COBA crossover process. In addition, CWF shall populate the value "BN" in association with the newly developed "COBA Bypass" field on page 2 of the HIMR Part B and DME MAC claim detail screen and on page 3 of the HIMR intermediary claim detail screen. (See Pub.100-04, chapter 27, §80.14 for more details.)

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

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

G. New CWF Requirements for Other Federal Payers

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

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

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

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

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

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

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

CWF shall mark claims that it excludes due to "Other Insurance" with crossover disposition indicator "M" when storing them within the CWF claims history screens. (See §80.15 of this chapter for additional information concerning this indicator.)

II. Contractor Actions Relating to CWF Claims Crossover Inclusion or Inclusion/Exclusion Logic

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

All Medicare contractors shall continue to identify mass adjustment claims-MPFS and mass adjustment claims—other by including an "M" (mass adjustment claims—MPFS) or "O" (mass adjustment claims—other) within the header of the HUIP, HUOP, HUHH, HUHC, HUBC, and HUDC claim transactions, as specified in Pub.100-04, chapter 27, §80.16. (Refer to Pub.100-04, chapter 27, §80.18 for CWF specific requirements relating to the unique inclusion of mass adjustment claims for crossover purposes.)

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

Upon receipt of a HUIP, HUOP, HUHH, HUHC, HUBC, or HUDC claim transaction that contains an "M" or "O" mass adjustment indicator, CWF shall undertake all additional actions with respect to determination as to whether the claim should be included or excluded for crossover purposes as specified in chapter 27, §80.18.

Contractor Flat File Requirements

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

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

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

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

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

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

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

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

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

Through this instruction, all contractor systems shall develop a method for uniquely identifying all varieties of RAC-requested adjustments, which occur as the result of post-payment review activities.

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

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

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

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

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

Prior to sending their processed RAC adjustment transactions to CWF for normal verification and validation, the Part B and Durable Medical Equipment Medicare Administrative Contractor (DMAC) shared systems shall input the "R" indicator in the newly defined header field of the HUBC and HUDC claim transactions.

Unique COBA ID Assignment to Trading Partners That Accept RAC-Initiated Adjustment Claims Only and Attendant Contractor Responsibilities

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

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

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

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

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

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

Effective July 6, 2004, the COBC will begin to send initial copies of the COBA Insurance File (COIF) to the nine CWF host sites. The COIF will contain specific information that will identify the COBA trading partner, including name, COBA ID, address, and tax identification number (TIN). It will also contain each trading partner's claims selection criteria along with an indicator (Y=Yes or N=No) of whether the trading partner wishes its name to be printed on the Medicare Summary Notice (MSN). Effective with the October 2004 systems release, the COIF will also contain a 1-digit Test/Production Indicator that will identify whether a COBA trading partner is in test (T) or production (P) mode. The CWF will be required to return that information as part of the BOI reply trailer (29) to Medicare contractors.

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

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

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

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

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

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

1. BOI Reply Trailer Process

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

When a BOI reply trailer (29) is received, the COBA assigned ID will identify the type of crossover (see the Data Elements Required for the BOI Aux File Record Table in Chapter

27, §24). Although each COBA ID will consist of a five-digit prefix that will be all zeroes, Medicare contractors are only responsible for picking up the last five digits within these ranges, which will be right justified in the COBA number field. In addition to the trading partner's COBA ID, the BOI reply trailer shall also include the COBA trading partner name (s), an "A" crossover indicator that specifies that the claim has been selected to be crossed over, and a one-digit indicator ["Y"=Yes; "N"=No] that specifies whether the COBA trading partner's name should be printed on the beneficiary MSN. As discussed above, effective with the October 2004 systems release, CWF shall also include a 1-digit Test/Production Indicator on the BOI reply trailer (29) that is returned to the Medicare contractor.

Larger-Scale Implementation of the COBA Process

Medicare contractors should note that the larger-scale COBA process, where additional trading partners are first identified as testing participants with the COBC and then are moved to crossover production with the COBC following the successful completion of testing, may be activated at any time during the COBA smaller-scale parallel production period. Activation of the larger-scale COBA process will most likely not occur before the early months of calendar year 2005.

MSN Crossover Messages

Effective with the October 2004 systems release, the Medicare contractor will begin to receive BOI reply trailers (29) that contain an MSN indicator "Y" (Print trading partner name on MSN) or "N" (Do not print trading partner name on MSN).

Also, effective with the October 2004 systems release, when a Medicare contractor receives a BOI reply trailer (29) that contains a Test/Production Indicator of "T," it shall ignore the MSN indicator on the trailer. Instead, the Medicare contractor shall follow its existing procedures for inclusion of trading partner names on MSNs for those trading partners with whom it has existing TPAs.

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

(For all COBA ID ranges other than Medigap)

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

(For the Medigap COBA ID range)

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

Beginning with the October 2004 systems release, contractors shall follow these procedures when determining whether to update its claims history to show that a beneficiary's claim was selected by CWF to be crossed over.

- If the Medicare contractor receives a BOI reply trailer (29) that contains a Test/Production Indicator "T," it shall not update its claims history to show that a beneficiary's claim was selected by CWF to be crossed over.

- If the Medicare contractor receives a BOI reply trailer (29) that contains a Test/Production Indicator "P," it shall update its claims history to show that a beneficiary's claim was selected by CWF to be crossed over.

Effective January 5, 2009, when CWF returns a BOI reply trailer (29) to a Medicare contractor that contains **only** a COBA ID in the range 89000 through 89999, the contractor's system shall suppress all crossover information, including name of insurer and generic message#35.1, from all beneficiary MSNs.

Contractors shall **not** update their claims histories to reflect transference of "tagged" claims with COBA ID range 89000 through 89999 to the COBC. Contractors shall, however, accrue for credit (expect payment) on such claims.

Electronic Remittance Advice (835)/Provider Remittance Advice Crossover Messages

Beginning with the October 2004 release, when CWF returns a BOI reply trailer (29) that contains a "T" Test/Production Indicator to the Medicare contractors, they shall not print information received from the BOI reply trailer (29) in the required crossover fields on the 835 Electronic Remittance Advice or other provider remittance advices that are in production. Contractors shall, however, populate the 835 ERA (or provider remittance advice(s) in production) with required crossover information when they have existing agreements with trading partners.

Beginning with the October 2004 release, when CWF returns a BOI reply trailer (29) that contains a "P" Test/Production Indicator to the Medicare contractors, they shall use the returned BOI trailer information to take the following actions on the provider's 835 Electronic Remittance Advice:

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

b. Update the 2100 Loop (Crossover Carrier Name) on the 835 ERA as follows:

- NM101 [Entity Identifier Code]—Use "TT," as specified in the 835 Implementation Guide.

- NM102 [Entity Type Qualifier]—Use "2," as specified in the 835 Implementation Guide.

- NM103 [Name, Last or Organization Name]—Use the COBA trading partner's name that accompanies the first sorted COBA ID returned to you on the BOI reply trailer.

- NM108 [Identification Code Qualifier]—Use "PI" (Payer Identification)

- NM109 [Identification Code]—Use the first COBA ID returned to you on the BOI reply trailer. (See line 24 of the BOI aux. file record

If the 835 ERA is not in production and the contractor receives a "P" Test/Production Indicator, it shall use the information provided on the BOI reply trailer (29) to populate the existing provider remittance advices that it has in production.

Effective with January 5, 2009, if CWF returns **only** COBA ID range 89000 through 89999 on a BOI reply trailer (29) to a Medicare contractor, the contractor's system shall suppress all crossover information (the entire 2100 loop) on the 835 ERA.

CWF Sort Routine for Multiple COBA IDs

Effective with October 3, 2011, when a beneficiary's claim is associated with more than one COBA ID (i.e., the beneficiary has more than one health insurer/benefit plan that pays after Medicare), CWF shall sort the COBA IDs and trading partner names in the following order on the returned BOI reply trailer (29): 1) Eligibility-based Medigap (30000-54999); 2) Medigap claim-based (55000-59999); 3) Supplemental (00001-29999); *4)* Other Insurer (80000-80213); 5) *Other Insurance (80215-88999); 6) TRICARE (60000-69999); 7) CHAMPVA (80124); 8)* Medicaid (70000-79999); and *9)* Other-Health Care Pre-payment Plan [HCPP] (89000-89999). When two or more COBA IDs fall in the same range (see element 24 of the "Data Elements Required for the BOI Aux File Record" Table in chapter 27, §80.14 for more details), CWF shall sort numerically within the same range.

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

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

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

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

COBA Parallel Production Period

During the COBA parallel production period, which began July 6, 2004, the Medicare contractor shall observe the following business rules when it receives a BOI reply trailer 29 and some other indication of crossover eligibility:

If the Medicare contractor receives a BOI reply trailer 29 with COBA IDs that fall in the ranges of 00001-89999, it shall continue to cross over claims a) per its existing TPAs and b) when Medigap or Medicaid information is reported on the claim.

NOTE: The preceding claim-based scenario does not apply to Part A contractors. In addition, the Medicare contractor shall send claims for which it receives BOI reply trailers to the COBC on the 837 v4010A1 flat file or National Council for Prescription Drug Programs (NCPDP) file.

NOTE: The COBA trading partner will only be charged for the claims that the Medicare contractor continues to cross to it during the parallel production period.

During the parallel production period, the Medicare contractor shall not change its current procedures regarding suppression of Medicaid claims when a beneficiary has non-Medigap and/or Medigap insurance. The Medicare contractor's Medicaid suppression logic should remain the same as today with its existing trading partners, even when it receives a BOI reply trailer that includes a Medicaid COBA ID.

Larger-Scale Implementation of the COBA Process

Beginning with the October 2004 release, Medicare contractors shall follow these rules when they receive a BOI reply trailer (29) that contains Test/Production Indicator "T" and there is some other indication of crossover eligibility:

If the Medicare contractor receives a BOI reply trailer (29) with COBA IDs that fall in the ranges of 00001-89999 (See Attachment A, element 24), it shall cross over claims 1) per its existing TPAs or 2) when Medigap or Medicaid information is reported on the claim (if that is how the Part B or DMERC contractor currently crosses over claims to Medicaid).

NOTE: Claim-based crossover scenarios only apply to Part B and DMERC/ DME MAC contractors.

In addition, the contractor shall send claims for which it receives BOI reply trailer to the COBC on the 837 v4010A1 flat file or National Council for Prescription Drug Programs (NCPDP) file.

When a COBA trading partner is in test mode, the contractor shall not change its current procedures regarding suppression of Medicaid claims when a beneficiary has non-Medigap and/or Medigap insurance. The contractor's Medicaid suppression logic should remain the same as with current existing trading partners, even when you receive a BOI reply trailer (29) that includes a Medicaid COBA ID.

Beginning with the October 2004 release, contractors shall follow these rules when they receive a BOI reply trailer (29) that contains Test/Production Indicator "P" and there is some other indication of crossover eligibility:

a. If the Medicare contractor receives a BOI reply trailer (29) with a COBA ID that falls in the Medigap eligibility-based range (30000-54999), it shall not cross over claims based on an existing Medigap TPA or when Medigap information is reported on the claim. Instead, the Medicare contractor shall send the claim to the COBC (based on the BOI reply trailer 29) on the 837 v4010A1 flat file or NCPDP file for crossover by the COBC to the COBA trading partner.

NOTE: The assumption is that a beneficiary will have only one true Medigap insurer.

b. If the Medicare contractor receives a COBA ID via a BOI reply trailer (29) that falls in the Supplemental range (00001-29999) and it has an existing TPA with a supplemental insurer for the beneficiary, it shall transmit the claim to the COBC for crossover to the COBA trading partner and cross the claim to your existing trading partner.

c. If the Medicare contractor receives a COBA ID via a BOI reply trailer (29) that falls in the Supplemental range (00001-29999), and it also receives Medigap crossover information on the claim, it shall cross the claim to the Medigap insurer identified on the claim and transmit the claim to the COBC for crossover to the COBA trading partner based on the Supplemental COBA ID.

d. If the Medicare contractor receives a COBA ID via a BOI reply trailer (29) that falls in the Medicaid range (70000-77999), it shall not cross over claims based on an existing Medicaid TPA or when Medicaid information is reported on the claim (if that is how the Part B or DMERC contractor currently crosses over claims to Medicaid). Instead, the Medicare contractor shall send the claim to the COBC (based on the BOI reply trailer 29) on the 837 v4010A1 flat file or NCPDP file for crossover by the COBC to the COBA trading partner.

e. If the Medicare contractor receives a BOI reply trailer (29) that contains a Medicaid COBA ID (70000-77999) and it has an existing TPA with a supplemental insurer or Medigap insurer, it shall suppress the Medicaid claim from inclusion on the COB 837 flat file or NCPDP file and cross the claim to the supplemental insurer.

f. If the Medicare contractor receives a BOI reply trailer (29) that contains a Supplemental COBA ID (00001-29999) or a Medigap eligibility-based COBA ID (30000-54999) and it has an existing TPA with Medicaid, it shall suppress its crossover to Medicaid but send the claim to the COBC.

NOTE: For the scenarios above, the trading partner shall be responsible for canceling any existing TPA that it has with the Medicare contractor once it has signed a COBA with the Coordination of Benefits Contractor (COBC).

Contractor Actions Relating to the Transition from HIPAA 837 4010-A1 to 5010 and NCPDP 5.1 batch standard 1.1 to NCPDP D.O

1. CWF COIF and BOI Reply Trailer (29) Processes

Effective January 5, 2009, the COBC will, at CMS's direction, create a new 1-byte "5010 Test/Production Indicator" and a new 1-byte "NCPDP D.0 Test/Production Indicator" on the COBA Insurance File [COIF] (valid values= "N"—not applicable or not ready as yet; "T"—test; "P"—production). In addition, the CWF maintainer shall add a new "5010 Test/Production Indicator" and an "NCPDP D.0 Test/Production Indicator" to the BOI reply trailer (29) format. (See Pub.100-04 chapter 27, §80.17 for additional details regarding CWF requirements relating to the new crossover claim formats.)

The CWF shall not post crossover disposition indicators in association with claims whose 5010 and NCPDP D.0 indicators are "N" or "T." (See Pub.100-04 chapter 27, §80.15 for more details regarding claims crossover disposition indicators.)

2. Contractor Actions Regarding Claim Format to Send to COBC

Prior to the initiation of HIPAA 837 5010 or NCPDP D.0 testing with COB trading partners, if CWF returns to a Medicare contractor a BOI reply trailer (29) that contains an "N" 5010 Test/Production indicator or NCPDP D.0 indicator, the contractor's shared system shall 1) ignore the indicator; and 2) continue to send the existing 837 flat file and NCPDP file formats to the COBC.

NOTE: CMS will issue a future instruction that addresses contractor and contractor shared system requirements for receipt of "T" or "P" 5010 and NCPDP D.0 indicators.

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

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

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

Effective with October 2, 2006, the contractors or their Data Centers shall transmit a combined COBA "test" and "production" 837 flat file and a combined "test" and "production" NCPDP file to the COBC.

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

Flat File Conventions for Transmission to the COBC

With respect to 837 COB flat file submissions to the COBC, Part B contractors, including MACs, and DME MACs shall observe these process rules:

The following segments shall not be passed to the COBC:

1. ISA (Interchange Control Header Segment);
2. IEA (Interchange Control Trailer Segment);
3. GS (Functional Group Header Segment); and
4. GE (Functional Group Trailer Segment).

The 1000B loop of the NM1 segment denotes the crossover partner. If multiple COBA IDs are received via the BOI reply trailer, the contractor system shall ensure that a separate 837

transaction should be submitted for each COBA ID received. As the crossover partner information will be unknown to the standard systems, the following fields should be formatted as indicated for the NM1 segment:

NM103—Use spaces; and
NM109—Include COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29).

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

NM1 segment—For NM103, NM104, NM105, and NM107, use spaces;
NM1 segment—For NM109, include HICN;
N3 segment—Use all spaces; and
N4 segment—Use all spaces.

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

NM1 segment—For NM103, use spaces;
NM1 segment—For NM109, include the COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29);
N3 segment—Use all spaces; and
N4 segment—Use all spaces.

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

NM103—Use spaces; and
NM109—Include COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29).

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

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

SBR01—Treat as normally do.

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

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

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

NM103—Use spaces; and
NM109—Include COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29).

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

NM1 segment – For NM103, NM104, NM105, and NM107, use spaces;
NM1 segment—For NM109, include HICN;
N3 segment—Use all spaces; and
N4 segment—Use all spaces.

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

M1 segment—For NM103, use spaces;
NM1 segment—For NM109, include COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29);
N3 segment—Use all spaces; and
N4 segment—Use all spaces.

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

NM103—Use spaces; and
NM109—Include COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29).

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

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

SBR01—Treat as normally do.

D. COBC Processing of COB Flat Files or NCPDP Files

When a Medicare contractor receives the reject indicator "R" via the Claims Response File, it is to retransmit the entire file to the COBC. If the Medicare contractor receives an acceptance indicator "A," this confirms that its entire COB flat file or NCPDP file transmission was accepted. Once COB flat files or NCPDP files are accepted and translated into the appropriate outbound format(s), COBC will cross the claims to the COBA trading partner. The format of the Claims Response File that will be returned to each Medicare contractor by the COBC, following its COB 837 flat file or NCPDP file transmission, appears in the table below. (See §70.6.1 for specifications regarding the receipt and processing of the COBC Detailed Error Reports.)

Claims Response File Layout (80 bytes)				
Field	Name	Size	Displacement	Description
1.	Contractor Number	5	1-5	Contractor Identification Number
2.	Transaction Set Control Number/Batch Number	9	6-14	Found within the ST02 data element from the ST segment of the X12N 837 flat file or in field 806-5C from the batch header of the NCPDP file.
3.	Number of claims	9	15-23	Number of Claims contained in the X12N 837 flat file or NCPDP file. This is a numeric field that will be right justified and zero-filled.
4.	Receipt Date	8	24-31	Receipt Date of X12N 837 flat file or NCPDP file in CCYYMMDD format
5.	Accept/Reject indicator	1	32	Indicator of either the acceptance or rejection of the X12N 837 flat file or NCPDP file. Values will either be an "A" for accepted or "R" for rejected.
6.	Filler	48	33-80	Spaces

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

COB 837 flat files and NCPDP files that will be transmitted by the Medicare contractor to the COBC will be assigned the following file names, regardless of whether a COBA trading partner is in test or production mode:

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

Note that "xxxxx" denotes the Medicare contractor number.

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

Files transmitted by the Medicare contractor to the COBC shall be stored for 51 business days from the date of transmission.

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

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

E. The COBA Medigap Claim-Based Process Involving CWF

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

F. COBA Customer Service Issues

1. Customer Service

    a. Medicare Contractors shall use the COBC and CMS COBA Problem Inquiry Request Form to identify and send COBA related problems and issues to the COB contractor for research.

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

    CMS is also requiring Medicare contractors to use the COBA Problem Inquiry Request Form when requesting a COBC representative to research a COBA issue. The combined COBC-CMS COBA Problem Inquiry Request Form appears below.

MEDICARE CONTRACTOR: COBA PROBLEM INQUIRY REQUEST FORM

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

Contractor ID**# (Enter the Contractor ID # assigned by CMS)**		
Contractor Reference ID (If applicable - BHT03)		
Reported By **(Enter submitter's last name, first name)**		
Date Submitted (Enter current date – MM/DD/YR)		
Contact # (Enter submitter's phone #)		

E-mail Address (Enter submitter's e-mail address)		
COBA ID #		

Description of Problem (Check applicable category)

☐ **HIPAA Error Code**

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

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

File Name	
Transmission Date	

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

COBC USE ONLY. Date: Ticket #:

IV. Identification of Mass Adjustments for COBA Crossover Purposes

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

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

Working Definition of "Mass Adjustment"

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

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

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

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

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

If contractors send values other than "M" or "O" within the newly designated field within the header of their HUBC, HUDC, HUIP, HUOP, HUHH, or HUHC entry code "5" or action code "3" claims, CWF shall apply an edit to reject the claims back to the contractor. Upon receipt of

the CWF rejection edit, the contractors' systems shall correct the invalid value and retransmit the claims to CWF for verification and validation.

V. Special 835 ERA and MSN Requirements for Health Care Pre-Payment Plans (HCPPs) that Receive Crossover Claims

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

Upon receipt of a BOI reply trailer (29) that contains **only** a COBA ID in the range 89000 through 89999, the contractor's shared system shall suppress **all** crossover information (including name of the insurer; generic message; and specific code (for 835 ERA, code MA-18; for MSN, code 35.1) indicating that the claim will be crossed over) from the associated 835 ERA and beneficiary MSN. (See §70.6.1 of this chapter for contractor requirements relating to the COBC Detailed Error Report processes and receipt of claims that contain COBA ID range 89000 through 89999.)

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

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

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

(Rev. 2189, Issued: 04-04-11, Effective: 04-01-11, Implementation: 04-04-11)

Effective with the July 2005 release, CMS will implement an automated process to notify physicians, suppliers, and providers that specific claims that were previously tagged by the Common Working File (CWF) for crossover will not be crossed over due to claim data errors. Claims transmitted via 837 flat file by the Medicare contractor systems to the COBC may be rejected at the flat file level, at an HIPAA ANSI pre-edit validation level, or by trading partners as part of a financial dispute arising from an invoice received. By contrast, claims transmitted via NCPDP file will be rejected only at the flat file and trading partner dispute levels. Effective with the April 2005 release, the contractor systems will have begun to populate the BHT 03 (Beginning of Hierarchical Reference Identification) portion of their 837 COB flat file submissions to the COBC with a unique 22-digit identifier. This unique identifier will enable the COBC to successfully tie a claim that is rejected by the COBC at the flat file or HIPAA ANSI pre-edit validation levels as well as claims disputed by trading partners back to the original 837 flat file submissions.

Effective with October 4, 2005, contractors or their shared systems will receive notification via the COBC Detailed Error Reports, whose file layout structures appear below, that a COBA

trading partner is in test or production mode via the BHT 03 identifier that is returned from the COBC.

Effective with April 3, 2011, all Medicare contractors shall begin an extra 1-byte "Original versus Adjustment Claim Indicator" value within the BHT03 identifier on all 837 institutional and professional claims they transmit to the COBC for crossover purposes. The COBC shall, in turn, return this value to the appropriate Medicare contractor via the COBC Detailed Error Report process. In addition, the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) shared system shall send an additional 1-byte value (defined as "reserved for future use") as spaces in field 504-F4 (Message) of the NCPDP flat file sent to the COBC. The COBC shall, in turn, also return this value to the appropriate Medicare contractor via the COBC Detailed Error Report process.

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

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

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

a. Contractor number (9-bytes; until the 9-digit contractor number is used, report the 5-digit contractor number, left-justified, with spaces for the remaining 4 positions);

b. Julian date as YYDDD (5 bytes);

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

d. Claim version indicator (2 bytes, numeric, to denote claim version)
**Acceptable values=40 (for 4010A1 version claims), 50 (for 5010 claims), 11 (for NCPDP 5.1 claims), and 20 (for NCPDP D.0 claims);

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

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

O—for original claims;

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

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

S—for mass adjustment claims—all others;

R—for RAC adjustment claims, and

A—for routine adjustment claims, not previously classified.

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

2. NCPDP 23-Digit Unique Identifier

Effective with April 3, 2011, the DMERC/DME Medicare Administrative Contractor (DME MAC) contractor system shall also adopt a unique 23-digit format, referenced directly above under "Populating the BHT 03 Portion of the 837 Flat File." However, the system shall populate the unique 23-digit identifier (defined as "future use") with spaces in field 504-F4 (Message) within the NCPDP file (field length=35 bytes). The DMERC/DME MAC contractor system shall populate the unique identifier, left justified, in the field. Spaces shall be used for the remaining bytes in the field.

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

The contractor systems shall accept the COBC Institutional, Professional, and NCPDP Detailed Error Reports received from the COBC. The formats for each of the Detailed Error Reports appear below.

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

In addition, contractors and their systems shall now base their decision making calculus for initiation of a claims repair of "111" (flat file) errors upon the number of errors received rather than upon an established percent parameter, as otherwise described within this section.

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

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

COBC Detailed Error Report

Institutional Error File Layout
(Detail Record)

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

Institutional Error File Layout – (Summary Record)

1. Date	**8**	**1-8**
2. Total Number of Claims For Processing Date	**10**	**9-18**
3. Number of ‘111’ Errors	**10**	**19-28**
4. Number of ‘222’ Errors	**10**	**29-38**
5. Percentage of ‘222’ Errors	**3**	**39-41**
6. Number of ‘333’ Errors	**10**	**42-51**
7. Percentage of ‘333’ Errors	**3**	**52-54**
8. Filler	**19**	**55-73**
9. Summary Record Id (Error Source Code)	**3**	**74-76 (‘999’)**
10. Filler	524	77-600

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

COBC Detailed Error Report

Professional Error File Layout
(Detail Record)

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

Professional Error File Layout – (Summary Record)

1. Date	**8**	**1-8**
2. Total Number of Claims For Processing Date	**10**	**9-18**
3. Number of ‘111’ Errors	**10**	**19-28**
4. Number of ‘222’ Errors	**10**	**29-38**
5. Percentage of ‘222’ Errors	**3**	**39-41**
6. Number of ‘333’ Errors	**10**	**42-51**
7. Percentage of ‘333’ Errors	**3**	**52-54**
8. Filler	**19**	**55-73**
9. Summary Record Id (Error Source Code)	**3**	**74-76 (‘999’)**
10. Filler	524	77-600

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

COBC Detailed Error Report

NCPDP Error File Layout
(Detail Record)

1.	**Date**	**8**	**1-8**
2.	**Batch Number**	**7**	**9-15**
3.	**COBA-ID**	**5**	**16-20**
4.	**HICN**	**12**	**21-32**
5.	**CCN**	**14**	**33-46**
6.	**Record Number**	**9**	**47-55**
7.	**Batch Record Type**	**2**	**56-57**
8.	**Segment ID**	**2**	**58-59**
9.	**Error Source Code**	**3**	**60-62 ('111' or '333')**
10.	**Error/Trading Partner Dispute Code**	**6**	**63-68**
11.	**Error Description**	**100**	**69-168**
12.	**Field Contents**	**50**	**169-218**
13.	**Unique File Identifier**	**30**	**219-248** (23 bytes used)
14.	**CCN**	**23**	**249-271**
15.	**Filler**	**18**	**272-289**

NCPDP Error File Layout – (Summary Record)

1.	**Date**	**8**	**1-8**
2.	**Total Number of Claims For Processing Date**	**10**	**9-18**
3.	**Number of '111' Errors**	**10**	**19-28**
4.	**Number of '333' Errors**	**10**	**29-38**
5.	**Percentage of '333' Errors**	**3**	**39-41**
6.	**Filler**	**18**	**42-59**
7.	**Summary Record Id (Error Source Code)**	**3**	**60-62 ('999')**
8.	**Filler**	**227**	**63-289**

If the COB Contractor has rejected back to the contractor system for 2 or more COBA Identification Numbers (IDs), the contractor system shall receive a separate error record for each COBA ID. Also, if a file submission from a contractor system to the COBC contains multiple provider, subscriber, or patient level errors for one COBA ID, the system will receive a separate

error record for each provider, subscriber, or patient portion of the file on which errors were found.

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

1. Error Source Code

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

The DME MACs, or their shared system, will only receive error source codes for a flat file error ("111") and for a trading partner dispute ("333"). Both error types shall be used to identify shared system changes necessary to prevent future errors and notify physicians, suppliers, and providers that claims with error source codes of "111" and "333" will not be crossed over to the COBA trading partner.

2. Time frames for Notification of Contractor Financial Management Staff and Providers

Contractors, or their shared systems, shall provide notification to contractor financial management staff for purposes of maintaining an effective reconciliation of crossover fee/ complementary credit accruals within five (5) business days of receipt of the COBC Detailed Error Report.

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

a) Special Automated Provider Correspondence

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

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

Number (DCN), Health Insurance Claim (HIC) number, Medical Record Number (for Part A only), Patient Control Number (only if it is contained in the claim), beneficiary name, date of service, and the date claim was processed.

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

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

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

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

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

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

b) Special Exemption from Generating Provider Notification Letters

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

000120 (duplicate ST-SE), all contractor systems shall automatically suppress generation of the special provider notification letters, as would normally be required in accordance with this section as well as §70.6.3 of this chapter.

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

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

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

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

1) Suppress generation of the special provider letters; and

2) Not update their affiliated contractors' claims histories to indicate that the COBC will **not** be crossing the affected claims over.

70.6.1.1 - Coordination of Benefits Agreement (COBA) 837 5010 Coordination of Benefits (COB) Flat File Errors

(Rev. 1844; Issued: 11-06-09; Effective Date: 04-01-10; Implementation Date: 04-05-10)

Effective with the implementation of the Health Insurance Portability and Accountability Act (HIPAA) 837 5010 COB requirements, the Coordination of Benefits Contractor (COBC) will return the error codes shown in the chart below to Medicare contractors whose flat file submissions lack structural elements necessary for the building of outbound HIPAA compliant crossover claims.

The shared systems shall, in addition, make modifications to any "111" error tables that they maintain, in accordance with the following charts, **only** in association with 837 5010 COB flat files.

COBC DETAILED ERROR REPORT "111" ERROR CRITERIA FOR 837 VERSION 5010

INSTITUTIONAL COB CLAIMS

Error Code	Error Description	Control #	COBA ID	HICN	CCN	Loop ID	Segment	Element	Content	BHT 03	Reject Level
100	No ST Segment	NO	NO	NO	NO	NO	YES	NO	NO	NO	HEAD
101	No BHT Segment	YES	NO	NO	NO	NO	YES	NO	NO	NO	HEAD
103	Missing 1000A Records	YES	NO	NO	NO	YES	YES	NO	NO	YES	HEAD
104	Missing 1000B Records	YES	NO	NO	NO	YES	YES	NO	NO	YES	HEAD
105	Invalid 1000A.NM109	YES	NO	NO	NO	YES	YES	YES	YES	YES	HEAD
110	Invalid 1000B.NM103	YES	NO	NO	NO	YES	YES	YES	YES	YES	HEAD
115	Invalid 1000B.NM109	YES	YES	NO	NO	YES	YES	YES	YES	YES	HEAD
120	Multiple 1000A per ST/SE	YES	NO	NO	NO	YES	YES	NO	NO	YES	HEAD

Error Code	Error Description	Control #	COBA ID	HICN	CCN	Loop ID	Segment	Element	Content	BHT 03	Reject Level
125	Multiple 1000B per ST/SE	YES	NO	NO	NO	YES	YES	NO	NO	YES	HEAD
199	All 2000B Rejected	YES	YES	NO	NO	YES	YES	NO	NO	YES	HEAD
200	Missing 2000A	YES	YES	NO	NO	YES	YES	NO	NO	YES	PROV
201	Missing 2010AA	YES	YES	NO	NO	YES	YES	NO	NO	YES	PROV
210	Multiple 2010AA per 2000A	YES	YES	NO	NO	YES	YES	NO	NO	YES	PROV
211	Multiple 2010AB per 2000A	YES	YES	NO	NO	YES	YES	NO	NO	YES	PROV
212	Invalid presence of 2010AC per 2000A	YES	YES	NO	NO	YES	YES	NO	NO	YES	PROV
300	Missing 2000B	YES	YES	NO	NO	YES	YES	NO	NO	YES	SUB
301	Missing 2010BA	YES	YES	NO	NO	YES	YES	NO	NO	YES	SUB
302	Missing 2010BB Loop	YES	YES	YES	NO	YES	YES	NO	NO	YES	SUB
305	Multiple 2010BB per 2000B	YES	YES	YES	NO	YES	YES	NO	NO	YES	SUB

Error Code	Error Description	Control #	COBA ID	HICN	CCN	Loop ID	Segment	Element	Content	BHT 03	Reject Level
306	Multiple 2010BA per 2000B	YES	YES	YES	NO	YES	YES	NO	NO	YES	SUB
310	2010BB.NM109 not equal 1000B.NM109	YES	YES	YES	NO	YES	YES	YES	YES	YES	SUB
320	2010BB.N3 not equal spaces	YES	YES	YES	NO	YES	YES	YES	YES	YES	SUB
321	2010BB.N4 not equal spaces	YES	YES	YES	NO	YES	YES	YES	YES	YES	SUB
351	More than 100 2300 per 2000B	YES	YES	YES	NO	YES	YES	NO	NO	YES	SUB
355	2300 REF01 Equal F5 Missing	YES	YES	YES	NO	YES	YES	NO	NO	YES	SUB
356	2300 HI Invalid	YES	YES	YES	NO	YES	YES	NO	NO	YES	SUB
399	All 2300 Loops Rejected	YES	YES	YES	NO	YES	YES	NO	NO	YES	SUB
400	2010CA Found	YES	YES	YES	NO	YES	YES	NO	NO	YES	
500	2300 Not Found	YES	YES	YES	NO	YES	YES	NO	NO	YES	CLM
505	2320 Not Found	YES	YES	YES	NO	YES	YES	NO	NO	YES	CLM

Error Code	Error Description	Control #	COBA ID	HICN	CCN	Loop ID	Segment	Element	Content	BHT 03	Reject Level
506	# of 2320 Loops GT 10	YES	YES	YES	YES	YES	YES	NO	NO	YES	CLM
507	2320 OI Not Found	YES	YES	YES	YES	YES	YES	NO	NO	YES	CLM
515	2400 Not Found	YES	YES	YES	YES	YES	YES	NO	NO	YES	CLM
520	# of 2400 Loops GT 999	YES	YES	YES	YES	YES	YES	NO	NO	YES	CLM
575	2330A Not Found	YES	YES	YES	NO	YES	YES	NO	NO	YES	CLM
576	2330B Not Found	YES	YES	YES	NO	YES	YES	NO	NO	YES	CLM
580	2320.SBR01 not equal P (must be at least one “P” segment)	YES	YES	YES	NO	YES	YES	YES	YES	YES	CLM
581	2320.SBR Field Invalid (SBR09 does not equal MB when Medicare is primary in SBR01)	YES	YES	YES	NO	YES	YES	NO	NO	YES	CLM
590	Multiple 2330A	YES	YES	YES	NO	YES	YES	NO	NO	YES	CLM
591	Multiple 2330B	YES	YES	YES	NO	YES	YES	NO	NO	YES	CLM

Error Code	Error Description	Control #	COBA ID	HICN	CCN	Loop ID	Segment	Element	Content	BHT 03	Reject Level
595	2330B.REF02 Equal	YES	YES	YES	YES	YES	YES	YES	YES	YES	CLM
596	2330B.NM109 Invalid COBA ID (Not Used)	YES	YES	YES	YES	YES	YES	YES	YES	YES	CLM
597	2330B REF not found	YES	YES	YES	YES	YES	YES	YES	YES	YES	CLM
598	2330B NM103 equals spaces and invalid COBA ID in 2330B NM109	YES	YES	YES	YES	YES	YES	YES	YES	YES	CLM
610	# of 2430 Loops greater than 15	YES	YES	YES	YES	YES	YES	NO	NO	YES	CLM
620	2430.SVD01 not equal 1000A.NM109	YES	YES	YES	YES	YES	YES	YES	NO	YES	CLM
999	SE Segment Missing	YES	YES	NO	NO	NO	YES	NO	NO	YES	HEAD

COBC DETAILED ERROR REPORT "111" ERROR CRITERIA FOR PROFESSIONAL COB CLAIMS

Error Code	Error Description	Control #	COBA ID	HICN	CCN	Loop ID	Segment	Element	Content	BHT 03	Reject Level
100	No ST Segment	NO	NO	NO	NO	NO	YES	NO	NO	NO	HEAD
101	No BHT Segment	YES	NO	NO	NO	NO	YES	NO	NO	NO	HEAD
103	Missing 1000A Records	YES	NO	NO	NO	YES	YES	NO	NO	YES	HEAD
104	Missing 1000B Records	YES	NO	NO	NO	YES	YES	NO	NO	YES	HEAD
105	Invalid 1000A.NM109	YES	NO	NO	NO	YES	YES	YES	YES	YES	HEAD
110	Invalid 1000B.NM103	YES	NO	NO	NO	YES	YES	YES	YES	YES	HEAD
115	Invalid 1000B.NM109	YES	YES	NO	NO	YES	YES	YES	YES	YES	HEAD
120	Multiple 1000A per ST/SE	YES	NO	NO	NO	YES	YES	NO	NO	YES	HEAD
125	Multiple 1000B per ST/SE	YES	NO	NO	NO	YES	YES	NO	NO	YES	HEAD

Error Code	Error Description	Control #	COBA ID	HICN	CCN	Loop ID	Segment	Element	Content	BHT 03	Reject Level
199	All 2000B Rejected	YES	YES	NO	NO	YES	YES	NO	NO	YES	HEAD
200	Missing 2000A	YES	YES	NO	NO	YES	YES	NO	NO	YES	PROV
201	Missing 2010AA	YES	YES	NO	NO	YES	YES	NO	NO	YES	PROV
210	Multiple 2010AA per 2000A	YES	YES	NO	NO	YES	YES	NO	NO	YES	PROV
211	Multiple 2010AB per 2000A	YES	YES	NO	NO	YES	YES	NO	NO	YES	PROV
212	Invalid presence of 2010AC per 2000A	YES	YES	NO	NO	YES	YES	NO	NO	YES	PROV
300	Missing 2000B	YES	YES	NO	NO	YES	YES	NO	NO	YES	SUB
301	Missing 2010BA	YES	YES	NO	NO	YES	YES	NO	NO	YES	SUB
302	Missing 2010BB Loop	YES	YES	YES	NO	YES	YES	NO	NO	YES	SUB
305	Multiple 2010BB per 2000B	YES	YES	YES	NO	YES	YES	NO	NO	YES	SUB
306	Multiple 2010BA per 2000B	YES	YES	YES	NO	YES	YES	NO	NO	YES	SUB

Error Code	Error Description	Control #	COBA ID	HICN	CCN	Loop ID	Segment	Element	Content	BHT 03	Reject Level
310	2010BB.NM109 not equal 1000B.NM109	YES	YES	YES	NO	YES	YES	YES	YES	YES	SUB
320	2010BB.N3 not equal spaces	YES	YES	YES	NO	YES	YES	YES	YES	YES	SUB
321	2010BB.N4 not equal spaces	YES	YES	YES	NO	YES	YES	YES	YES	YES	SUB
351	More than 100 2300 per 2000B	YES	YES	YES	NO	YES	YES	NO	NO	YES	SUB
355	2300 REF01 Equal F5 Missing	YES	YES	YES	NO	YES	YES	NO	NO	YES	SUB
356	2300 HI Invalid	YES	YES	YES	NO	YES	YES	NO	NO	YES	SUB
399	All 2300 Loops Rejected	YES	YES	YES	NO	YES	YES	NO	NO	YES	SUB
400	2010CA Found	YES	YES	YES	NO	YES	YES	NO	NO	YES	
500	2300 Not Found	YES	YES	YES	NO	YES	YES	NO	NO	YES	CLM
505	2320 Not Found	YES	YES	YES	NO	YES	YES	NO	NO	YES	CLM
506	# of 2320 Loops GT 10	YES	YES	YES	YES	YES	YES	NO	NO	YES	CLM

Error Code	Error Description	Control #	COBA ID	HICN	CCN	Loop ID	Segment	Element	Content	BHT 03	Reject Level
507	2320 OI Not Found	YES	YES	YES	YES	YES	YES	NO	NO	YES	CLM
515	2400 Not Found	YES	YES	YES	YES	YES	YES	NO	NO	YES	CLM
520	# of 2400 Loops GT 50	YES	YES	YES	YES	YES	YES	NO	NO	YES	CLM
575	2330A Not Found	YES	YES	YES	NO	YES	YES	NO	NO	YES	CLM
576	2330B Not Found	YES	YES	YES	NO	YES	YES	NO	NO	YES	CLM
580	2320.SBR01 not Equal P (must be at least one “P” segment)	YES	YES	YES	NO	YES	YES	YES	YES	YES	CLM
581	2320.SBR Field Invalid (SBR09 does not equal MB when Medicare is primary in SBR01)	YES	YES	YES	NO	YES	YES	NO	NO	YES	CLM
590	Multiple 2330A	YES	YES	YES	NO	YES	YES	NO	NO	YES	CLM
591	Multiple 2330B	YES	YES	YES	NO	YES	YES	NO	NO	YES	CLM
595	2330B.REF02 Equal	YES	YES	YES	YES	YES	YES	YES	YES	YES	CLM

Error Code	Error Description	Control #	COBA ID	HICN	CCN	Loop ID	Segment	Element	Content	BHT 03	Reject Level
596	2330B.NM109 Invalid COBA ID (Not Used)	YES	YES	YES	YES	YES	YES	YES	YES	YES	CLM
597	2330B REF not found	YES	YES	YES	YES	YES	YES	YES	YES	YES	CLM
598	2330B NM103 equals spaces and invalid COBA ID in 2330B NM109	YES	YES	YES	YES	YES	YES	YES	YES	YES	CLM
610	# of 2430 Loops greater than 15	YES	YES	YES	YES	YES	YES	NO	NO	YES	CLM
620	2430.SVD01 not equal 1000A.NM109	YES	YES	YES	YES	YES	YES	YES	NO	YES	CLM
999	SE Segment Missing	YES	YES	NO	NO	NO	YES	NO	NO	YES	HEAD

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

(Rev. 727, Issued: 05-01-09, Effective: 10-01-09, Implementation: 10-05-09)

Effective with the July 2006 release, CMS will implement a full claim file repair process at its Medicare contractors to address situations where one or more of the contractor shared systems inadvertently introduced a severe error condition into the claims processing cycle, with the effect being that the Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X12-N 837 Coordination of Benefits (COB) Institutional and Professional crossover claims files or National Council for Prescription Drug Programs (NCPDP) claim files become unusable for COB purposes**.**

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

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

1. Medicare Contractor or Shared System Identification of a Full Claim File Problem and Subsequent Actions

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

The contractor shall work closely with its system maintainer to determine the timeframes for developing, testing, and applying a fix to correct the severe error(s) that was/were identified within the 837 or NCPDP files that were previously transmitted to the COBC. The Part A, Part B, or DME MAC shared system maintainers shall then report the timeframes for developing, testing, and applying a fix to the full claim file problem in accordance with their procedures as outlined in their systems maintenance contract. If CMS determines that the time frames for affecting a full claim file repair of the previously transmitted claims exceed what is considered reasonable (a maximum of 14 work days, unless determined otherwise by CMS), a designated COBA team representative will notify the Medicare contractors and their shared system maintainers via e-mail to abort the full claim file repair process. (**NOTE**: This process will remain unchanged with the transition to claim version 5010.)

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

2. Alerting Contractors to the Possible Need for a Full Claim File Repair via the COBC Detailed Error Reports and Subsequent Contractor Actions

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

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

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

contractor shall continue with the generation of the provider notification letters for those errors while it is analyzing the "111" severe error(s).)

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

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

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

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

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

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

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

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

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

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

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

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

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

c. Contractor Actions Following Suppression of the Special Provider Notification Letters to Analyze Possible Severe Error Conditions

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

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

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

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

3. Steps for Ensuring that Only “Repaired” Claims are Re-transmitted to the COBC

Once the contractors' shared systems have determined that they are able to affect a "timely" repair to the full claim files that were previously transmitted to the COBC, they shall take the following actions:

a.) Apply the fix to the unusable claims;

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

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

d.) Recreate the job; and

e.) Send only the "repaired" claims to the COBC.

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

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

4. COBA 4010-A1 to 5010 Transitional Requirements

A. <u>Repairing 5010 Flat File ("111") Errors</u>

As is true of the current COBA crossover process involving the usage of 4010-A1 claims, all Medicare contractors shall effectuate repair of even one "111" errored 5010 COB claim if the COBA trading partner is currently in 5010 "production" mode. (**NOTE:** Parties interested in previewing a listing of all "111" errors that the COBC will apply to incoming 5010 COB flat files should refer to §70.6.1.1 of this chapter.) The shared systems shall accept the "111" error codes (see §70.6.1.1 of this chapter) that the COBC generates during its application of business level editing to incoming 837 5010 COB flat files. The shared systems shall make modifications to any "111" error tables that they maintain <u>**only**</u> in association with 837 5010 COB flat files.

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

B. Repairing "222" and "333" Errors Associated with 5010 Claims

Contractors and their shared systems shall repair "222" or "333" errors in association with "production" 5010 claims if the error percentage meets or exceeds four (4) percent.

As happens with 4010-A1 claim repairs currently, contractors shall alert their shared system or Data Center, as per established protocol, for purposes of initiating each needed claims repair process in association with 5010 COB claims. **IMPORTANT:** As is true of 4010-A1 claims, contractors that wish to effectuate a repair of 5010 "production" claims whose error percentage falls below four (4) percent shall contact a member of the CMS COBA team before attempting that action. (**NOTE:** As a rule, CMS will grant approval for such a repair if the volume of errored claims justifies that action **and** if the timeframe for repair is acceptable.)

In accordance with §70.6.1 of this chapter, Medicare contractors shall issue special provider notification letters in those instances where 1) error percentages for "222" and "333" errors fall below four (4) percent; 2) the volume of errors on "production" 5010 COB is **not** substantial enough to cause the Medicare contractor to request a claims repair; or 3) the timeframes for claim repair, as determined by the associated shared system, are **not** acceptable to CMS.

C. Generally Applicable Requirements

While Medicare contractors are **not** expected to initiate the repair of "test" 4010-A1 claims or "test" 5010 claims, they shall 1) continue to monitor the COBC Detailed Error Reports; and 2) notify their shared systems of errors returned so that necessary shared system changes to improve HIPAA compliance rates may be realized.

D. New Date Parameter Logic and Cutover Claims Repair Requirements

To ensure appropriate cutover to the HIPAA 5010 COB flat file format, all shared systems shall develop new date parameter logic to become operational as of January 1, 2012. All shared systems shall ensure that the new logic addresses all of the following scenarios: repairing any errored 4010-A1 claims in the 5010 claim format; converting claims held in suspense from a 4010-A1 format to the 5010 claim format; converting previously adjudicated 4010-A1 claims to the 5010 "skinny" non-SFR COB claim format

in adjustment claim situations; and converting claims held in "provider alert status" from a 4010-A1 (or earlier) format to the 5010 "skinny' non-SFR COB claim format.

For claims repair scenarios involving claims previously sent to the COBC in the 4010-A1 format just prior to January 1, 2012, shared systems shall retransmit repaired claims to the COBC in the 5010 format. To that end, all shared systems shall utilize CMS-issued 5010 mapping and gap-filling guidance provided in chapter 24 §40.4 and chapter 28 §70.6.5 of Pub.100-04 when repairing their originally transmitted 4010-A1 errored crossover claims in the HIPAA 5010 claim format on and after January 1, 2012. In addition, the shared systems shall apply 5010 non-SFR "skinny" logic to claim repair situations where they originally transmitted claims to the COBC prior to January 1, 2012 in the 4010-A1 claim format.

IMPORTANT: Contractors shall **not** repair errored 4010-A1 claims that they transmitted to the COBC just prior to January 1, 2012 if the errors returned via the COBC Detailed Error Report relate to a field or segment that no longer exists in the 5010 claim format. Instead, contractors shall issue provider notification letters for those errored claims to the affected providers.

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

(Rev. 1727, Issued: 05-01-09, Effective: 10-01-09, Implementation: 10-05-09)

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

During the transitional period from the 4010-A1 to 5010 COB claim format (January 2010 to December 31, 2011), all requirements indicated above and below will remain intact, except that the shared system shall recover claims in the claim format (4010-A1 or 5010 that the COBC specifies to each affected Part A or Part B contractor's crossover contacts. As of January 1, 2012, all contractors shall utilize the 5010 COB claims format in association with claims recovery activities.

Following the telephone discussion between the CMS and the Medicare contractor crossover staff, the COBA eligibility file recovery process will further unfold as detailed below.

1. Receipt and Processing of the COBC COBA Eligibility File and Searching Claims History for the Needed Claims

After the COBC sends the contractor copies of the trading partner's COBA eligibility file(s), which will be prepared in accordance with the CMS proprietary format, the contractor shall initiate recovery of the processed claims within the contractor's claims history that meet the beneficiaries' eligibility dates, as provided on the COBC eligibility file(s), and that fall within the specified CWF date span or date of service parameters, or both, that CMS has provided to the contractor. (**NOTE**: The COBC will transmit the COBA eligibility file to the Medicare contractors through its existing Network Data Mover (NDM) connection with each contractor.)

2. Time Frames for Recovery

The contractor shall complete its claims recovery process, culminating with transmission of the recovered claims to the COBC, within eight (8) work days following the date that it receives the COBC COBA eligibility file.

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

Contractors shall perform the following activities related to the COBA eligibility file:

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

b) Apply the specified CWF date span; or

c) Apply the date of service parameters; or

d) Both items b and c above.

Once the Medicare contractor, working with its Data Center, has recovered the specified claims, it shall copy the COBA ID from the COBC COBA eligibility file (field E01.002) and place it within the NM109 segment of the 1000B loop of the flat file containing the recovered Part A and B claims.

4. Scope of the Claims Recovery Effort

Neither the contractor nor its Data Center shall be required to search archived claims history while fulfilling the COBA eligibility file claims recovery process.

The contractor and its Data Center shall not be required to apply the COBA production trading partner's selection criteria before transmitting the recovered claims to the COBC.

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

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

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

6. Preparation and Transmission Requirements

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

Contractor Data Centers shall transmit the recovered claims to the COBC via a separate 837 flat file transmission. Contractors shall transmit the recovered claims to the COBC using the following dataset names:

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

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

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

Contractor Data Centers shall send no more than 100,000 recovered claims (which equates to 20 ST-SE envelopes per contractor with 5,000 claims per envelope) to the COBC per transmission.

Contractor Data Centers shall transmit recovered claims files to the COBC via the existing Network Data Mover (NDM) connectivity that they have with that entity.

7. Marking Claims History To Assist Customer Service Efforts

When the contractor or its Data Center transmits the recovered claims to the COBC, the contractor shall mark its claims history to indicate that each claim was recovered and transmitted to the COBC to be crossed over to the COBA trading partner.

Contractors shall notify their customer service representatives that they will be able to determine that recovered claims were sent to the COBC by referencing claims history.

8. COBC Detailed Error Report Processes In Relation to the Claims Recovery Process

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

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

9. The Possibility of Repairing COBA Recovery Claims

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

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

Unlike the process documented in §70.6.2 of this chapter, contractors shall transmit 'repaired' COBA recovery claims to the COBC via the separate 837 flat file transmission for recovery claims, as described within "Preparation and Transmission Requirements" above.

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

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

10. COBA Claims Recovery Financial Management Processes

The CMS will reimburse the contractor for individual claims accepted by the trading partner at the per claim rates published in the current Budget and Performance Requirements document. Contractors shall not establish accruals for the recovered claims with BHT-03 identifiers that end with 'R' due to the certainty that numerous claims will be rejected by the COBA trading partner as not meeting its claims selection criteria.

Medicare contractor financial staff shall report reimbursements on recovered claims for the COBA crossover process on the 'COB Credits' line as part of the contractor's monthly Interim Expenditure Report (IER). (**NOTE**: The contractors' systems shall develop a separate report for their associated Medicare contractors to enable them to fulfill the foregoing requirements.)

Contractors shall charge their costs for each individual COBA recovery process to Activity Code 11207 or include them within any other cost reporting mechanism needed to capture costs incurred in support of the national COBA crossover process.

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

(Rev. 1420; Issued: 01-25-08; Effective: 10-01-07; Implementation: 02-01-08)

The Centers for Medicare & Medicaid Services (CMS) plans to transfer the mandatory Medigap ("claim-based") crossover function from its Medicare Part B contractors, including Medicare Administrative Contractors (MACs), and Durable Medical Equipment Medicare Administrative Contractors (DMACs) effective October 1, 2007. During the period from June through September 2007, CMS envisions that its COBC will have signed national crossover agreements with all the Medigap claim-based crossover recipients, assigned new Medigap claim-based COBA IDs to these entities, and successfully tested the new process with these insurers in anticipation of the new COBA Medigap claim-based crossover process being inaugurated on October 1, 2007. The COBC will assign the new claim-based COBA IDs to the Medigap insurers on a graduated basis throughout the three month period. CMS will regularly apprise the affected Medicare contractors when they have assigned new COBA Medigap claim-based IDs to the Medigap insurers and will post this information on its COB Web site so that contractors may direct providers to that link for purposes of obtaining regular updates. For this purpose, CMS will be making a "Medigap Claim-based Billing Identifier" spreadsheet available on the Coordination of Benefits Contractor (COBC) website. The COBC will **not** populate the spreadsheet until after 1) it has signed a national crossover agreement with a Medigap insurer, and 2) that insurer has tested the Medigap claim-based crossover process with the COBC.

Per a CMS directive issued on September 18, 2007, all Part B contractors, including MACs, and DMACs shall **not** be required to perform file maintenance to include the newly assigned COBA Medigap claim-based ID within their insurer tables in advance of October 1, 2007. The indicated contractors may retain their older Other Carrier Name and Address

(OCNA) or N-key identifiers within their internal insurer files/tables for purposes of avoiding system abends or for the printing of post-hoc beneficiary-requested Medicare Summary Notices (MSNs). However, contractors shall have disabled the logic that they formerly used to tag claims for crossover to Medigap insurers effective prior to claims they received for processing on October 1, 2007.

Effective with claims filed to Medicare on October 1, 2007, all participating providers that have been granted a billing exception under the Administrative Simplification Compliance Act (ASCA) shall be required to enter CMS' newly assigned Coordination of Benefits Agreement (COBA) Medigap claim-based identifier (ID) within block 9-D of the incoming CMS-1500 claim for purposes of triggering Medigap claim-based crossovers. All other participating providers shall enter the newly assigned COBA Medigap claim-based ID within the NM109 portion of the 2330B loop of the incoming HIPAA ANSI X12-N 837 professional claim and within field 301-C1 of the T04 segment on incoming National Council for Prescription Drug Programs (NCPDP) claims for purposes of triggering Medigap claim-based crossovers. These provider requirements will be addressed at greater length via a separate future non-systems instruction.

Effective with October 1, 2007, Medigap claim-based crossovers will occur exclusively through the Coordination of Benefits Contractor (COBC) in the Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X12-N 837 professional claim format (version 4010A1 or more current standard).

A. Changes to Contractor Up-Front Screening Processes for COBA Claim-based Medigap Crossovers

The affected contractors' processes for screening incoming claims for Medigap claim-based crossovers shall feature a syntactic editing of the incoming COBA claim-based Medigap ID to ensure that the identifier begins with a "5" and contains 5 numeric digits. Additionally, for incoming 837 or NCPDP claims, the Medigap claim-based COBA ID must be included within the appropriate designated fields, as indicated above.

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

If the provider-populated value for the claim-based Medigap ID passes the contractor's syntactic editing process, the affected contractors' systems shall copy the claim-based Medigap COBA ID value from the incoming claim to the first 10-byte iteration of field

34 of the HUBC or HUDC claims transactions that are sent to CWF for verification and validation.

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

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

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

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

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

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

Special Note Regarding Information to Print on the MSN and ERA

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

C. CWF Processing for COBA Claim-based Medigap Crossovers

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

The CWF shall then perform a duplicate check to determine if the beneficiary is identified for crossover to a **"production"** Medigap eligibility file-based insurer (COBA ID 30000-54999) and to a claim-based Medigap insurer (COBA ID 0000055000 to 0000059999). If CWF determines that the beneficiary is identified for crossover to both a **"production"** Medigap eligibility file-based insurer and a claim-based Medigap insurer, it shall suppress the BOI reply trailer (29) for the claim-based Medigap insurer (COBA ID range 0000055000 to 0000059999). After CWF has determined that beneficiary has already been identified for Medigap eligibility file-based crossover, it shall 1) mark the associated claim with indicator "AA" and, 2) display this indicator, together with the affected claim-based Medigap COBA ID, in association with the claim on the appropriate HIMR detailed history screen in the "claim-based crossover" segment. (See Pub. 100-04, chapter 27 §80.17 for more information regarding this process.)

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

D. Modification of the CWF Sort Routine For Multiple COBA IDs and Accompanying Contractor Actions Following Receipt of the BOI Reply Trailer (29)

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

1) Medigap eligibility file-based (30000-54999);
2) Medigap claim-based (55000-59999);
3) Supplemental (00000-29999);
4) TRICARE for Life (60000-69999);
5) Other insurer (80000-89999); and
6) Medicaid (70000-77999).

Upon receipt of the BOI reply trailer (29), the affected contractors shall continue to utilize information from this source to populate the beneficiary's MSN and provider ERA (or other provider remittance advice in production). The affected contractors shall continue to report the name of **only** the first listed entity returned via the BOI reply trailer 29 on the provider ERA or remittance advice if they receive multiple COBA IDs and accompanying insurer names via the BOI reply trailer 29. (Refer to chapter 27 §80.14 for additional details.)

E. Impact Upon Flat File Creation Processes

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

F. The Contractor Shut-Down Processes Pertaining to Claim-based Medigap Crossovers

All Part B contractors, including MACs, and DMACs shall ensure that the claims they sent to CWF for verification and validation **prior to** October 1, 2007 (before the installation of the October 2007 release), are tagged and crossed over via their own mandatory Medigap ("claim-based") crossover process.

The affected contractors shall modify their systems control facility (SCF) logic, or, as applicable, "MM" or other insurer screen/table logic, to cross the final claims to the Medigap claim-based crossover recipients at the point that CWF approves the claims for payment and before they finalize on their payment floor. If contractors are unable to cross the final claims over to their claim-based Medigap recipients at "approved to pay," they shall provide their rationale for not doing so in writing or via phone to a member of the COBA crossover team. The affected contractors may alternatively set a crossover time indicator date of October 1, 2007, to effectuate the crossing over of their "final" claims at the point the claims are "approved to pay."

Following transmission of their last claims files or notices to the Medigap claim-based insurers (including those claims that the contractor had already sent to CWF for verification and validation prior to October 1, 2007, but remained in suspense status until

after October 1, 2007), all Part B contractors, including MACs, and DMACs shall 1) cancel all contracts with Medigap claim-based insurers immediately, and 2) discontinue their outbound crossover transactions to Medigap claim-based recipients. These actions shall occur no later than October 31, 2007.

The affected contractors shall invoice the Medigap claim-based crossover recipients for the final claims file that they transmitted (or the final paper Notices of Medigap Claims Information [NOMCIs] mailed) to these entities. Contractors shall ensure that they do not invoice for claims that CWF tags for Medigap claim-based crossover effective with October 1, 2007. The COBC will invoice the Medigap insurers directly for these claims.

70.6.5 - Coordination of Benefits Agreement (COBA) 5010 Coordination of Benefits (COB) Requirements

(Rev. 2090, Issued: November 10, 2010, Effective Date: April 1, 2011, Implementation Date: April 4, 2011)

I. Health Insurance Portability and Accountability Act (HIPAA) 837 4010-A1 to HIPAA 5010 COB Transitional Period Requirements

During the 837 5010 transitional period, the Medicare shared systems shall accommodate the multi-faceted scenarios that follow below each broad category with respect to creation of 837 COB flat files.

INCOMING HIPAA 5010 CLAIMS IN ASSOCIATION WITH COBA TRADING PARTNER COB FORMAT SPECIFICATIONS

Scenario 1: During the 837 5010 transitional period, if a provider or supplier submits a HIPAA 837 5010 institutional or professional claim to a Medicare contractor and if the Medicare contractor receives a CWF BOI reply trailer (29) that contains a "P" 4010-A1 Test/Production indicator and a "T" 5010 indicator, the affected shared systems shall: 1) produce a "skinny" non-SFR "production" claim in the 4010-A1 837 COB flat file for transmission to the COBC; and 2) produce an 837 5010 "test" COB flat file that contains a claim with full SFR content for transmission to the COBC.

Scenario 2: If a provider or supplier submits a HIPAA 837 5010 institutional or professional claim to a Medicare contractor and if the Medicare contractor receives a CWF BOI reply trailer (29) that contains a "P" 4010-A1 Test/Production indicator and a "N" 5010 indicator, the affected shared systems shall: 1) produce a "skinny" non-SFR "production" claim in the 4010-A1 837 COB flat file for transmission to the COBC; and 2) produce nothing in terms of an 837 5010 COB flat file.

Scenario 3: If a provider of supplier submits a HIPAA 837 5010 institutional or professional claim to a Medicare contractor and if the Medicare contractor receives a CWF BOI reply trailer (29) that contains an "N" 4010-A1 Test/Production indicator and a "T" 5010 indicator, the affected shared system shall: 1) produce nothing in terms of a

4010-A1 837 COB flat file; and 2) produce a 5010 "test" claim with full SFR content for COBA testing purposes.

Scenario 4: If a provider of supplier submits a HIPAA 837 5010 institutional or professional claim to a Medicare contractor and if the Medicare contractor receives a CWF BOI reply trailer (29) that contains an "N" 4010-A1 Test/Production indicator and a "P" 5010 indicator, the affected shared system shall: 1) produce nothing in terms of a 4010-A1 837 COB flat file; and 2) produce a "production" 5010 claim with full SFR content for COBA "production" purposes.

(**NOTE:** This will be the profile of a COBA trading partner that has cut-over to 5010 COB production.)

INCOMING HIPAA 4010-A1 CLAIMS IN ASSOCIATION WITH COBA TRADING PARTNER COB FORMAT SPECIFICATIONS

Scenario 1: During the transitional period, if a provider or supplier submits an 837 4010-A1 institutional or professional claim to a Medicare Part A contractor or DME MAC and if the Medicare contractor receives a Common Working File (CWF) Beneficiary Other Insurance (BOI) reply trailer (29) that contains a "P" 4010-A1 Test/Production (4010-A1) indicator and a "T" 5010 indicator, the affected shared systems shall: 1) create an 837 COB flat file that contains full 4010-A1 store-and-forward (SFR) content for the "production" claim for transmission to the COBC; and 2) create a "skinny" non-SFR claim in the 5010 837 COB flat file format for the "test" 5010 claim and transmit the file to the COBC.

Scenario 2: If a provider or supplier submits an 837 4010-A1 institutional or professional claim to a Medicare Part A contractor or DME MAC, as appropriate, and if the Medicare contractor receives a Common Working File (CWF) Beneficiary Other Insurance (BOI) reply trailer (29) that contains a "P" 4010-A1 Test/Production (4010-A1) indicator and a "N" 5010 indicator, the affected shared systems shall: 1) create an 837 COB flat file that contains full 4010-A1 store-and-forward (SFR) content for the "production" claim; and 2) create nothing in terms of a 5010 COB claim.

Scenario 3: If a provider or supplier submits an 837 4010-A1 institutional or professional claim to a Medicare Part A contractor or DME MAC and if the Medicare contractor receives a Common Working File (CWF) Beneficiary Other Insurance (BOI) reply trailer (29) that contains a "N" 4010-A1 Test/Production (4010-A1) indicator and a "T" 5010 indicator, the affected shared systems shall: 1) create nothing in terms of a 4010-A1 COB claim; and 2) create a "test" 5010 non-SFR COB claim.

Scenario 4: If a provider or supplier submits an 837 4010-A1 institutional or professional claim to a Medicare Part A contractor or DME MAC and if the Medicare contractor receives a Common Working File (CWF) Beneficiary Other Insurance (BOI) reply trailer (29) that contains a "N" 4010-A1 Test/Production (4010-A1) indicator and a

"P" 5010 indicator, the affected shared systems shall: 1) create nothing in terms of a 4010-A1 COB claim; and 2) create a "production" 5010 non-SFR COB claim.

SPECIAL ONGOING RULE FOR ADJUSTMENT CLAIMS, CLAIMS HELD IN SUSPENSE, AND CLAIMS TO BE REPAIRED

The shared system shall produce a 5010 "skinny" claim, without SFR content, in the event that a claim that a Medicare contractor originally adjudicated in the 4010-A1 format is later released from suspense status or is adjusted during a time frame when a COBA trading partner has moved to 837 5010 production (that is, the BOI reply trailer 29 contains a "P" 5010 Test/Production indicator).

In addition, as of the mandatory cutover date to the 5010 claim transaction, all shared systems shall have the capability of repairing claims that previously errored out in the 4010-A1 format prior to the cutover date in the 5010 COB claim format on and after January 1, 2012.

ADDRESSING INCOMING PAPER CLAIMS FOR OUTBOUND COB PURPOSES

Scenario 1: During the transitional period, if a provider or supplier submits a hard-copy claim (paper UB-04 or CMS-1500) or, as applicable, enters a direct-data-entry (DDE) claim to a Medicare Part A contractor or DME MAC and if the Medicare contractor receives a CWF BOI reply trailer (29) that contains a "P" 4010-A1 Test/Production indicator and a "T" 5010 indicator, the affected shared system shall: 1) produce a "skinny" non-SFR 4010-A1 "production" COB claim; and 2) produce a "skinny" non-SFR 5010 "test" COB claim.

Scenario 2: If a provider or supplier submits a hard-copy claim (paper UB-04 or CMS-1500) or, as applicable, enters a DDE claim to a Medicare Part A contractor or DME MAC and if the Medicare contractor receives a CWF BOI reply trailer (29) that contains a "P" 4010-A1 Test/Production indicator and a "N" 5010 indicator, the affected shared system shall: 1) produce a "skinny" non-SFR 4010-A1 "production" COB claim; and 2) produce nothing in terms of a 5010 COB claim.

Scenario 3: If a provider or supplier submits a hard-copy claim (paper UB-04 or CMS-1500) or, as applicable, enters a DDE claim to a Medicare Part A contractor or DME MAC and if the Medicare contractor receives a CWF BOI reply trailer (29) that contains a "N" 4010-A1 Test/Production indicator and a "T" 5010 indicator, the affected shared system shall: 1) produce nothing in terms of a 4010-A1 claim; and 2) produce a "skinny' non-SFR 5010 "test" COB claim.

Scenario 4: Finally, if a provider or supplier submits a hard-copy claim (paper UB-04 or CMS-1500) or, as applicable, enters a DDE claim to a Medicare Part A contractor or DME MAC and if the Medicare contractor receives a CWF BOI reply trailer (29) that contains a "N" 4010-A1 Test/Production indicator and a "P" 5010 indicator, the affected

shared system shall: 1) produce nothing in terms of a 4010-A1 COB claim; and 2) produce a "skinny" non-SFR 5010 "production" COB claim.

IMPORTANT: For all scenarios, if the inbound claim's format is the same as the outbound claim, the shared system shall produce crossover claims with full SFR claim content as part of their contractors' 837 COB flat file transmissions to the COBC.

II. General 5010 COB Flat File Mapping Requirements

A. 837 Institutional COB Claim Mapping Rules

Effective with the testing and implementation of the Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X12-N 837 institutional claim (version 5010), the Fiscal Intermediary Shared System (FISS) shall observe the following business rules for mapping of the 5010 COB (institutional) flat file:

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

    a. ISA (Interchange Control Header Segment);
    b. IEA (Interchange Control Trailer Segment);
    c. GS (Functional Group Header Segment); and
    d. GE (Functional Group Trailer Segment).

2. The shared system shall map the claim version (version 005010X223A2 upon adoption of the 5010 Errata changes) in the field of the 837 5010 COB flat file that corresponds to the ST03 segment. (**NOTE:** The shared system shall **not** take this approach with respect to 4010-A1 claims that it will be transmitting to the COBC during the transitional period.)

3. The BHT02 (Beginning of the Hierarchical Transaction—Transaction Set Purpose Code) shall be passed either with value 00 or 18 under the following circumstances:

    a. Normal claims submission to the COBC—use "00"; and
    b. COBA claims repair process—use "18."

4. The BHT03 (Beginning of the Hierarchical Transaction—Reference Identification or Originator Application Transaction ID) shall contain identifiers populated as follows:

    a. 22 bytes for non-COBA recovery claims as follows:

    Bytes 1-9—Contractor ID (9 bytes; contractor ID, left justified, followed by 4 spaces);
    Bytes 10-14—Julian Date (5 bytes, expressed as "YYDDD");

Bytes 15-19—Sequence Number (5 bytes, starting with “00001”; should increment for each ST-SE envelope);
Bytes 20-21—Claim Version Indicator (2 bytes; values=40 for 4010A1 and 50 for 5010 claims); and
Byte 22—Test/Production Indicator (1 byte; valid values=”T”—test; “P”—production).

b. 22 bytes for COBA recovery claims as follows:

Bytes 1-9—Contractor ID (9 bytes; contractor ID, left justified, followed by 4 spaces);
Bytes 10-14—Julian Date (5 bytes, expressed as “YYDDD”);
Bytes 15-19—Sequence Number (5 bytes, starting with “00001”; should increment for each ST-SE envelope);
Bytes 20-21—Claim Version Indicator (2 bytes; values=40 for 4010A1 and 50 for 5010 claims); and
Byte 22—COBA recovery indicator (1 byte; indicator =R).

5. The 1000-A PER (Submitter EDI Contact Information) shall be populated as follows:

a. PER01—populate “1C”;
b. PER02—populate “COBC EDI Department”;
c. PER03—populate “TE”; and
d. PER04—populate “6464586740.”

6. The 1000-B loop NM1 (Receiver Name) denotes the crossover trading partner. If an A/B MAC on FISS receives multiple COBA IDs via the BOI reply trailer (29), the shared system shall submit a separate 837 transaction for each COBA ID received. Since crossover trading partner information will be unknown to the standard systems, the shared systems shall format the following fields as indicated:

a. NM101—populate “40”;
b. NM102—populate “2”;
c. NM103—populate spaces (COBC will complete);
d. NM108—populate “46”; and
e. NM109—include COBA ID (5-digit COBA ID obtained from the BOI reply trailer 29).

7a. To populate the 2010AA NM1 (Billing Provider Name), FISS shall complete the segments as indicated below if the incoming claim is electronic.

a. NM101—populate “85”;
b. NM102—populate “2”;
c. NM103—derived from contractor’s internal provider file;

d. NM108—populate “XX”; and
e. NM109—populate NPI value, as derived from the incoming claim.

For 2010AA N3 and N4 segments, FISS shall derive the required segments from the contractor’s internal provider file.

7b. If the incoming claim is paper UB04 or direct data entry (DDE), which is treated as paper, FISS shall complete the 2010AA NM1 (Billing Provider Name segments as follows:

a. NM101—populate “85”;
b. NM102—populate “2”;
c. NM103—derive from the contractor’s internal provider file;
d. NM108—populate “XX”; and
e. NM109—derive NPI from Form Locator (FL) 56 of the UB04 claim or applicable DDE field.

For 2010AA N3 and N4 segments, FISS shall derive the required segments from FLs 1 and 2 of the UB04 claim or internal provider file as necessary.

8a. To populate the 2010AB NM1 (Pay-to Address Name), the Part A shared system shall complete the segments as indicated below if the incoming claim is electronic.

a. NM101—populate “87”;
b. NM102—populate “2”; and
c. NM103—derived from contractor’s internal provider file.

For 2010AB N3 and N4 segments, FISS shall derive the required segments from the contractor’s internal provider file.

8b. If the incoming claim is paper UB04 or direct data entry (DDE), which is treated as paper, FISS shall complete the 2010AB NM1 (Pay-to Address Name) segments as follows:

a. NM101—populate “87”;
b. NM102—populate “2”; and
c. NM103—derived from incoming claim.

For 2010AB N3 and N4 segments, FISS shall derive the required segments from the contractor’s internal provider file as necessary.

9. FISS shall derive the 2010AA REF (Billing Provider-TAX ID) segments as follows, regardless of incoming claim’s format:

a. For REF01—populate “EI”; and

b. For REF02—derive from contractor's internal provider file.

10a. For the 2000A and 2310-PRV in association with incoming electronic claims, FISS shall map the PRV01, PRV02, and PRV03 segments (which have already been validated for syntactical correctness at each affiliate contractor's front-end) to the equivalent 837 COB flat as follows:

a. For PRV01—populate "BI";
b. For PRV01—populate "PXC"; and
c. For PRV03—populate taxonomy code value from incoming claim.

10b. If the incoming claim is paper UB04 or DDE entered, FISS shall only populate the 2000A-PRV (Bill-to Taxonomy) segments within the equivalent 837 COB flat fields as follows if the reported taxonomy code is syntactically correct:

a. For PRV01—populate "BI";
b. For PRV01—populate "PXC"; and
c. For PRV03—populate taxonomy code as derived from the keying of FL 81cc(a) of the UB04 claim form or as derived from the appropriate field from the online DDE screen.

NOTE: The only reason why the 2310A PRV cannot be included on the 837 COB flat file is that the UB04 claim and DDE claim entry screens can only accommodate Bill-to Provider taxonomy code reporting.

11. FISS shall derive information for 2010AA PER 03, PER04, PER05, and PER06 if such information is present on the incoming electronic or paper claim or is available within the contractor's internal provider files. If the information is **not** available, or is available in incomplete form (i.e., fewer digits than required), the shared system shall **not** create the 2010AA PER loop within the 837 5010 COB institutional flat file.

12a. For the 2320B SBR01, in situations where there is only one (1) payer that is primary to Medicare, FISS shall apply "P" to any payer that is primary before Medicare; "S" for Medicare as the secondary payer; and "U" for all supplemental payers after Medicare.

SPECIAL NOTE: If, for example, a claim contains at least two (2) primary payers before Medicare, FISS shall reflect the first payer as 2320 SBR01= "P"; the second as 2320 SBR01= "S"; and, the tertiary payer, Medicare, as 2320 SBR01="T." FISS shall reflect all additional supplemental payers as SBR01= "U."

12b. For 2000B SBR01 (element 1138), FISS shall apply "P" when Medicare is the primary payer and shall apply "U" for all other supplemental payers after Medicare.

13. For additional 2000B requirements, FISS shall take the following actions:

a. SBR03—map spaces; and
b. SBR09—map "MC" if the COBA ID returned via the BOI reply trailer (29)=70000-79999; for all other COBA IDs, map "ZZ."

14. The 2010BA loop denotes beneficiary subscriber information. FISS shall populate this loop and accompanying segments within the equivalent 837 COB flat file fields as indicated below.

2010BA NM1—Subscriber Name:

a. NM101—populate "IL";
b. NM102—populate "1";
c. NM103—derive from internal beneficiary eligibility file;
d. NM104—derive from internal beneficiary eligibility file;
e. NM105—derive from internal beneficiary eligibility file if available; otherwise populate spaces;
f. NM108—populate "MI"; and
g. NM109—populate HICN.

2010BA N3—Subscriber Address:

a. N301—derive from internal beneficiary eligibility file; and
b. N302—derive, as necessary, from internal beneficiary eligibility file; otherwise populate spaces.

2010BA N4—Subscriber City/State/ZIP Code:

a. N401—derive from internal beneficiary eligibility file;
b. N402—derive from internal beneficiary eligibility file;
c. N403—derive from internal beneficiary eligibility file; and
d. N407—derive if available and applicable from internal beneficiary eligibility file; otherwise populate spaces.

15. The shared systems shall populate the 2330A (Other Subscriber) NM1, N3, and N4 segments as follows:

2330A—NM1:

a NM101—populate "IL";
b. NM102—populate "1";

c. NM103—derive from internal beneficiary eligibility file;
d. NM104—derive from internal beneficiary eligibility file;
e. NM105—derive from internal beneficiary eligibility file if available; otherwise populate spaces;
f. NM108—populate "MI"; and
g. NM109—populate HICN.

2330A-N3:

a. N301—derive from internal beneficiary eligibility file; and
b. N302—derive, as necessary, from internal beneficiary eligibility file as necessary; otherwise populate spaces.

2330A-N4:

Upon implementation of the 5010 Errata, the shared system shall **not** attempt to gap-fill or systems-fill any elements (N401—N407) within this segment. Also, if these elements are available but are incomplete, the shared system shall not create the N4 segment tied to loop 2330A within the 837 COB flat file.

a. N401—derive from internal beneficiary eligibility file; and
b. N402, N403, N404, N407—derive from internal beneficiary eligibility file if available and applicable; otherwise populate spaces.

16. The 2010BB loop denotes the payer name. Per the HIPAA Implementation Guide, this loop should define the secondary payer when sending the claim to the second destination payer. Thus, since the payer related to the COBA ID will be unknown by the contractor shared systems, FISS shall format the NM1, N3, and N4 segments as follows, with the COBC completing any missing information:

2010BB—NM1:

a. NM101—populate "PR";
b. NM102—populate "2";
c. NM103--populate spaces;
d. NM108—populate "PI"; and
e. NM109—populate the COBA ID (5 digit COBA ID as obtained from the BOI reply trailer 29).

2010BB-N3 & 2010BB-N4:

a. N301 & N302—populate spaces; and
b. For N401, N402, N403, N404, N407, populate spaces.

17. FISS shall **not** create the 2010AC loop within the 837 5010 COB flat file.

18. If FISS notes the presence of other payers within 2320 SBR and 2330B loops that had made no financial determination on a claim prior to Medicare, as in the case of Medicare secondary payer (MSP) situations, the shared system shall **not** move those loops to the 837 5010 COB institutional flat file. (**NOTE:** The shared system shall continue to populate information as received from the CWF BOI reply trailer (29) within the 2320 SBR and 2330 loops of the associated 837 COB flat file fields.)

19. The 2330B loop denotes other payers for the claim following Medicare. All should note that there will always be one (1) 2330B that denotes Medicare as a payer, with FISS completing all required information for NM101, NM102, NM103, NM108, NM109, as well as the N3 and N4 segments.

20. For additional 2330B loop iterations relating to COB, if the A/B MAC receives multiple COBA IDs via the BOI reply trailer (29), payer information for additional COBA IDs will be unknown. As with the 2010BB loop, the NM1 segment should be formatted as follows, with COBC completing missing information:

2nd and additional iterations of 2330B—NM1:

a. NM101—populate "PR":
b. NM102—populate "2";
c. NM103—populate spaces;
d. NM108—populate "PI"; and
e. NM109—populate the COBA ID (5 digit COBA ID as obtained from the BOI reply trailer 29).

2nd and additional iterations of 2330B-N3 & 2330B-N4:

a. N301 & N302—populate spaces; and
b. For N401, N402, N403, N404, N407, populate spaces.

21. FISS shall always send at least one (1) complete iteration of 2320, 2330A, and 330B on all 837 COB flat files.

22a. FISS shall populate the required 2310-A (Attending Provider Name), 2310B (Operating Physician Name), and 2310C (Other Operating Physician Name) NM1 segments, with information derived from the incoming electronic claim. FISS shall **always** populate the NM108 segment always indicating "XX" and shall derive the NPI from the incoming claim.

22b. If the incoming claim is paper or DDE entered, FISS shall derive the attending, operating, and other operating physician name from the UB04 claim or DDE entry, or as necessary from the contractor's internal provider files. FISS shall

always populate the NM108 segment with "XX" and shall derive the NPI from the UB04 claim or DDE entry screen.

23. When the incoming claim is paper UB04 or DDE entered, FISS shall continue with all other mapping practices not otherwise addressed above and now pursued for creation of the outbound "skinny" 837 COB flat file (version 4010-A1) when creating the outbound "skinny" 837 COB flat file (version 5010). [For example, FISS shall continue to derive the discharge hour, admission date/hour, admission source code, medical record number, principal diagnosis, admitting diagnosis code, principal procedure information, occurrence codes, occurrence span codes, value codes, and condition codes from the associated FL fields of the UB04 or from the DDE keyed information.]

24. FISS shall migrate the Line Item Control Number data from the Store and Forward Repository (SFR) to the area of the 837 5010 COB flat file that corresponds to loop 2400, REF02, where REF01=6R, as per the Implementation Guide.

25. Upon implementation of the 5010 Errata changes, FISS shall take the following action with respect to the creation of the field corresponding to 2300 CL101 on the 837 COB flat file as a gap-fill or systems-fill value when necessary:

    Map the value "9" (Information Not Available) to the field corresponding to 2300 CL101 on the 837 COB flat file if the incoming claim is received in a claim format other than version 5010, and the CWF BOI reply trailer 29 indicator for "5010" returned to the Medicare contractor for the claim= "T" or "P."

B. 837 Professional COB Claim Mapping Rules

Effective with the testing and implementation of the Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X12-N 837 institutional claim (version 5010), the Multi-Carrier System (MCS, the Part B shared system) and the ViPS Medicare System (VMS, the DME MAC shared system) shall observe the following common business rules for mapping of the 5010 COB (professional) flat file:

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

   a. ISA (Interchange Control Header Segment);
   b. IEA (Interchange Control Trailer Segment);
   c. GS (Functional Group Header Segment); and
   d. GE (Functional Group Trailer Segment).

2. The shared system shall map the claim version (version 005010X222A1) in the field of the 837 5010 COB flat file that corresponds to the ST03 segment.

(**NOTE:** The shared system shall not take this approach with respect to 4010-A1 claims that it will be transmitting to the COBC during the transitional period.)

3. The BHT02 (Beginning of the Hierarchical Transaction—Transaction Set Purpose Code) shall be passed either with value 00 or 18 under the following circumstances:

   a. Normal claims submission to the COBC—use "00"**;** and
   b. COBA claims repair process—use "18."

4. The BHT03 (Beginning of the Hierarchical Transaction—Reference Identification or Originator Application Transaction ID) shall contain identifiers populated as follows:

   a. 22 bytes for non-COBA recovery claims as follows:

   Bytes 1-9—Contractor ID (9 bytes; contractor ID, left justified, followed by 4 spaces);
   Bytes 10-14—Julian Date (5 bytes, expressed as "YYDDD");
   Bytes 15-19—Sequence Number (5 bytes, starting with "00001"; should increment for each ST-SE envelope);
   Bytes 20-21—Claim Version Indicator (2 bytes; values=40 for 4010A1 and 50 for 5010 claims); and
   Byte 22—Test/Production Indicator (1 byte; valid values="T"—test; "P"—production).

   b. 22 bytes for COBA recovery claims as follows:

   Bytes 1-9—Contractor ID (9 bytes; contractor ID, left justified, followed by 4 spaces);
   Bytes 10-14—Julian Date (5 bytes, expressed as "YYDDD");
   Bytes 15-19—Sequence Number (5 bytes, starting with "00001"; should increment for each ST-SE envelope);
   Bytes 20-21—Claim Version Indicator (2 bytes; values=40 for 4010A1 and 50 for 5010 claims); and
   Byte 22—COBA recovery indicator (1 byte; indicator =R).

5. The 1000-A PER (Submitter EDI Contact Information) shall be populated as follows:

   a. PER01—populate "1C";
   b. PER02—populate "COBC EDI Department";
   c. PER03—populate "TE"; and
   d. PER04—populate "6464586740."

6. The 1000-B loop NM1 (Receiver Name) denotes the crossover trading partner. If the Medicare contractor receives multiple COBA IDs via the BOI reply trailer (29), the shared system shall submit a separate 837 transaction for each COBA ID received. Since crossover trading partner information will be unknown to the standard systems, the shared system shall format the following fields as indicated:

    a. NM101—populate "40";
    b. NM102—populate "2";
    c. NM103—populate spaces;
    d. NM108—populate "46"; and
    e. NM109—include COBA ID (5-digit COBA ID obtained from the BOI reply trailer 29).

7a. For all 2000A, 2310B, and 2420A PRV (Billing Provider Specialty Information) segments, the Part B and DME MAC shared system shall map the taxonomy code values reported in PRV01 through PRV03 on the incoming electronic claim to the corresponding fields within the 837 COB flat file. If the values reported for these loops on the incoming claim are incomplete or syntactically incorrect, the shared system shall **not** create the loop and associated segments.

7b. The Part B shared system shall continue the practice of only mapping 2420A-level PRV segments if the incoming electronic claim is multi-line, with differing rendering physicians associated to each line. The Part B shared system shall **not** map a 2420A-level reported PRV segment if the incoming electronic claim contains a single detail line.

8. The Part B and DME MAC shared system shall derive information for 2010AA PER 03, PER04, PER05, and PER06 if such information is present and syntactically complete within the contractor's internal provider files. If such information is unavailable or incomplete, the affected shared systems shall **not** create the 2010AA PER loop on the 837 5010 professional COB flat file.

9. The Part B and DME MAC shared system shall derive all provider specific information necessary to populate the NM1 and N3 and N4 segments of such loops as 2010AA, 2010AB, and 2310B from each contractor's internal provider files. In addition, where a provider's tax ID is required within a secondary REF segment, the shared system shall also derive this information from each contractor's internal provider files.

10a. For 2320 SBR01, in situations where there is only one (1) payer that is primary to Medicare, VMS shall apply "P" to any payer that is primary before Medicare; "S" for Medicare as the secondary payer; and "U" for all supplemental payers after Medicare.

SPECIAL NOTE: If, for example, a claim contains at least two (2) primary payers before Medicare, the DME MAC shared system shall reflect the primary

payer as 2320 SBR01as “P”; the secondary payer as 2320 SBR01 = “S”; and, the tertiary payer, Medicare, as 2320 SBR01 = “T.” MCS shall reflect all additional supplemental payers as 2320 SBR01 = “U.”

10b. For 2000B SBR01 (element 1138), the shared system shall apply “P” when Medicare is the primary payer and shall apply “U” for all other supplemental payers after Medicare.

11. For additional 2000B requirements, the shared system shall take the following actions:

    a. SBR03—map spaces; and
    b. SBR09—If the COBA ID returned via the BOI reply trailer (29)=70000-79999, map “MC”; for all other COBA IDs, map “ZZ.”

12. The 2010BA loop denotes beneficiary subscriber information. There are two (2) crossover scenarios o address: Regular, eligibility file-based crossover, and Medigap claim-based crossover.

(1) For regular eligibility file-based crossover (COBA ID=anything except 55000 through 59999), the shared system shall populate the NM1, N3, and N4 segments as follows:

2010BA NM1—Subscriber Name:

a. NM101—populate “IL”;
b. NM102—populate “1”;
c. NM103—derive from internal beneficiary eligibility file;
d. NM104—derive from internal beneficiary eligibility file;
e. NM105—derive from internal beneficiary eligibility file if available; otherwise populate spaces;
f. NM108—populate “MI”; and
g. NM109—populate HICN.

2010BA N3—Subscriber Address:

a. N301—derive from internal beneficiary eligibility file; and
b. N302—derive, as necessary, from internal beneficiary eligibility file; otherwise populate spaces.

2010BA N4—Subscriber City/State/ZIP Code:

a. N401—derive from internal beneficiary eligibility file;
b. N402—derive from internal beneficiary eligibility file;
c. N403—derive from internal beneficiary eligibility file; and

d. N407—derive if available and applicable from internal beneficiary eligibility file; otherwise populate spaces.

(2) Medigap claim-based crossover (COBA ID=55000 through 59999 only), the shared system shall populate the NM1, N3, and N4 segments as follows:

2010BA NM1—Subscriber Name:

a. NM101—populate "IL";
b. NM102—populate "1";
c. NM103—derive from internal beneficiary eligibility file;
d. NM104—derive from internal beneficiary eligibility file;
e. NM105—derive from internal beneficiary eligibility file if available; otherwise populate spaces;
f. M108—populate "MI"; and
g. M109—populate beneficiary policy number as derived from Item 9-D of Form CMS-1500 claim or 2330B NM109 of the incoming 837 professional claim. The shared system shall only populate HICN here if the policy number is unavailable on the incoming claim.

2010BA N3—Subscriber Address:

a. N301—derive from internal beneficiary eligibility file;

b. N302—derive, as necessary, from internal beneficiary eligibility file; otherwise populate spaces.

2010BA N4—Subscriber City/State/ZIP Code:

a. N401—derive from internal beneficiary eligibility file;
b N402—derive from internal beneficiary eligibility file;
c. N403—derive from internal beneficiary eligibility file; and
d. N407—derive, if available, from internal beneficiary eligibility file; otherwise populate spaces.

13. The shared system shall populate the 2330A (Other Subscriber) NM1, N3, and N4 segments as follows:

2330A—NM1:

a. NM101—populate "IL";
b. NM102—populate "1";
c. NM103—derive from internal beneficiary eligibility file;
d. NM104—derive from internal beneficiary eligibility file;
e. NM105—derive from internal beneficiary eligibility file if available; otherwise populate spaces;
f. NM108—populate "MI"; and

g. NM109—populate HICN.

2330A-N3:

a. N301—derive from internal beneficiary eligibility file; and
b. N302—derive, as necessary, from internal beneficiary eligibility file as necessary; otherwise populate spaces.

2330A-N4:

Upon implementation of the 5010 Errata, the Part B and DME MAC shared systems shall **not** attempt to gap-fill or systems-fill any elements (N401—N407) within this segment. Also, if these elements are available but are incomplete, the shared systems shall **not** create the N4 segment tied to loop 2330A within the 837 COB flat file.

a. N401—derive from internal beneficiary eligibility file; and
b. N402, N403, N404, N407—derive from internal beneficiary eligibility file if available and applicable; otherwise populate spaces.

14. The 2010BB loop denotes the payer name. Per the HIPAA Implementation Guide, this loop should define the secondary payer when sending the claim to the second destination payer. Thus, since the payer related to the COBA ID will be unknown by the contractor shared systems, the shared system shall format the NM1, N3, and N4 segments as follows, with the COBC completing any missing information:

2010BB—NM1:

a. NM101—populate "PR";
b. NM102—populate "2";
c. NM103—populate spaces;
d. NM108—populate "PI"; and
e. NM109—populate the COBA ID (5 digit COBA ID as obtained from the BOI reply trailer 29).

2010BB-N3 & 2010BB-N4:

a. N301 & N302—populate spaces; and
b. For N401, N402, N403, N404, N407, populate spaces.

15. The shared system shall **not** create the 2000C or the 2010CA loops within the 837 5010 professional COB flat file.

16. If the shared system notes the presence of other payers within 2320 SBR and 2330B loops that had made no financial determination on a claim prior to

Medicare, as in the case of Medicare secondary payer (MSP) situations, the shared system shall **not** move those loops to the 837 5010 COB professional flat file.

17. The 2330B loop denotes other payers for the claim following Medicare. There will always be one (1) 2330B that denotes Medicare as a payer, with the shared system completing all required information for NM101, NM102, NM103, NM108, NM109, as well as the N3 and N4 segments.

18. For additional 2330B loop iterations relating to COB, if the Medicare contractor receives multiple COBA IDs via the BOI reply trailer (29), payer information for additional COBA IDs will be unknown. As with the 2010BB loop, the shared system shall format the NM1 segment as follows, with COBC completing missing information:

    2nd and additional iterations of 2330B—NM1:

    a. NM101—populate "PR";
    b. NM102—populate "2";
    c. NM103—populate spaces;
    d. NM108—populate "PI"; and
    e. NM109—populate the COBA ID (5 digit COBA ID as obtained from the BOI reply trailer 29).

    2nd and additional iterations of 2330B-N3 & 2330B-N4:

    a. N301 & N302—populate spaces; and
    b. For N401, N402, N403, N404, N407, populate spaces.

19. The shared system shall always send at least one (1) complete iteration of 2320, 2330A, and 2330B on all 837 COB flat files.

20. For 2300 REF (4081-Mandatory Crossover Indicator), the shared system shall take the action indicated below in accordance with the applicable scenario:

    a. REF01, always map "F5";

    b. REF02, map "Y" if the COBA ID returned via the BOI reply trailer (29)=55000 through 55999 (Medigap claim-based crossover); and

    c. REF02, map "N" if the COBA ID returned via the BOI reply trailer (29) =anything except for 55000 through 55999 (regular crossover).

Additional Mapping Requirements When Incoming Claim is Paper/Hard-Copy

****IMPORTANT: The shared system shall create an outbound 5010 "skinny" claim, as derived from paper/hard copy claim input, in the same manner that it now does when creating an outbound 4010-A1 "skinny" claim unless otherwise specified above or below.**

1. The shared system shall **always** map NDC codes keyed from hard-copy claims to the field that corresponds to 2410 LIN03 on the 837 5010 COB professional flat file and shall discontinue the practice of mapping the NDC code to the equivalent flat file field that corresponds to 2300 NTE-02. In addition, the shared system shall auto-plug the appropriate qualifier that designated NDC within the field that corresponds to 2410 LIN02.

2. If the incoming paper claim contains an NPI in block 32 of the CMS-1500, the shared system shall continue to utilize this keyed value for purposes of deriving the information necessary to populate all required segments associated with 2310C (Service Facility Name). The shared system shall continue to not create the 2310C loop if block 32 on the incoming paper claim is blank.

3. If the incoming claim is paper and does **not** contain information necessary to derive 2410 CTP5-1 (in association with Part B drugs), the shared system shall auto-plug the value "F2."

III. Gap-Filling Requirements for 837 5010 COB Files

A. 837 Institutional COB Claims

1. For all instances of the N403 segment, where created, the Part A shared system (FISS) shall ensure that it creates a 5-byte base ZIP code and additional 4-byte component for the COB flat file when required.

2. The Part A shared system shall universally gap-fill or system-fill required address information, when not otherwise obtainable, for all loops as follows:

   N401 (City Name) = Cityville;
   N402 (State or Province Code) = MD; and
   N403 (Postal Zone/ZIP Code) = 96941.

3. The Part A shared system shall gap-fill the +4 ZIP code component with 9998 when the actual +4 ZIP code component is unavailable when creating the N403 in association with loops 2010AA (Billing Provider) and 2310E (Service Facility). (**NOTE:** The full 9-byte ZIP code is required **only** for the N403 segment of the indicated loops.)

4. The Part A shared system shall never input "0000" as a gap-fill or system-fill +4 ZIP code in association with any of the N403 segments.

5a. If the shared system has valid city, state, and 5-byte ZIP code information available, it shall only gap-fill or system-fill the +4 ZIP code component, where required, with "9998" when creating outbound 837 COB claim files.

5b. The shared system shall continue to send full ZIP code content (9-bytes) on outbound 837 COB claim files, if available, for creation of situational N403 segments.

6. When the shared system determines that it has data within its internal provider file to populate 2010AA PER 04, it shall **only** move that information to the corresponding flat file field if the available data are complete. If the available data are incomplete (i.e., fewer than 10 digits for telephone number), the shared system shall **not** attempt to gap-fill the missing digits. The shared system shall also not create that PER segment.

7. With respect to 2010BA N301 and 2330A N301, when the contractor's internal beneficiary eligibility record contains blank or incomplete line-1 street address information, FISS shall apply "Xs" to satisfy the minimum length requirements of the N301 segments.

8. If the incoming claim is paper UB04 or DDE-entered and the dosage information necessary to populate 2410 CTP05-1 is not available, FISS shall always default to the value of "F2."

9. If the incoming claim is paper or electronic, FISS shall map "non-specific procedure code" within the 837 5010 COB flat file field that corresponds to loop 2400 SV202-7 (non-specific composite medical procedure description) if a non-specific procedure code description is required, as per the Implementation Guide, and the associated procedure code is defined as "not otherwise classified." (See the following link for the latest listing of not otherwise classified procedure codes: <http://www.cms.hhs.gov/apps/ama/license.asp?file=/HospitalOutpatientPPS/Downloads/CY2009_Unlisted_Codes.zip>.)

10. FISS shall **not** attempt to gap-fill or systems-fill the N4 segment (now situational) within the field corresponding to loop 2330B on the 837 COB flat file. In addition, if information needed to create the N4 segment is available but is incomplete, FISS shall not create the loop 2330B N4 segment.

11. FISS shall **not** attempt to gap-fill or systems-fill any of the composite SVD03 elements within loop 2430.

B. 837 Professional COB Claims

1. For all instances of the N403 segment, where created, the Part B and DME MAC shared systems shall ensure that it creates a 5-byte base ZIP code and additional 4-byte component for the COB flat file when required.

2. The Part B and DME MAC shared systems shall universally gap-fill or system-fill required address information, when not otherwise obtainable, for all loops as follows:

   N401 (City Name) = Cityville;
   N402 (State or Province Code) = MD; and
   N403 (Postal Zone/ZIP Code) = 96941.

3. The Part B and DME MAC shared systems shall gap-fill the +4 ZIP code component with 9998 when the actual +4 ZIP code component is unavailable when creating the N403 in association with loops 2010AA (Billing Provider), 2310C (Service Facility—claim level), and 2420C (Service Facility—service line level). (**NOTE:** The full 9-byte ZIP code is required **only** for the N403 segment of the indicated loops.)

4. The Part B and DME MAC shared systems shall never input "0000" as a gap-fill or system-fill +4 ZIP code in association with any of the N403 segments.

5a. If the Part B and DME MAC shared systems have valid city, state, and 5-byte ZIP code information available, they shall only gap-fill or system-fill the +4 ZIP code component, where required, with "9998" when creating outbound 837 COB claim files.

5b. The Part B and DME MAC shared system shall continue to send full ZIP code content (9-bytes) on outbound 837 COB claim files, if available, for creation of situational N403segments

6. When the shared system determines that it has data within its internal provider file to populate 2010AA PER 04, it shall **only** move that information to the corresponding flat file field if the available data are complete. If the available data are incomplete (i.e., fewer than 10 digits for telephone number), the shared system shall not attempt to gap-fill the equivalent field on the 5010 COB flat file.

7. With respect to 2010BA N301 and 2330A N301, when the contractor's internal beneficiary eligibility record contains blank or incomplete line-1 street address information, the shared system shall apply "Xs" to satisfy the minimum length requirements of the N301 segments.

8a. In association with paper-submitted Part B ambulance claims, the Part B shared system shall apply gap-filling to the N3 and N4 portions of loop 2310E and 2310F as follows for the segments indicated:

For N301: The Part B shared system shall map "Xs" to the **minimum** standard required for the field.

For N401—N403: The Part B shared system shall undertake the following actions:

a. N401 (City)—populate “Cityville”;
b. N402 (State Code)—populate “MD”; and
c. N403 (Postal Zone/ZIP Code)—populate “96941.”

8b. In addition, the Part B shared system shall gap-fill the required +4 component of ZIP code (N403 segment) with 9998 **only** in association with loops 2010AA, 2310C, and 2420C.

9. The shared system shall map “UN” in the 837 5010 COB flat file field that corresponds to loop 2410 (CTP) and segment CPT04 only when the 2410 (CTP) CTP04 segment is either blank or contains a non-valid value.

10. The shared system shall apply the gap-fill value “X” to the field corresponding to loop 2430 (SVD) and segment SVD03-2 in situations where the value on the incoming claim is either missing or non-valid.

11. The Part B shared system shall discontinue the process of gap-filling diagnosis code information within loop 2300 HI in association with ambulance claims that ambulance suppliers file to Medicare on paper.

12a. Following adjudication of both electronic and paper billed claims, the shared system shall discontinue the practice of applying gap-fill values of all “9s” within the 837 5010 COB flat file field that corresponds to 2410 LIN03 if the incoming claim contains an incomplete or non-valid national drug code (NDC). If an incoming paper claim contains a syntactically non-valid NDC code that the Medicare contractor subsequently keys, the shared system shall not attempt to gap-fill the field that corresponds to 2410 LIN03 on the 837 5010 COB flat file.

12b. The DME MAC shared system shall gap-fill the loop 2430 (SVD) SVD03-2 segment with “S5000” or “S5001,” as appropriate, in situations where the incoming claim contains an NDC within the 2410 LIN02 that does not correspond to a HCPCS on the NDC/HCPCS crosswalk.

13. If the incoming claim is paper and contractor’s internal provider file contains incomplete information necessary to populate the 2310C loop (in cases where required), the shared system shall gap-fill all required segments with “Xs.” NOTE: The shared system shall discontinue the practice of mapping “submitted but not forwarded” as a gap-fill convention in this situation for segments where information is required.

14. If the incoming claim is paper or electronic, FISS shall map “non-specific procedure code” within the 837 5010 COB flat file field that corresponds to loop 2400 SV202-7 (non-specific composite medical procedure description) if a non-specific procedure code description is required, as per the Implementation Guide, and the associated procedure code is defined as “not otherwise classified.” (See

the following link for the latest listing of not otherwise classified procedure codes: <http://www.cms.hhs.gov/apps/ama/license.asp?file=/HospitalOutpatientPPS/Downloads/CY2009_Unlisted_Codes.zip>.)

15. The Part B shared system shall utilize the claim's earliest service date to satisfy the requirement for 2300 DTP03 (date of admission), where required, in association with claims whose place of service code is 21, 51, or 61.

16. The Part B shared system shall populate 99 as a gap-fill/default value for loop 2300 (CLM) segment CLM05-1 (Facility Type Code) within the corresponding field of the 837 5010 COB flat file.

17. For ambulance claims, the Part B shared system shall map LB in the 837 5010 COB flat file field the corresponds to 2400 CR101 if that field would otherwise contain spaces where there is a value (weight) present in 2400 CR102.

18. Also, for ambulance claims, the Part B system shall produce spaces in the field that corresponds to loop 2400 CR101 when loop 2400 CR102 on the incoming claim is blank.\

19. All shared systems shall **not** attempt to gap-fill or systems-fill the N4 segment (now situational) within the field corresponding to loop 2330B on the 837 COB flat file. In addition, if information needed to create the N4 segment is available but is incomplete, the shared systems shall **not** create the loop 2330B N4 segment.

IV. Other 837 5010 COB Requirements

A. Complementary Credits

Upon receipt of a Beneficiary Other Insurance (BOI) reply trailer (29) that contains a "P" 837 5010 indicator, the shared systems shall ensure that their affiliate contractors are able to: 1) book complementary credits for the affected claim; and 2) transmit the "production" claim to the COB Contractor (COBC) after it has finalized on the contractor's payment floor.

Following receipt of a BOI reply trailer (29) that contains a "T" 837 5010 indicator, the shared systems shall ensure that their affiliate contractors: 1) do **not** book complementary credits for that version of the claim; and 2) transmit the "test" claim to the COBC after it has finalized on the contractor's payment floor.

All shared systems shall, in addition, **not** book complementary credits in association with their affiliated contractors' receipt of a CWF BOI reply trailer (29) that contains either an "N" 4010-A1 Test/Production indicator or an "N" 5010 indicator.

B. Coordination of Benefits Contractor (COBC) Business-Level Editing of Incoming 5010 COB Flat Files

With the implementation of the 5010 claim standards, the COBC will apply business level edits to ensure that incoming claims possess the structure necessary for successful translation into the HIPAA ANSI X12-N 837 version 5010 claim formats. See §70.6.1.1 of this chapter for charts that define the "111" level errors that COBC will return to the Medicare contractors when their incoming 837 COB flat files cannot be utilized to build compliant outbound 837 claim transactions.

70.6.6 - National Council for Prescription Drug Programs (NCPDP) Version D.0 Coordination of Benefits (COB) Requirements

(Rev. 1920, Issued: 02-19-10; Effective Date; 07-01-10 Implementation Date: 07-06-10)

I. Transitional Scenarios

During the NCPDP D.0 transitional period, the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) through their shared system shall accommodate the following multi-faceted scenarios with respect to creation of NCPDP COB flat files:

Scenario 1: If a supplier submits an NCPDP 5.1 claim to a DME MAC, and if that contractor receives a Common Working File (CWF) Beneficiary Other Insurance (BOI) reply trailer (29) that contains a "P" NCPDP 5.1 Test/Production indicator and a "T" NCPDP D.0 indicator, the shared system shall: 1) create an NCPDP COB flat file that contains full NCPDP 5.1 store-and-forward (SFR) content for the "production" claim for transmission to the COBC; and 2) create a "skinny" non-SFR claim in the NCPDP D.0 flat file format and transmit the claim to the COBC.

Scenario 2: If a supplier submits an NCPDP 5.1 claim to a DME MAC, and if that contractor receives a CWF BOI reply trailer (29) that contains a "P" NCPDP 5.1 Test/Production indicator and an "N" NCPDP D.0 indicator, the shared system shall: 1) create an NCPDP COB flat file that contains full NCPDP 5.1 SFR content for the "production" claim for transmission to the COBC; and 2) create nothing in terms of an NCPDP D.0 COB claim.

Scenario 3: If a supplier submits an NCPDP 5.1 claim to a DME MAC, and if that contractor receives a CWF BOI reply trailer (29) that contains an "N" NCPDP 5.1 Test/Production indicator and a "T" NCPDP D.0 indicator, the shared system shall: 1) create nothing in terms of an NCPDP 5.1 COB flat file; and 2) create a "skinny" non-SFR "test" claim in the NCPDP D.0 flat file format for transmission to the COBC.

Scenario 4: If a supplier submits an NCPDP 5.1 claim to a DME MAC, and if that contractor receives a CWF BOI reply trailer (29) that contains an "N" NCPDP 5.1 Test/Production indicator and a "P" NCPDP D.0 indicator, the shared system shall: 1) create nothing in terms of an NCPDP 5.1 COB flat file; and 2) create a "skinny" non-SFR "production" claim in the NCPDP D.0 flat file format for transmission to the COBC.

Scenario 5: If a supplier submits an NCPDP D.0 claim to a DME MAC, and if that contractor receives a CWF BOI reply trailer (29) that contains a "P" NCPDP 5.1 Test/Production indicator and a "T" NCPDP D.0 indicator, the shared system shall: 1) produce a "skinny" NCPDP 5.1 batch 1.1 COB claim for transmission to the COBC; and 2) produce an NCPDP D.0 COB "test" claim with full SFR content for transmission to the COBC.

Scenario 6: If a supplier submits an NCPDP D.0 claim to a DME MAC, and if that contractor receives a CWF BOI reply trailer (29) that contains a "P" NCPDP 5.1 Test/Production indicator and an "N" NCPDP D.0 indicator, the shared system shall: 1) produce a "skinny" non-SFR "production" NCPDP 5.1 claim for transmission to the COBC; and 2) create nothing in terms of an NCPDP D.0 COB claim.

Scenario 7: If a supplier submits an NCPDP D.0 claim to a DME MAC, and if that contractor receives a CWF BOI reply trailer (29) that contains an "N" NCPDP 5.1 Test/Production indicator and a "T" NCPDP D.0 indicator, the shared system shall: 1) produce nothing in terms of an NCPDP 5.1 COB claim; and 2) create an NCPDP D.0 COB flat file that contains full NCPDP D.0 SFR content for the "test" claim for transmission to the COBC.

Scenario 8: If a supplier submits an NCPDP D.0 claim to a DME MAC, and if that contractor receives a CWF BOI reply trailer (29) that contains an "N" NCPDP 5.1 Test/Production indicator and a "P" NCPDP D.0 indicator, the shared system shall: 1) produce nothing in terms of an NCPDP 5.1 COB claim; and 2) create an NCPDP D.0 claim with full SFR content for COBA "production" purposes. (**NOTE:** This will be the profile of a COBA trading partner that has cut-over to NCPDP D.0 COB production.)

IMPORTANT: For all of the foregoing scenarios, if the inbound claim's format is the same as the outbound claim, the affected shared system shall produce crossover claims with full SFR claim content as part of their affiliate contractors' NCPDP COB flat file transmissions to the COBC.

II. BASIC REQUIREMENTS

Prior to the mandatory cut-over to NCPDP D.0, the DME MAC shared system shall develop an NCPDP 5.1 "skinny" non-SFR claim format to accommodate those situations where COBA trading partners are unable to accept provider-submitted claims in the NCPDP D.0 format. In addition, the DME MAC shared system shall develop an NCPDP D.0 "skinny" non-SFR format that addresses the scenario of claims originally adjudicated in the NCPDP 5.1 format and later adjusted after the NCPDP D.0 format is required in association with all incoming and outgoing NCPDP D.0 claims.

The DME MAC shared system shall also develop an NCPDP D.0 "skinny" non-SFR format that addresses the scenario of claims that a contractor originally adjudicated in the NCPDP 5.1 format but suspended for a period of time that meets or transcends the date

by which the NCPDP D.0 format is required in association with all incoming and outgoing NCPDP D.0 claims.

III. NCPDP D.0 Mapping Requirements

With respect to the NCPDP D.0 COB flat file submissions to the COB Contractor (COBC), the ViPS Medicare System (VMS) maintainer shall observe the following business rules for mapping:

A. General

1. The 504-F4 ("Message") Trailer portion of the file shall contain a 22-byte identifier populated as follows:

    a.) Bytes 1-9—Contractor ID (9 bytes; contractor ID, left justified, followed by spaces);

    b.) Bytes 10-14—Julian Date (5 bytes, expressed as "YYDDD");

    c.) Bytes 15-19—Sequence Number (5 bytes, starting with "00001"; should increment for each ST-SE envelope);

    d.) Bytes 20-21—Claim Version Indicator (2 bytes; values= 11 for NCPDP version 5.1 claims and 20 for NCPDP version D.0 claims); and

    e.) Byte 22—Test/Production Indicator (1 byte; valid values="T"—test; "P"—production).

B. Transmission/Transaction Header Segment

1. Create 101-A1 ("BIN assigned number") with spaces.

2. Create the claim version release number (102-A2) within the Transmission/Transaction Header Segment.

3. Populate the appropriate transaction code (103-A3), the processor control number (104-A1), and transaction count value (109-A9).

4. Always map the service provider ID qualifier corresponding to the national provider identifier (NPI) in 202-B2.

5. Always map the supplier's NPI in 201-B1 ("Service Provider ID").

6. Map date of service from incoming claim for 401-D1.

7. Map 110-AK ("Software Vendor/Certification ID") from incoming claim.

IMPORTANT: For "skinny" NCPDP claim scenarios, where the incoming claim is NCPDP 5.1, the shared system shall map "unknown" in 110-AK.

C. Transmission Insurance Segment

1. Map the beneficiary's Health Insurance Claim Number (HICN) in 302-C2 ("Cardholder ID").

2. Map 312-CC and 313-CD ("Cardholder's First and Last Names") using information from the DME MAC's internal eligibility file.

3. Do not create 301-C1 ("Group ID"), as CMS no longer authorizes claims-based transfers to Medicaid State Agencies.

4. Do not create 336-8C ("Facility ID"), even in "skinny" claim situations.

5. For Medigap claim-based crossover purposes only, the shared system shall continue to populate the Medigap claim-based COBA ID (range 55000-55999) in the flat file field corresponding to 301-C1 (Group ID), as derived from the incoming claim.

   In addition, the shared system shall populate the Medigap policy ID in the newly created 359-2A (Medigap ID) element, as derived from the incoming claim.

6. Always map an "A" value for element 361-2D ("Provider Accept Assignment Indicator").

7. Do **not** create elements 115-N5, 116-N6, 314-CE, 303-C3, and 306-C6.

8. Create 524-F0 ("Plan ID") in the future only when CMS directs.

D. Transmission Patient Segment

1. Create element 331-CX ("Patient ID Qualifier") as appropriate.

2. Create 307-C7 ("Place of Service") based upon the incoming claim.

3. Always map the HICN in 332-CY ("Patient ID").

4. Map elements 304-C4, 305-C5, 310-CA, and 311-CB from the DME MAC's internal beneficiary eligibility file.

5. Map elements 322-CM, 323-CN, 324-CO, and 325-CP from the DME MAC's internal beneficiary eligibility file. (*--See Gap Filling Requirements in Attachment B to address situations where the beneficiary's line-1 address, as derived from the DME MAC's internal beneficiary eligibility file, is blank or incomplete.)

6. Map 326-CQ ("Patient Phone Number") and 350-HN ("Patient E-mail Address") from incoming claim. (**Assumption:** CEDI will ensure these values are syntactically correct as a condition of inbound claim acceptance.)

7. Do not create element 335-2C ("Pregnancy Indicator") on the NCPDP D.0 COB file.

D. Transaction Prescriber Segment

1. Map element 466-EZ ("Prescriber ID Qualifier") from the incoming claim.

2. Always map "01" for element 468-2E ("Primary Care Provider ID Qualifier").

3. Map the NPI, as derived from the incoming claim, in element 421-DL ("Primary Care Provider ID").

4. Map the supplier's name, as derived from the DME MAC's internal provider files, for 470-4E ("Primary Care Provider Last Name").

5. Map 411-DB based upon adjudicated claim data.

6. Map 427-DR ("Prescriber Last Name") and 364-2J ("Prescriber First Name") from the DME MAC's internal supplier files.

7. Map 365-2K ("Prescriber Address"), 366-2M ("Prescriber City"), 367-2N ("Prescriber State"), 368-2P ("Prescriber Zip"), and 498-PM ("Prescriber Phone Number") based upon the availability of these elements in the SFR. (See Attachment B for special gap-filling requirements that will come into play for NCPDP skinny mapping.)

E. Transaction COB/Other Payments Segment

1. Map element 337-4C from the incoming claim.

2. Prepare element 338-5C to appropriately quality deductible or co-insurance remaining. (NOTE: In the case of adjustment claims, where the DME MAC used 98 or 99 previously, the shared system shall populate the NCPDP D.0 equivalent qualifying value on the COB flat file.)

3. Map value “05” for element 339-6C in relation to Medicare’s role as payer of the claim.

4. Map the DME MAC’s workload identifier (e.g., 16003) in element 340-7C.

5. Map the Internal Control Number (element 993-A7) as received from CEDI and as a result of claim adjudication.

6. Map the following out on the COB flat file only if received on the incoming claim: 443-E8, 341-HB, 342-HC, 431-DV, 471-5E, 472-6E.

7. Create 353-NR, 351-NP, and 352-NQ in terms of primary payer’s patient responsibility count, qualifier, and remaining amount, as applicable, or the patient responsibility count, qualifier, and remaining amount after Medicare.

8. Do not map 392-MU, 393-MV, and 394-MW, as these are not used for Medicare purposes.

9. Do not create any portion of the Transaction Workers’ Compensation Segment.

F. Transaction Claim Segment

1. Map 343-HD, 344-HF, and 345-HG based upon availability on the data on the incoming claim.

2. Create 455-EM and 402-D2 as required, without gap-filling.

3. Create 403-D3, 405-D5, 406-D6, and 407-D7 as required, without gap-filling.

4. Create all of the following if received on the incoming claim: 408-D8, 414-DE, 415-DF, 418-DI, 419-DJ, 420-DK, 453-EJ, 445-EA, 446-EB, and 457-EP. (**NOTE:** Gap-filling of 453-EJ with spaces is acceptable if the shared system is also concurrently gap-filling 445-EA with spaces.)

5. Create procedure modifier count (458-SE) based upon claim adjudication.

6. Create procedure modifier code as appropriate.

7. Map 442-E7 and 426-E1 as required, without gap-filling.

8. Create 456-EN, 420-DK, 308-C8, and 429-DT to the COB file if received on the incoming claim.

9. Map 454-EK (now required in certain situations) and 600-2B if received on the incoming claim.

10. Do not create 461-EU, 462-EV, 463-EW, 464-EX, 354-NX, 357-NV, 995-E2, 996- G1, and 147-U7 if received on the incoming claim.

11. Always create 391-MT ("Patient Assignment Indicator") on the COB flat file. (**NOTE:** CEDI shall reject NCPDP claims with this element missing at the DME MAC's front-end.)

G. Transaction Compound Segment

1. Create all of the following required elements without gap-filling: 447-EC, 448-ED, 449-EE, 450-EF, 451-EG, 488-RE, and 489-TE.

2.

3. Create the following if received on the incoming claim: 490-UE, 362-2G, and 363-2H.

H. Transaction Pricing Segment

1. Create the following required elements without gap-filling: 409-D9 and 430-DU.

2. Create the following based upon claims adjudication: 412-DC, 423-DN, 426-DQ, 433-DX, 438-E3, 478-H7, 47-H8, 480-H9.

3. Do not create 482-GE, 483-HE, and 484-JE, given that VMS currently does not produce these as part of the NCPDP 5.1 COB flat file.

I. Transaction Prior Authorization Segment - Do not create for COB flat file.

J. Transaction Clinical Segment

1. Create all situational elements indicated only if received.

2. Do not create "Transaction Additional Doc" segment or Additional Documentation Type ID (369-2Q), as they relate to passage of CMN information, which is no longer supported.

K. Transaction Facility Segment

Create associated elements only if received; otherwise, do not attempt to gap-fill.

L. Narrative Segment.

Create the 390-BM (Narrative Message) element only if information is populated on the inbound NCPDP D.0 batch claim.

IV. NCPDP D. O Gap-Filling Requirements

The DME MAC shared system shall observe the following gap-filling requirements when creating NCPDP D.0 COB flat files for transmission to the COBC:

A. For rare instances where there is not a valid base 5-byte zip code available to populate a required zip code field, VMS shall populate "96941" within the field corresponding to that segment on the 837 5010 COB flat file.

B. With respect to element 322-CM (Transmission Patient Segment), when the contractor's internal beneficiary eligibility record contains blank or incomplete line-1 street address information, VMS shall populate this element with an initial "X" followed by 29 spaces.

D. The shared system shall continue the practice of gap-filling element 453-EJ (Originally Prescribed Product/Service ID Qualifier) when element 445-EA (Originally Prescribed Product Service Code) is gap-filled with spaces.

E. The shared system shall continue the practice of gap-filling 446-EB (Originally Prescribed Quantity) when the value for this element from the inbound claim is present but non-numeric.

F. For "skinny" processing, the shared system shall initialize elements 498-PM, 364-2J, 365-2K, 366-2M, 367-2N to spaces as a gap-fill measure.

G. For "skinny" processing, the shared system shall initialize element 368-2P to zeroes as a gap-fill measure.

H. If element 427-DR ("Prescriber Last Name") cannot be found within the DME MAC's internal supplier files, the shared system shall set element 427-DR to "Unknown."

SPECIAL NOTE: When DME MACs encounter particular gap-filling scenarios that are not specifically addressed above, their shared system shall deploy the current gap-fill requirements for the creation of required NCPDP 5.1 COB flat file data content when creating NCPDP D.0 COB flat files for transmission to the COBC.

V. COBA Contractor Financial Processes Relating to NCPDP D.0 Claims

A. During the transitional period (January through December 2011), the DME MACs shall **not** book complementary credits if the Common Working File (CWF) returns a Beneficiary Other Insurance (BOI) reply trailer 29 that contains values of NCPDP 5.1=T **or** N **and** NCPDP D.0 values of T or N.

B. The DME MACs shall book complementary credits if the CWF BOI reply trailer (29) contains a value of "P" for **either** claim version NCPDP 5.1 **or** NCPDP D.0 during the transitional period.

VI. Medigap Claim-Based Crossover Processes Involving NCPDP D.0 Claims

In advance of their acceptance of incoming NCPDP D.0 claims, all DME MACs shall inform their affiliate "participating" suppliers that they may initiate Medigap claim-based crossover processes by taking the following steps:

- Continue to enter the Medigap claim-based COBA ID (range 55000 to 59999) in the existing 301-C1 (Group ID) portion of the "Transmission Insurance Segment"; and

- Now report the beneficiary's Medigap policy number in the newly developed 359-2A (Medigap ID) portion of the Transmission Claim Segment.

VII. DME MAC NCPDP D.0 Cut-Over Requirements

The COB Contractor (COBC) shall effectuate cut-over of COBA trading partners to the NCPDP D.0 format through actions taken via the COIF.

Upon receipt of a CWF BOI reply trailer (29) that contains a "P" NCPDP D.0 indicator and an "N" NCPDP5.1 indicator, VMS shall cease creation of NCPDP 5.1 batch 1.1 full COB or NCPDP 5.1 batch 1.1 non-SFR skinny COB claims as well as transmission of these files to the COBC.

IX. Dual COBC Detailed Error Reports During The Transitional Period and Accompanying New "222" Errors

During the NCPDP D.0 transitional period, all DME MACs shall accept and process two COBC Detailed Error Reports—one generated by the COBC for claims transmitted by the DME MACs in the NCPDP 5.1 COB flat file format, and another generated by the COBC for claims transmitted by the DME MACs in the NCPDP D.0 COB flat file format.

The DME MAC shared system now accept "222" error conditions as part of the COBC Detailed Error Report for NCPDP claims, as may be referenced in §70.6.1 of this chapter. In this vein, the DME MAC shared system shall not effectuate changes to expand the error description field portion of the COBC NCPDP Detailed Error Report to accommodate receipt of the new "222" errors.

The COBC will return the following new 222 errors to Medicare contractors via the COBC NCPDP Detailed Error Reports:

- N22230—NCPDP 5.1 “production” claim received, but the COBA trading partner is not accepting NCPDP 5.1 “production” claims;

- N22231—NCPDP 5.1 “test” claim received, but the COBA trading partner is not accepting NCPDP 5.1 “test” claims;

- N22232—NCPDP D.0 “production” claim received, but the COBA trading partner is not accepting NCPDP D.0 “production” claims; and

- N22233—NCPDP D.0 “test” claims received, but the COBA trading partner is not accepting NCPDP D.0 “test” claims.

IMPORTANT: The COBC shall not begin applying “222” editing to incoming claims until 14 calendar days after a COBA trading partner’s production cut-over to the NCPDP D.0 format have elapsed. The DME MACs shall not attempt to repair claims that the COBC returns via the COBC Error Reports with error codes N22230 through N22233, regardless of error percentage.

All DME MACs shall create special provider letters to their affiliate supplier, in accordance with §70.6.1 of this chapter, for “production” claims with error codes N22230 or N22232.

X. NCPDP D.0 Claims Repair Processes

The DME MACs, working with their shared system, shall initiate NCPDP D.0 claims repair actions when: 1) the error percentage for “333” errors equals or exceeds four (4) percent; and 2) they receive even one (1) “111” error as noted on the COBC Detailed Error Reports.

As part of their process to initiate a claims repair, the DME MACs shall alert their shared system or Data Center, as per established protocol. The DME MACs shall also suppress generation of their provider notification letters, in accordance with §70.6.1 of this chapter, for up to 14 days.

If the DME MACs determine that the timeframes for effectuating claim repairs for “111” or “333” errors fall outside of acceptable CMS parameters (e.g., will take 30-60 days or longer) or if the volume of affected claims is low (1,000 claims or less per week), the DME MACs shall allow for the release of their special provider notification letters to affected suppliers. Any DME MACs that wish to effectuate a repair of NCPDP D.0 “production” claims whose error percentage falls below four (4) percent shall contact a member of the CMS COBA team before attempting that action. As a rule, CMS will grant approval for such a repair if the volume of errored claims justifies that action and if the time frame for repair is acceptable.

While Medicare contractors will not be expected to initiate the repair of “test” 5010 claims, they shall continue to: 1) monitor the COBC Detailed Error Reports; and 2)

notify their shared systems of errors returned so that necessary shared system changes to improve HIPAA compliance rates may be realized.

IMPORTANT: The DME MAC shared system shall apply NCPDP D.0 non-SFR "skinny" logic to claim repair situations where they originally transmitted claims to the COBC prior to January 1, 2012, in the NCPDP 5.1 claim format.

XI. Installation of Cut-over Date Parameter Logic to Address Conversion of Older Claim Formats

To ensure appropriate cutover to the NCPDP D.0 COB flat file format, the DME MAC shared system shall develop new date parameter logic to become operational as of January 1, 2012.

The shared system shall ensure that the new logic addresses all of the following scenarios:

A. Repairing any errored NCPDP 5.1 claims in the NCPDP D.0 claim format;

B. Converting claims held in suspense from a NCPDP 5.1 format to the NCPDP D.0 claim format;

C. Converting previously adjudicated NCPDP 5.1 claims to the NCPDP D.0 "skinny" non-SFR COB claim format in adjustment claim situations; and

D. Converting claims held in "provider alert status" from an NCPDP 5.1 format to the NCPDP D.0 "skinny' non-SFR COB claim format.

80 - Electronic Transmission - General Requirements

(Rev. 448, Issued: 01-21-05, Effective: 02-22-05, Implementation: 02-22-05)

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

The CMS requires that the outbound format for the transfer of health care claim information is the ANSI X12N 837 COB, or for transmissions before the required implementation date for X12N, the NSF or UB-92 outbound format may be used. Also, if the recipient wants electronic attachments, attachment data must be furnished in UB-92 or NSF format because X12N does not support electronic attachments (e.g., UB-92 RTs

74, 75, 76). Only the attachment records will be furnished in UB-92 or NSF format after X12N becomes mandatory. Other data will be in the X12N format. The recipient must coordinate any attachments received with the claim record.

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

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

The Medicare Claim/COB flat file is the format to be used to re-associate all data required to map to the COB transaction. Until all trading partners have executed national COBAs and been moved into production with the COBC, the intermediary or carrier's translator will continue to build its outbound COB transaction from the Medicare Claim/COB flat file.

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

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

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

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

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

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

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

Non-Medicare data (and Medicare data elements where field sizes are in excess of the core system) are written to the SFR; and adjudicated data is combined with repository data to create the outbound COB. Under the COBA process, the COBC will receive flat files containing processed Medicare claims. The COBC will then convert the flat files into the appropriate HIPAA outbound COB format and transmit the claims to the COBA trading partner. Implementation of this process will begin on July 6, 2004, with a small-scale parallel production period. Refer to §70.6 of this chapter for more details.

80.1 - HIPPA Provisions Affecting Medigap Transactions

(Rev. 1, 10-01-03)

PM-A-01-20

The HIPAA administrative simplification provisions have the following impact on data communications with Medigap and other complementary insurers.

- Medicare will switch to exclusive use of the outbound COB by October 16, 2003;

- Medicare will cease issuance of non-version 4010 COB transactions and acceptance of non-837 version 4010 electronic claims by October 2003;

- Medicare will cease support of DDE for Part B claims submission;

- Each provider that has elected to submit claims electronically must submit all of their claims in compliance with the HIPAA Implementation Guide (IG) requirements for ANSI X12N 837 version 4010. Vendors that submit electronic claims for Medicare providers must also comply with the IG requirements;

- Each trading partner that has elected to accept COB electronically must accept the IG outbound claim format, or contract with a [health] clearinghouse to translate its claim data from the IG format. An entity that elects to use a clearinghouse for translation services is liable for those costs; and

- COB trading partners must either request system compatibility testing for use of the COB transaction prior to October 2003, or be confident that they have completed system changes as required to accept production COB transactions by October 2003. Any trading partner that prefers to have COB testing conducted prior to transmission of production data must schedule testing with the intermediary or carrier as soon as possible to assure testing will be completed before October 2003. Current trading partners either accept production ANSI

X12N 837 COB transactions starting October 2003, or advise their contractor that they are terminating their COB agreement. If the trading partner has not advised the FI or carrier which alternative it intends to pursue, the FI or carrier terminates sending COB transactions after September, 2003.

The Implementation Guide and X12N data dictionary can be downloaded without charge from www.wpc-edi.com/HIPAA.

There is no Medicare charge for furnishing test files for this system testing.

Medigap carriers should refer to http://www.cms.hhs.gov/providers/edi/edi3.asp for specifications for Version 6.0 of the COB UB-92 flat file as well as the NSF and ANSI X12N 837 formats.

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

(Rev. 448, Issued: 01-21-05, Effective: 02-22-05, Implementation: 02-22-05)

The intermediary or carrier charges Medigap and other complementary insurers (but not Medicaid) for the cost of preparing and sending COB transactions. The transfer agreement must include a description of data elements on the invoice (bill). (See §70.3 above.) Once CMS has fully consolidated the claims crossover process under the COBC, the COBC will have exclusive responsibility for the collection of crossover claim fees for those Medigap and non-Medigap claims that are sent to the COBC to be crossed over to trading partners. The COBC will also have responsibility for distribution of the collected crossover fees to Medicare intermediaries and carriers. (See also Pub.100-06, Chapter 1, §450 and Pub.100-04, Chapter 28, §70.6.)

If a Medigap insurer refuses to pay or does not pay it regularly and completely, the carrier should notify the appropriate State insurance commission that the Medigap insurer is not complying with the payment provisions of §4081 of OBRA 1987 (also found at §1842(h)(3)(B) of Title XVIII of the Act). First, the carrier should contact the insurance department of the State in which the policyholder resides. If that State insurance department does not accept jurisdiction, the carrier informs the appropriate RO. The RO contacts CMS Central Office for assistance in determining the department of jurisdiction. If, after contacting the insurance department recommended by CMS, the problem is unresolved, the carrier treats it as a CMS debt under 42 CFR 401.601-401.625. (**NOTE:** This responsibility shall cease once all Medigap insurers, including those that presently participate in mandatory Medigap [also known as "claim-based"] crossover as well as those that participate in eligibility file-based crossover, have been transitioned to the COBC).

The requirements in §§20 - 30.1 do not supplant existing agreements which the intermediary or carrier may have with any other insurer to exchange complementary insurance information except for possible amendment to recognize the beneficiary's right to assign Medigap payment to participating physicians and suppliers on a claim-by-claim basis. The intermediary or carrier should modify these agreements to state that it is the

beneficiary's right to designate a particular insurer to receive a notice for payment. If the intermediary or carrier has transmitted an ANSI X12N 837 COB transaction to a designated Medigap insurer based on a properly executed assignment, that insurer should send claims information to other insurers under complementary arrangements.

80.3 - Medigap Electronic Claims Transfer Agreements

(Rev. 448, Issued: 01-21-05, Effective: 02-22-05, Implementation: 02-22-05)

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

At a minimum, all transfer agreements include:

- Functions of the carrier;
- Functions of the Medigap insurer;
- Fees and payment schedules;
- Confidentiality/Disclosure of information furnished;
- Office of Inspector General (OIG) review access;
- Contract periods and automatic renewal provisions;
- Contract termination provisions; and
- Dated signatures of authorized carrier/Medigap insurer representatives

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

By current estimates, effective with the end of fiscal year 2005 (i.e., September 30, 2005), all electronic transfer agreements [formally known as Coordination of Benefits Agreement (or COBAs)] will be negotiated and administered by the COBC, working on behalf of CMS. The COBAs will be executed between health insurers and health benefits programs that pay after Medicare and CMS rather than between intermediaries/carriers and these entities. Refer to §70.6 in this chapter for more details.

80.3.1 - Intermediary Crossover Claim Requirements

(Rev. 448, Issued: 01-21-05, Effective: 02-22-05, Implementation: 02-22-05)

A. Outbound COB

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

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

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

The shared system maintainer must accommodate the COB transaction.

The flat file creation process and responsibility for sending outbound COB files to crossover trading partners will change appreciably once CMS' COBA process is implemented. The small-scale implementation of COBA will begin July 6, 2004, with a parallel production period involving ten beta-tester trading partners. This parallel production process will continue until CMS, COBC, and the trading partners conclude the testing results demonstrate a high level of confidence. The larger-scale COBA process, where additional trading partners are first identified as testing participants with the Coordination of Benefits Contractor (COBC) and then are moved to crossover production with the COBC following the successful completion of testing, may be activated at any time during the COBA parallel production process. Activation of the larger-scale COBA process will most likely not occur before the early months of calendar year 2005.

B. Summary of Process

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

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

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

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

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

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

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

80.3.2 - Carrier/DMERC Crossover Claim Requirements

(Rev. 448, Issued: 01-21-05, Effective: 02-22-05, Implementation: 02-22-05)

A. Outbound Coordination of Benefits (COB)

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

The ANSI X12N-based flat file is the format to be used to re-associate all data required to map to the outbound ANSI X12N 837. The translator will build the outbound ANSI X12N 837 COB from the ANSI X12N-based flat file.

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

The flat file creation process and responsibility for sending outbound COB files to crossover trading partners will change appreciably once CMS' COBA process is implemented. The small-scale implementation of COBA will begin July 6, 2004, with a parallel production period involving ten beta-tester trading partners. This parallel production process will continue until CMS, COBC, and the trading partners conclude the testing results demonstrate a high level of confidence. The larger-scale COBA process, where additional trading partners are first identified as testing participants with the Coordination of Benefits Contractor (COBC) and then are moved to crossover production with the COBC following the successful completion of testing, may be activated at any time during the COBA parallel production process. Activation of the larger-scale COBA process will most likely not occur before the early months of calendar year 2005.

B. Summary of Process

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

- Carrier's translator performs syntax edits and maps incoming claim data to the ANSI X12N flat file;
- Standard system creates implementation guide and Medicare edits for the flat file data;
- Medicare data on ANSI X12N flat file is mapped to the core system;

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

- Non-Medicare data (and Medicare data elements where field sizes are in excess of the core system) are written to the store-and-forward repository; and
- Adjudicated data is combined with repository data to create the outbound COB.

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

90 - Paper Submission

(Rev. 1, 10-01-03)

B3-4708

On paper submissions to Medigap insurers, the intermediary or carrier must include all of the same elements that are required on electronically transmitted claims notices **except** that the date of birth may be omitted. These elements are:

- Beneficiary Data;
- HICN;
- Name;
- Address;
- Date of Birth (not required);
- Medigap policy number;
- Claims Data;
- Medigap Assignment Indicator;
- Date of Service;

- Procedure Code (modifiers);
- Submitted Charge;
- Allowed Charge;
- Medicare Paid Amount;
- Amount Applied to Deductible;
- Part B Blood Deductible;
- Participating Physician/Supplier Data;
- Name;
- Address; and
- Tax Identification Number.

Medigap carriers that do not have trading partner agreements with the Medicare carriers or FIs usually receive paper claims consisting of Form CMS-1500 and UB-92 forms and/or Provider Remittance Advice (RA) from the provider. Medigap carriers that receive paper claims generally use claim level summary data to process and pay claims.

While Version 4A.01 of the electronic remittance advice will carry line-by-line payment and adjustment information that corresponds to each service line submitted on a claim, earlier versions of the electronic remittance advice and corresponding PC print version will support summary, claim level data only. Also the standard paper remittance advice reports summary, claim level payment data. There are no plans to change to include line level data.

100 - Medigap Insurers Fraud Referral

(Rev. 1, 10-01-03)

AB-00-23

Carriers and FI's should give high priority to fraud complaints made by Medicare supplemental insurers. If the referral by a Medigap insurer includes investigatory findings indicating fraud stemming from site reviews, beneficiary interviews, provider interviews and /or medical record reviews, contractors should (a) conduct an immediate data run to determine possible Medicare losses and (b) refer the case to the Office of the Inspector General (OIG).

In addition to the referral of such cases to the OIG, contractors should also identify and take additional corrective action to prevent future improper payments (e.g., by placing the

provider or supplier's claims on prepayment review). Contractors are responsible for taking reasonable and appropriate measures to protect the Trust Fund.

110 - Medigap Criminal Penalties/Types of Complaints Under Section 1882(d)

(Rev. 1, 10-01-03)

RO-2700

Although most States have some type of penalty provisions regarding fraud and misrepresentation in the sale of health insurance policies, Congress considered that many State laws either did not directly address the following types of abuses, or else the sanctions generally available under State laws were considered too limited. Therefore, in order to provide an additional avenue for prosecution of these cases as well as to provide stiff penalties (fines up to $25,000 and/or imprisonment for up to five years) these provisions were included in Section 507 of P.L. 96-265.

A. Section 1882(d)(l) - This paragraph prohibits the making of a false representation with regard to the compliance of a policy with the Federal requirements contained in this law. Additionally, it prohibits the making of any false statement or misrepresentation with respect to the use of the emblem that signifies the Secretary's certification of a policy under the Voluntary Certification Program. Policies submitted under this Voluntary Certification Program were accepted for review by the Medigap Operations Staff beginning January l, 1982. Any agent or company which represents that its policy has received the Secretary's certification, or that its policy has received or is eligible for the Secretary's emblem, when, in fact, it has not received such certification or emblem, can be prosecuted under this paragraph. This paragraph became effective June 9, 1980.

B. Section 1882(d)(2) - This paragraph prohibits the false representation of an association or agency relationship with the Medicare program or any Federal agency for the purpose of selling insurance. Of the complaints received by CMS, the majority involves alleged violations of this paragraph. These complaints indicate that agents gained entry and, in some cases, sold policies by misrepresenting, either by direct statement or by implication, that they were associated with Medicare, CMS, or the Social Security Administration. This paragraph became effective June 9, 1980.

C. Section 1882(d)(3) - This paragraph provides penalties for knowingly selling duplicative coverage (sometimes referred to as "stacking" or "loading)." This occurs when an agent sells insurance to an individual knowing that it duplicates coverage that he/she already has without duplicating benefits. This paragraph became effective June 9, 1980.

Although many States have statutes that specifically prohibit "twisting" (misrepresentations made by an agent for the purpose of inducing the policyholder to lapse, forfeit, or convert a policy), few States have specific prohibitions against "stacking." Therefore, Federal prosecution under §1882(d)(3) may prove to be a useful

approach where the available State statute does not specifically prohibit "stacking." Moreover, the Federal sanctions available for misrepresentations and "stacking" may prove to be useful for prosecution where the available State sanctions are more limited.

D. Section 1882(d)(4) - This paragraph provides penalties for knowingly soliciting, advertising, or offering for sale Medicare supplemental health insurance policies by mail into a State if these policies have not been approved by the Commissioner of Insurance for sale within the State or are not deemed to be approved for sale within the State. Section 1882(d)(4)(B) sets out the situations for deeming that a policy is approved within a State.

110.1 - Outline of Complaint Referral Process

(Rev. 1, 10-01-03)

RO-2700

Representatives of CMS, the Office of the Inspector General (OIG) and the Department of Justice (DOJ) have consulted to develop a coordinated procedure for the screening, investigation, and prosecution of cases arising under these penalty provisions.

The Fraud Section, DOJ, has expressed great interest in the prosecution of these cases and has sent an official communiqué to all U.S. Attorneys addressing the existence and importance of the Medigap law and alerting them to the probability of referrals of cases developed jointly by CMS, OIG, and by State Insurance Departments.

A. CMS/OIG Agreement

The CMS and OIG have reached the following agreement as to the division of functional responsibilities with regard to the screening and investigation of alleged violations of §1882(d):

1 - CMS, through its regional offices, is responsible for the preliminary screening of complaints and for providing information regarding the complaints to the appropriate State Insurance Department.

2. The OIG is responsible for the investigation of cases referred by the CMS RO and for coordinating investigatory activities with the State Insurance Departments if requested and warranted. Further, OIG will provide any necessary liaison between State Insurance Departments and the U.S. Attorneys.

B. CMS RO Responsibilities

Upon receipt of a complaint, the RO sends an informational copy of the complaint and any supporting documentation to the Regional Office of the Inspector General. The Special Agents in Charge will serve as the OIG contact point for CMS referrals.

Additionally, the RO sends a copy of the original complaint and any supporting documentation to the appropriate State Insurance Department. This is to be accompanied by a request for information as to the status of any State investigation regarding the same agent or company or the specific case in question.

l. If the State indicates that it is currently investigating, or intends to investigate the agent or company, the RO provides any information which may be helpful to the State and advise the State of the existence of the Federal penalty provisions and the availability of investigatory advice and/or assistance from the Regional Office of the Inspector General.

If the facts also indicate that a Federal violation may exist, the RO should keep the file open and request that the State advise them as to the status and, eventually, the disposition of the case.

If the facts indicate a possible State violation but no Federal violation, the RO out the case after referring it to the appropriate State Insurance Department.

In either event, the RO should respond to the complainant that the case has been referred to the State Insurance Department for investigation. The RO sends a copy of this response to the State, Regional OIG, and to the Medigap Operations Staff (MOS).

2. Where the State indicates that it does not plan to take action on the case, or where no response is received from the State within a reasonable period of time, i.e., not more than 30 days, the RO should proceed to screen the case. This activity consists of:

- Verifying the facts alleged in the complaint; and
- Determining whether the facts appear to constitute prohibited activity.

3. Where preliminary screening indicates that a mistake of fact exists, or that the facts do not indicate a Federal violation, the RO should respond to the complainant and attempt to clarify the misunderstanding. The RO sends a copy of the RO response to the complainant to MOS, the Special Agent in Charge, and the appropriate State Insurance Department.

Verification of Facts - The carrier or intermediary logs in complaints as they are received and establishes appropriate procedures to ensure that follow-up action is taken on any request for additional information. Verification of facts may include interviewing the complainant (either by phone or in person, as appropriate) to:

- Determine whether the facts, as originally reported, are accurate and precise;
- Clarify statements that are confusing or contradictory as originally recorded.
- Secure any missing or additional information; and

- Determine whether any similar complaints or additional information may be derived from others (e.g., relatives or neighbors).

In interviewing the complainant and others, keep in mind the substantive facts that may lead to prosecution. The carrier or intermediary uses the suggested format for referral to the Regional OIG as a checklist for the interview. As far as possible, the RO should keep the complainant informed of the status of the action taken on the complaint. So as to maintain a high level of cooperation; inform the complainant when he can expect to be contacted again, who will contact him, etc.

It is important that the RO **not** directly contact either the agent or the insurance company involved since this falls within the purview of investigation and is the function of the OIG.

Referral to the Regional Office of the Inspector General - When the preliminary screening process reveals an indication that the Federal law has been violated, refer the case to the Regional OIG for additional development. The OIG performs the necessary investigation and coordinates with the appropriate U.S. Attorney for prosecution. At this point, CMS will cooperate with any request by the U.S. Attorney, State Insurance Department, and OIG to promote timely and successful prosecution.

If there should be any questions regarding this screening and referral activity, contact the Director, Medigap Operations Staff at the address below.

Centers for Medicare & Medicaid Services
Director, Medigap Operations Staff
7500 Security Blvd.
Baltimore, Maryland 21244-1850

110.2 - Preliminary Screening and Referral to Regional Office of the Inspector General

(Rev. 1, 10-01-03)

RO-2700

The Regional Office should perform preliminary screening activities, which may include interviewing the complainant in person or by phone (if appropriate), in order to reach a determination as to referral of the case for further investigation to the Special Agent in Charge, Office of Investigations, Regional Office of the Inspector General, HHS.

At the point where the RO believes that there exists an indication of the violation of one of the Federal penalty provisions, the RO should prepare a formal referral to the Regional OIG. In cases where there is uncertainty as to whether the Federal law has been violated, the case should be referred notwithstanding the uncertainty. The referral should reflect the following information:

A. Type of violation, e.g., the complainant alleges a violation of §1882(d)(2);

B. Name, address, and telephone number of the complainant; and

C. A narrative description of the facts, which should include:

1. All circumstances regarding the contact made by the subject with the beneficiary:

a. Type of contact (phone, personal);

b. Stated reason (if any) for selection of the beneficiary by the subject making the contact, e.g.:

i. Beneficiary lives in a senior citizens community or complex;

ii. The existence of another insurance policy with the same company; and

iii. Referral by a third party.

2. Date, time, place, and duration of all contacts;

3. Words that were used to gain entry into the beneficiary's home, e.g., "I'm from Medicare," "…SSA," or other Federal Government agency;

4. Details of the subject's sales pitch or presentation:

a. Was there a discussion of the existence of other health insurance policies currently held by the beneficiary?

b. Did the agent know that his policy was duplicative of Medicare or a currently held policy?

c. Amount of premium of policy that agent was trying to sell. Obtain a copy of the policy if possible;

d. Existence of any hard sell or intimidation tactics on the part of the agent.

5. Details of the Agent's exit:

a. Business card left by agent; and

b. Follow-up calls by agent or others.

D. Other Information:

1. Name of contact person in the Regional Office;

2. Copy of the original complaint; and

3. Any other supporting documentation.

110.3 - CMS Regional Office Quarterly Report on Medicare Supplemental Health Insurance Penalty Provision Activity

(Rev. 1, 10-01-03)

RO-2700

The RO's should submit to the Director, Medigap Operations Staff, a report summarizing activities with regard to the screening and referral of complaints falling under the penalty provisions of §1882(d). This report will be used to compile the Secretary's report to Congress as required by §1882(f)(2). Under the terms of this paragraph, the Secretary must submit a report to Congress beginning July 1, 1982 (and at least every two years thereafter) evaluating, among other things, the effectiveness of the criminal penalties. The following information from the Regional Offices is necessary for that evaluation.

110.3.1 - Statistics

(Rev. 1, 10-01-03)

RO-2700

The number of complaints received broken down by the type of alleged violation, e.g., §1882(d)(2).

The origin of the complaints:

- Complaint was made directly to RO;
- Complaint was referred by other Federal agency; State agency;
- Complaint was referred by consumer group;
- Other;
- The number of interviews (contacts) held to validate the facts of the case;
- The number referred (after screening) to the Regional Office of the Inspector General for investigation; and
- The number of cases closed-out:
    - For mistake or misunderstanding;
    - Referral to State for violations of State law;

- Other.

- The number of cases prosecuted and, for each, the name of the agent/company and disposition of the case; and

- The number of cases currently pending.

110.3.2 - Narrative

(Rev. 1, 10-01-03)

RO-2700

The RO provides information as to the overall success of the complaint validation and referral procedure including the extent of cooperation among CMS, OIG, State Insurance Departments, and the U.S. Attorneys. This information will be used to correct or strengthen existing procedures.

This report should be submitted by the 15th of the month following the report quarter.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R2215CP	05/13/2011	Modifications to the COBA Process for Other Federal Payer Payment Order and Other Issues	10/03/2011	7393
R2189CP	04/04/2011	Modifications to the National Coordination of Benefits Agreement (COBA) Crossover Process Stemming Principally From the Affordable Care Act (ACA)	04/04/2011	7136
R2181CP	03/25/2011	Medicare Claims Processing Pub. 100-04 Chapter 24 Update for HIPAA 5010 and EDI Enhancements	04/25/2011	7269
R2090CP	11/10/2010	Implementation of Errata for Version 5010 of Health Insurance Portability and Accountability Act (HIPAA) Transactions, and Updates in 837I, 837P, and 835 Flat Files	04/04/2011	7202
R2087CP	11/05/2010	Implementation of Errata for Version 5010 of Health Insurance Portability and Accountability Act (HIPAA) Transactions, and Updates in 837I, 837P, and 835 Flat Files – Rescinded and replaced by Transmittal 2090	04/04/2011	7202
R2076CP	10/28/2010	Modifications to the National Coordination of Benefits Agreement (COBA) Crossover Process Stemming Principally From the Affordable Care Act (ACA) – Rescinded and replaced by Transmittal 2189	04/04/2011	7136
R1920CP	02/19/2010	Modifications to Gap-Filling Requirements for the Health Insurance Portability Accountability Act (HIPAA) 837 version 5010 Coordination of Benefits (COB) Claims Transactions and National Council for Prescription Drug Programs (NCPDP) Version D.0 Claim Files	07/06/2010	6816
R1844CP	11/06/2009	Additional Health Insurance Portability and	04/05/2010	6658

Rev #	Issue Date	Subject	Impl Date	CR#
		Accountability Act (HIPAA) 837 5010 Transitional Changes and Further Modifications to the Coordination of Benefits Agreement (COBA) National Crossover Process		
R1841CP	10/29/2009	National Council for Prescription Drug Programs (NCPDP) Version D.0. Coordination of Benefits (COB) Requirements for the National Claims Crossover Process	04/05/2010	6664
R1727CP	05/01/2009	Coordination of Benefits Agreement (COBA) Repair and Claims Recovery Requirements Stemming from the Health Insurance Portability and Accountability Act (HIPAA) 5010 Claims Transactions	10/05/2009	6420
R1720CP	04/24/2009	Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) 837 5010 Coordination of Benefits (COB) Requirements--Part II	07/06/2009	6374
R1704CP	03/20/2009	Modifications to the National Coordination of Benefits Agreement (COBA) Crossover	07/06/2009 and 10/05/2009	6343
R1640CP	11/21/2008	Modifications to the National Coordination of Benefits Agreement (COBA) Process	04/06/2009	6234
R1568CP	08/01/2008	Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X12-N 837 version 5010 Changes Necessary for Coordination of Benefits (COB) and other Coordination of Benefits Agreement (COBA) Process Revisions	01/05/2009	6103
R1507CP	05/16/2008	Coordination of Benefits Agreement (COBA) and Affiliate National Provider Identifier (NPI) Process Modifications	10/06/2008	6024

Rev #	Issue Date	Subject	Impl Date	CR#
R1497CP	05/02/2008	Modifications to the National Coordination of Benefits Agreement (COBA) Crossover Process	07/07/2008	6037
R1436CP	02/05/2008	Modifications to the National Coordination of Benefits Agreement (COBA) Crossover Process – Replaced by Transmittal 1497	07/07/2008	5866
R1420CP	01/25/2008	Clarification Regarding the Coordination of Benefits Agreement (COBA) Medigap Claim-Based Crossover Process	02/01/2008	5837
R1332CP	08/31/2007	Transitioning the Mandatory Medigap ("Claim Based") Crossover Process to the Coordination of Benefits Contractor (COBC)	10/01/2007	5601
R1296CP	07/18/2007	Modifications to the National Coordination of Benefits Agreement (COBA) Crossover Process	10/01/2007	5569
R1282CP	07/06/2007	Medicare Contractors Use of the Coordination of Benefits Agreement (COBA) Problem Inquiry Request Form and Send COBA Related Issues to the COB Contractor	08/06/2007	5656
R1242CP	05/18/2007	Transitioning the Mandatory Medigap ("Claim Based") Crossover Process to the Coordination of Benefits Contractor (COBC)	10/01/2007	5601
R1232CP	04/27/2007	Modification to the Coordination of Benefits Agreement (COBA) Crossover Process - Replaced by Transmittal 1296	10/01/2007	5569
R1189CP	02/28/2007	Differentiating Mass Adjustments From Other Types of Adjustments and Claims for Crossover Purposes and Revising the Detailed Error Report Special Provider Notification Letters – Replaced by Transmittal 1189	07/02/2007	5472
R1179CP	02/02/2007	Differentiating Mass Adjustments From Other Types of Adjustments and Claims for Crossover Purposes and Revising the Detailed	07/02/2007	5472

Rev #	Issue Date	Subject	Impl Date	CR#
		Error Report Special Provider Notification Letters – Replaced by Transmittal 1189		
R1110CP	11/09/2006	Excluding Sanctioned Provider Claims from the Coordination of Benefits Agreements (COBA) Crossover Process	04/02/2007	5353
R1038CP	08/25/2006	COBC Sending Copy of Trading Partner's Eligibility File to Medicare Contractor for Use in Recovery Process	01/02/2007	5250
R1006CP	07/21/2006	Modification to the Coordination of Benefits Agreement (COBA) Claims Selection Criteria and File Transfer Protocols	10/02/2006	5094
R967CP	05/26/2006	Modification to the Coordination of Benefits Agreement (COBA) Claims Selection Criteria and File Transfer Protocols	10/02/2006	5094
R837CP	02/03/2006	Coordination of Benefits Agreement (COBA) Full Claim File Repair Process	07/03/2006	4277
R666CP	09/02/2005	Updates to the Coordination of Benefits Contractor (COBC) Detailed Error Report File Layouts	10/03/2005	4042
R586CP	06/17/2005	Modification to the National Coordination of Benefits Agreement (COBA) File Transfer and Financial Reporting Processes	10/03/2005	3906
R474CP	02/11/2005	Detailed Error Report Notification Process to COBA Partners	07/05/2005	3709
R448CP	01/21/2005	Timeframe for Execution of Crossover Agreements and Update on the Transition to the National Coordination of Benefits Agreement (COBA) Program	02/22/2005	3658
R250CP	07/23/2004	Update of CWF Procedures	01/03/2005	3404
R158CP	04/30/2004	Transition to Medicare Coordination of	10/04/2004	3273

Rev #	Issue Date	Subject	Impl Date	CR#
		Benefits Contractor (COBC)		
R138CP	04/09/2004	Transition to Medicare Coordination of Benefits Contractor (COBC)	07/06/2004	3218
R098CP	02/06/2004	Transition to Medicare Coordination of Benefits Contractor (COBC)	07/06/2004	3109
R001CP	10/01/2003	Initial Publication of Manual	NA	NA

Back to top of Chapter