

## **SECTION I - ELIGIBILITY FILES**

- 1. Will the eligibility file format change? Does CMS plan on migrating the current eligibility file formats to the ANSI X12-834 at some point?**

No. The current 200-byte standard COB Eligibility file format will be used for COBA.

- 2. How often will the Trading Partner be allowed to provide eligibility files? How often will eligibility files be loaded?**

Regular updates can be sent weekly, bi-weekly, or monthly. If you receive an error file, you should correct the file immediately/off-schedule and resend to COBC. Eligibility updates will be processed nightly.

- 3. Is the COBC expecting a full file replacement of our eligibility file? When will our eligibility file be loaded?**

The COBA process will support full file replacement or adds, updates, and deletes. The COBC will load Eligibility Files on a daily basis. The Trading Partner will need to indicate its frequency of Eligibility File submission to the COBC in the COBA Attachment. The Eligibility File data are uploaded to CWF within five business days of receipt. For examples, please refer to the Eligibility File Section of the COBA Implementation User Guide found on the website at <http://www.cms.hhs.gov/medicare/cob/coba/coba.asp>.

- 4. Since the data centers receive Medigap carriers' eligibility files as full file replacements, what happens if a carrier misses the cut off time for submitting a file?**

There is no cut-off time for eligibility file submission.

**Will their old eligibility be used?**

Eligibility remains on CWF until altered

**If not, what procedure will be followed?**

As noted the full file replacement will be loaded to CWF within 5 days of receipt.

- 5. The eligibility file processing indicates that there must be a separate header record for each COBA ID. When I review the header record layout for the eligibility file there is a Header Beneficiary state code. From reviewing the header record layout it looks like what is required is a file sorted by COBA ID and by Beneficiary State. Which sort should be primary?**

Trading Partners should sort the Eligibility File by COBA ID. The COBA process will not utilize the optional beneficiary state code field. For examples, please refer to the Eligibility Update Process Section of the COBA Implementation User Guide on the website at <http://www.cms.hhs.gov/medicare/cob/coba/coba.asp>.

- 6. In the eligibility file processing COBA eligibility layout there is no indication as to what should be reported in the "Eligibility To Date" field when the coverage extends indefinitely into the future. How does the COBC expect this date to be filled where the insured's coverage extends indefinitely into the future?**

Trading Partners should indicate zeros in the field for open-ended dates. Do not use default dates.

- 7. The eligibility file load “BO Error Report” looks like it will be sent to us via Connect Direct and we should make corrections based on the report. Once the corrections have been made, what is the process for sending them back to the COBC and having them updated onto the eligibility master file?**

For those who use full file replacement, the corrected file must be a full file replacement. For those who use adds, updates and deletes, submit only the corrected records. Corrections will be allowed on off-schedule transmissions. Please refer to the Full File Replacement Section of the Eligibility Update Process in the COBA Implementation User Guide.

- **What turn-around time should we expect from the time the file is sent to you until the time the “BO Error Report” is available to us?**

We will process eligibility files, including corrected files, within five business days of receipt and you will have the BO Error Report on the sixth day.

- **What turn-around time is the COBC expecting to receive corrections from us?**

The Trading Partner should correct the errors immediately and resend to the COBC.

- **What turn-around time should we expect from the COBC before the corrections we prepare are applied to the eligibility file?**

Eligibility File corrections to the CWF system will occur within five business days of receipt of the Eligibility File

- 8. The error report description indicates an eligibility record will not be updated when one or more “BO...” errors are found but only the first error encountered will be reported. Since up to five eligibility dates could be reported on the file, at worst case a record could be resubmitted fourteen times to correct all the errors. Can the report be modified to show all the errors that prevent update instead of only the first one encountered?**

BO01 through BO04 could occur once, while BO14 and BO15, the effective and termination errors, could occur for each of the five dates on the eligibility file-or at worst case ten times. CWF will accommodate up to four BOI error replies per eligibility record.

- 9. Please explain how full file replacement eligibility will be differentiated by COBC from Adds/Updates/Deletes?**

The COBA process will not utilize the File Update Indicator field on the Eligibility File for Full File Replacement. The use of Full File Replacement should be indicated in Section III.A.3 of the COBA Attachment.

- 10. If the beneficiary gender code is unknown to us, should we use M or F as a default? In the eligibility file layout these are the only allowed values indicated. What are the implications of using a default? Would claims that may otherwise match to one of our insureds miss being reported to us?**

The primary match will be on HICN. A secondary match will be on the first initial of the beneficiary’s First Name, Date of Birth, Sex Code and the first six characters of the

beneficiary surname. Trading Partners should use the value code representation of M as a default for the beneficiary sex code. Eligibility records that match on three out of the four matching criteria in addition to the HIC number will pass the secondary match.

**11. Can we send a partial eligibility file with which to perform testing?**

Yes.

**12. Should the eligibility file include only those instances where the Trading Partner is secondary to Medicare? For example, can the eligibility file include records for beneficiaries where the Trading Partner is the primary payer and Medicare is secondary?**

The COBA Eligibility File should contain records only for beneficiaries for whom the Trading Partner provides supplemental coverage.

**13. Based on the edit errors noted in the COBA Implementation User Guide, what would be considered an invalid match? For example, if a Trading Partner sends the wrong beneficiary surname or spelling of a surname will this constitute an invalid record?**

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

**14. When can we anticipate seeing the eligibility file layout denoting the mandatory fields?**

The layout is in the COBA Implementation User Guide found on the website at <http://www.cms.hhs.gov/medicare/cob/coba/coba.asp>.

**15. In the COBA Eligibility File Layout under Header Records item number 4 "Header Beneficiary State Code," a description is provided indicating "beneficiary state of residence." Please clarify the intended use of this field. Is this the reporting Plan's state or the actual address of the beneficiary? If this is the beneficiary address, does this need to appear in the header record or on each beneficiary's record and not the header?**

The Beneficiary State Code is not a required field and it will not be used in this process.

**16. If a record is rejected by CMS or if the record is excluded from the COBA eligibility feed, how will CMS process this information? Will this result in CMS deleting or canceling the member's crossover record?**

If an eligibility record fails then the record is not loaded. The COBA process will generate a detail report identifying all records receiving one or more errors. For those who use full file replacement, the corrected file must be a full file replacement. For those who use adds, updates and deletes, submit only the corrected records. Corrections will be allowed on off-schedule transmissions. Please refer to the Full File Replacement Section of the Eligibility Update Process in the COBA Implementation User Guide.

- 17. If an entire eligibility file is rejected or fails, will CMS delete all records or cancel all records based on that file? Or will CMS continue to hold the information received from the previous file and only reject the current file?**

If an entire Eligibility File rejects, the COBA process will generate a detailed report. The COBA process will continue to crossover claims based on the prior Eligibility File.

- 18. Will the error reporting mirror or look similar to MSP? Will there be specified error percentages for duplicates, deletes, etc., similar to MSP? Will error percentages for those Trading Partners belonging to the Blue Cross and Blue Shield Association be reported to the Association, similar to MSP?**

Refer to the COBA Implementation User Guide, found on the website at <http://www.cms.hhs.gov/medicare/cob/coba/coba.asp>, for a sample Eligibility Detail Report.

- 19. Once the agreement is signed and beta testing begins, can the eligibility file frequency be modified or changed. If weekly files are being sent initially, can we modify this to be bi-weekly sometime in the future?**

Yes. The Trading Partner may communicate any changes to its selected options by completing and submitting another COBA Attachment, indicating on page 1 that this is a change.

- 20. Would CMS consider sending back to the Trading Partners on the eligibility response file the Beneficiary Supplemental ID Number?**

Yes. The Eligibility Detail Report has been updated to include the beneficiary supplemental ID as submitted on the Eligibility File by the Trading Partner.

- 21. When looking at “Beneficiary Supplemental Eligibility to and from dates” and calculating end dates, does CMS consider the actual date recorded as a coverage end date or is that date the coverage through date?**

The date is the coverage through date.

- 22. If the effective date is equal to the cancel date, does CMS want to see these on the eligibility file?**

No. If received, it will be interpreted as one-day of coverage and we will assume you did not want this situation to occur.

- 23. Can a Trading Partner send multiple records for a beneficiary under two different Beneficiary Supplement ID Numbers? So, if a beneficiary is covered as a spouse under one policy and covered as the contract holder under another policy, both having secondary coverage to Medicare, can CMS accept both numbers?**

If you send the numbers in two different eligibility files, it will be accepted. If you send both numbers on the same eligibility file, it will be treated as a duplicate.

- 24. Can a Trading Partner submit an eligibility file from a different location, and/or using a different communication method than used for the claim file receipt? (That is, claims are received via NDM and eligibility sent via FTP.)**

Yes.

- 25. What if our eligibility file correctly contains less than 70% of the records currently in our database? We will be sending one eligibility file for many COBA ID's with full file replacement (we are a clearinghouse). There may be a time when our population of Trading Partners changes; therefore, a drastic variance will occur in the eligibility file sent to COBC. How will we be able to update the records with a file that contains less than a 70% match?**

Each COBA ID will be edited and checked for the required 70% threshold. Secondly, the COBC's EDI representative will notify the Trading Partner of COBA IDs that fail the threshold. The EDI representative will have the capability to override the system and continue process for approved COBA IDs that do not meet the required 70% threshold.

- 26. Does the date of birth have to be exact or is there a certain number of days leeway?**

Within date of birth, the month and year must match exactly, but the day can be incorrect.

- 27. How will we be able to receive/view the detail error report?**

The Eligibility File Detail Report will be forwarded electronically to Trading Partners upon processing of each incoming Eligibility File. It will be transmitted to you via the same transmission method as it is received.

- 28. If multiple insurance companies have the same insured on their eligibility file, will ALL companies receive the crossover claim?**

CWF is capable of holding 10 COBA IDs simultaneously, which represents the maximum number of entities that would receive the crossover claim. This is true for both test and production files.

- 29. Will it be acceptable under beta testing to send a separate COBA eligibility file for each COBA ID? Under live production is it expected that a separate COBA eligibility file be transmitted for each COBA ID? Or should these appear on one file with headers and trailers for both beta testing and live production?**

Trading Partners have the option of submitting a separate Eligibility File for each COBA ID or combining all their Eligibility records into a single file. In the combined file scenario, all beneficiary records must be sorted by COBA IDs and separated by a header and trailer.

- 30. In the event that multiple COBA files are acceptable, can the Trading Partner expect to receive error reports for each COB eligibility file transmitted? Or will the error report come back in one file? For example: 5 COBA ID eligibility files transmitted, will 5 error reports be submitted back to the Trading Partner?**

The Trading Partner can expect to receive an error report for each file submitted. If five COBA IDs are on one file, you will receive five separate error reports in that one file.

- 31. In the event that multiple files are submitted, how will the 20% threshold of errors be calculated? Will each file be subjected to the 20% threshold or will the files be combined and viewed as one file by CMS for calculating the 20%?**

The 20% threshold will be applied per COBA ID. The return error report will be broken out by COBA ID. If one file with multiple COBA IDs is submitted, the Trading Partner would receive one file with a separate report for each COBA ID.

- 32. In the event multiple files are submitted and one file contains over 20% errors, will all files be returned or just the file on the COBA ID that exceeded the 20%?**

Each ratio is applied to each COBA ID

- 33. CMS states that claim-based crossover is for Medigap and Medicaid insurers that do not provide COB eligibility files. Can a Trading Partner have a claim-based COBA ID and an eligibility-based COBA ID to ensure we receive claims for members on our eligibility file and those for members where we may not have them on file with the correct Medicare HICN?**

We are planning to convert as many people as possible to eligibility-based COBA ID's. We are not going to publish the eligibility-based COBA ID on the COB website. We hope to have all State Medicaid Agencies participate exclusively in eligibility file-based crossover with the COBC.

- 34. If our policy number changes for a member, this is communicated on our weekly eligibility file. This then is sent to update the BOI by the COBC. Will this maintenance occur as the file updates are sent?**

If a policy number changes, this will be communicated to CWF as an update.

- 35. We need to understand from Medicare what will print on the provider hard copy remit (those that do not get an electronic remit) or the PC Print of the 835. What will we see? Will we see the MA18 on the 835 or the paper remit for eligibility-based crossover? Chapter 28, section 50, implies MA18 will only be used on the remit for claim-based crossover. Will the N89 be used for multiple insurers?**

You will see the MA18 on the 835 for eligibility-based crossover. And, yes, the N89 will be used for multiple insurers.

- 36. Is there a limit to the number of eligibility files we send? Is there a limit to the number of claims file we wish to receive?**

There is no limit to the number of COBA IDs that can be contained in one eligibility file; however, multiple eligibility files per COBA ID are not acceptable. A COBA trading partner will receive up to three claims files (Institutional, Professional, and NCPDP) per COBA ID, based upon exclusion criteria selected in the COB Agreement.

- 37. In the future, how will crossover testing be accomplished when the COBC needs to add a new Trading Partner to the consolidated process? I assume the new Trading Partner's eligibility file will be loaded to the BOI file in CWF. Will the testing occur during the normal course of production claims files interfacing with CWF?**

Yes, the eligibility file will be loaded to the BOI file in CWF and testing will occur during the normal course of production.

**38. Will the COBC perform any other services, like editing, HIC number clean up, or other translation services?**

Data validation routines will be applied to all inbound and outbound files.

**39. How are BOI records maintained to ensure only plans with current coverage receive claims?**

BOI records are transmitted nightly to the Common Working File based on the eligibility files sent by the Trading Partner.

**40. If multiple BOI records exist, how will COBC determine which payer receives the claim?**

All payers will receive the claim.

**41. How will FEP be handled?**

Your FEP population can be isolated on a separate eligibility file, and can be subject to its own selection criteria.

**42. Will the eligibility files still be transmitted monthly and only contain complete replacements? Our policies give a 31-day grace period to pay the premiums, so we do not actually lapse a policy for 45 days. If the original issue date is around the first of the month, it will be two months later that the Medicare Contractor is notified that the policy has lapsed.**

The COBA allows for a variety of frequencies in transmitting eligibility files to be selected by the trading partner. Refer to Sections III.A and III.B of the COBA Attachment for those options. The Attachment can be viewed at <http://www.cms.hhs.gov/medicare/cob>.

**43. Will eligibility files need to be provided to each individual contractor, or only one file to the COBC?**

Only send one file to the COBC.

**44. We use different schemes on the eligibility file “to date” in order to denote the policyholder is still active. These include 121/31/999, 99/99/9999, and even 12/31/2063. What are the COBC’s requirements for reporting active policy coverage?**

Use zeroes if there is no termination date.

**45. In one of the transmittals, CMS indicates there will be 40 occurrences of BOI records. That number seems excessive. Why are so many occurrences needed? How often will they be deleted and how will they be maintained?**

CWF will be keeping a history of other insurance periods. After 40 records are archived, the earliest record will be deleted with the addition of a subsequent record.

**46. Will a parallel test be done with a full size production eligibility file?**

Yes

## **SECTION II - TECHNICAL REQUIREMENTS**

- 1. When will Trading Partners be able to test with the COBC?**  
The COBC will provide Trading Partners with an available test date once they have received and processed the executed COBA.
- 2. When will the technical guide be made available to Trading Partners?**  
The COBA Implementation User Guide is available to Trading Partners at <http://www.cms.hhs.gov/medicare/cob/coba/coba.asp>.
- 3. What types of file transfer methods will be supported by the COBA? What mode of transmission will the COBC use to transmit the HIPAA X-12N 837 COB (v. 4010-A1) files to the health insurers?**  
CMS' preferred method of electronic transmission is NDM via AGNS, which is the AT&T Global Network System, Connect: Direct using TCP/IP. Other methods of data transmission will be considered as long as they meet CMS' standard security data requirements. However, IP or SNA will be made available to the trading partner. CMS is also looking to implement a dial-up option for those trading partners that anticipate having low crossover volumes.
- 4. Will FTP via the Internet (Valicert) be acceptable?**  
File transmissions involving the Internet are currently not permissible by CMS.
- 5. If NDM through AGNS is used, how do we get the data? Do we have to go to AGNS to pull the data or does the data get pushed through AGNS to us?**  
COBC will use file transfer software, such as FTP, to push the data from the trading partner to the COBC and vice-a-versa.
- 6. Will tape transfers be supported?**  
Yes. The COBA program will accept 3480 cartridges as well as reel tapes (1600 BPI and 6250 BPI).
- 5. What encryption is required for FTP files?**  
Non-Internet based file transfer protocol options are acceptable to CMS. As Internet options for file transfers are approved, CMS will evaluate more closely the minimum standards for encryption of data exchanged as part of the COBA process.
- 6. For FTP connections, is it possible for the COBC to specify a list of IP addresses (up to 3) that would be used for outbound files?**  
As file transfer connectivity with the trading partner is established, the COBC will pass along its technical requirements for establishing IP addresses for outbound COB files to the COBA trading partner.

7. **For both, sending eligibility files to the COBC and receiving 837 COB files from the COBC, is there a public FTP option, or do we have to use the AT&T global network?**  
The COBC will advise prospective COBA trading partners of their available electronic connectivity options as part of the process of executing a national COBA.
8. **For sending/receiving FTP files, is there further information available regarding file encryption and key exchanges?**  
CMS is currently evaluating the minimum standards for encryption of outbound data files. Encryption of files may be considered, upon CMS approval, as a future enhancement within the COBA program.
9. **The CMS Change Requests indicate that APASS is waived from the implementation of these requirements. Who are the contractors processing on APASS and which states do they process claims for (including specialty type processing)?**  
There are no remaining contractors on APASS.
10. **What delimiters will be sent? For example, data element separator, sub element separator, segment terminator?**  
The delimiters are:  
Data Element = \*  
Sub Element Separator = :  
Segment Terminator = ~  
However, it should be noted that these are subject to change and the current values should be obtained from the ISA segment.
11. **How will COBC/CMS be submitting to us? (FTP, NDM etc)**  
That's up to you. There is an option in the COBA for you to specify. Our preferred method of submission is NDM via AGNS. However, other methods of data transmission will be considered as long they meet CMS' standard security data requirements.
12. **Will COBC/CMS be dialing into our Gateway to pick up reports, including 997?**  
No.
13. **Can the COBC accommodate transmitting file in an 80 byte wrapped format?**  
Yes, that is the only format we will be transmitting.
14. **Will COBC use compliance checking software such as Claredi or EDIFECs. Many problems that we run into with the FIs are their various interpretations of the HIPAA 837 Implementation Guide. We, as the crossover carrier, end up doing compliance review for them. It would be less frustrating for both parties if compliance checking occurred on both sides.**  
As of October 2004, the COBC began using Claredi for purposes of conducting HIPAA pre-edit compliance validation prior to sending claims to its COBA beta-site trading partners.

15. **Is the COBC using a commercial or proprietary translator? If commercial, which one?**  
COBC is using the commercial translator GENTRAN.
16. **What parallel processing time period will be provided for each insurer, such as a Medigap issuer, that is transitioning to the COBA?**  
Each trading partner will continue to receive production crossover claims via the existing process while testing the COBA process with the COBC.
17. **Medigap issuers say they need a minimum of 30-60 days of solid, error-free parallel testing.**  
See response above response for question#16. All trading partners will participate in a parallel testing period and will only move into production when CMS, the COBC, and these partners mutually agree that should occur.

### **SECTION III - COBA IDENTIFICATION NUMBER**

1. **Will the Trading Partner use its current insurer identification number as assigned by Medicare Contractors?**  
No. The COBC will assign a COBA number for use in generating test and production eligibility files.
2. **At what point in the COBA process will new COBA ID numbers be issued?**  
The COBA ID will be issued to the Trading Partner upon receipt of an executed COBA and Attachment.
3. **How many identification numbers will a Trading Partner receive from the COBC?**  
At a minimum, the COBC will assign separate COBA IDs to those insurers having Medigap and other lines of business for use in generating Eligibility Files. Trading Partners will also receive separate COBA IDs if: 1) the Trading Partner submits separate eligibility files, as in the case of two distinct lines of business; 2) the Trading Partner elects separate claims selection options within the same line of business or separate claims selection options per each line of business; 3) if there are differences with respect to Sections II, III, and IV of the COBA Attachment.
4. **If allowed, and the Trading Partner has multiple eligibility-based COBA ID, will we get different 837P file transmissions from the COBC based on the IDs? For example, one file for the eligibility-based ID 1111 and one for the eligibility-based ID 2222 both belonging to BCBSM?**  
Outbound files can be segregated when there are separate IDs. However, consolidation of the claim file is also available. Trading Partners will complete an Electronic Transmission Form on which they designate their transmission method.

5. **In the BOI file, data element 24, the COBA ID is listed. Can a Trading Partner have more than one number? For example, one or two for the eligibility-based COBA ID?**  
Yes, for example, if a Trading Partner has multiple lines of business or if a Trading Partner's claims selection criteria differ from one line to the next, separate COBA IDs would be assigned.
6. **How will payers be informed of their COBA ID numbers? We have found that some payers do not even know that they will be getting a new number.**  
Both eligibility file-based and claim-based trading partners will be required to sign a COB Agreement and will be assigned their COBA IDs at that time.
7. **Will payers receiving complementary crossovers (eligibility-based) also have COBA ID numbers? If so, will that number need to be sent in the secondary payer information when submitting the primary claim to Medicare? If not, what does the provider send in the other payer id (X12 837 format) for those payers.**  
It is CMS' intent for the provider to place the claim-based (Medigap) COBA ID in the other payer ID. It is not expected that the provider will put the eligibility based COBA ID in the other payer ID. If there is an eligibility file-based COBA ID, the Medicare contractors will become aware of this during claims processing and will add the number to the claim for crossover.
8. **When is the earliest possible date that providers would need to start using the COBA ID numbers on their claims to Medicare?**  
October 2005.
9. **Who can we contact regarding NDM specific connection information? (We currently have NDM connections with 5 Part A and Part B Trading Partners which will need to be changed to one connection with the COBC.)**  
Contact the EDI Representatives for more information at 1-646-458-6740 or send an e-mail to [cobva@COBCmedicare.com](mailto:cobva@COBCmedicare.com)

## **SECTION IV - CLAIMS FILES**

**1. What claims file formats will be used for COBA? What formats will COBC use to send claims? What format will COBC expect for the eligibility files?**

Trading Partners or Trading Partner Contractors will be sent the following HIPAA standard formats: (1) ANSI 837 Version 4010A1-Institutional, (2) ANSI 837 Version 4010A1-Professional, and (3) NCPDP Version 5.0.Batch 5.1. The COBA Implementation User Guide can be found at <http://www.cms.hhs.gov/medicare/cob/coba/coba.asp> and the companion guide can be found at [http://www.cms.hhs.gov/manuals/pm\\_trans/R83OTN.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R83OTN.pdf)

**2. Will there be a method to exclude specific claim types?**

Yes. Section IV of the COBA Attachment, Claims Selection Options, of the COBA Attachment will allow the Trading Partner to exclude specific types of claims.

**3. How will the Trading Partner be able to select claims for a specific state?**

Section IV of the COBA Attachment, Claims Selection Options, will allow the Trading Partner to include specific types of claims by provider state or provider identification number for Part A/RHHI claims and by provider state for Part B/DME/RRB claims.

**4. Will there be a method to select specific states for Durable Medical Equipment (DME) claims?**

Section IV of the COBA Attachment, Claims Selection Options will allow the Trading Partner to exclude specific DMERC regions.

**5. Will there be a method to exclude National Council Prescription Drug Programs (NCPDP) claims?**

This option will be made available in the future.

**6. Will the Trading Partner be able to modify claims selection criteria?**

Yes. The Trading Partner will need to provide 15 days advance written notification to the COBC for modifications to existing claims selection criteria.

**7. What will be the frequency of claims files transmissions?**

The COBA process will support daily, weekly, bi-weekly, and monthly transfer of claims.

**8. Will the Trading Partner receive a single ISA-IEA 837 envelope per transaction?**

Yes, there will be only one ISA-IEA per transmission, which can contain multiple ST-SE envelopes that can contain up to 5,000 claims per ST-SE envelope.

**9. Is there a limit to how many ST to SE's will be in a transaction (ISA to IEA)?**

No.

**10. What information will be reported in the following data elements:**

ISA05 – **ZZ**

ISA06 – **COBA**

ISA07 and ISA08 – **defined by the Trading Partner**

GS02- **COBA**

GS03 – **This will contain the same value as ISA08; whatever the Trading Partner wants in ISA08 will also display here.**

NM109 in loop 1000A—**CMS contractor-assigned ID**

NM109 in loop 1000B—**COBA ID**

NM109 [NM1 segment] in loop 2010BB (professional)—**COBA ID**

NM109 [NM1 segment] in loop 2010BC (institutional)—**COBA ID**

NM109 in loop 2330B—**COBA ID**

**11. Should Trading Partners expect separate GS-GE functional groups for each Medicare Intermediary and Carrier?**

No, there will be only one GS-GE functional group per transmission. However, there will be separate ST-SE loops for each Intermediary and Carrier.

**12. Will the ST-SE loops be limited?**

Yes, ST-SE loops will be limited to a maximum of 5,000 claims.

**13. How will the element NM109 of the 2330B Other Payer Name loop be populated?**

If the Trading Partner referenced in the 2330B loop has executed a COBA, its COBA ID will appear in the NM109 field. If the Trading Partner has not executed a COBA, but does have a crossover agreement directly with a Medicare Intermediary or Carrier, the NM109 field will contain the ID that the Intermediary or Carrier uses to identify that Trading Partner.

**14. Will the HIC numbers continue to be populated in element NM109 of the 2330A Other Subscriber Name loop?**

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

**15. Will contract numbers from the Trading Partner's Eligibility File be populated in element NM109 of the 2010CA Patient Name loop?**

If “contract numbers” refers to the COBA ID, it will appear in the NM109 field of the 1000B loop. If “contract numbers” refers to the supplemental insurer's ID, it will be populated in the NM109 field of the 2010BA loop.

**16. What will be reported as the subscriber's primary ID on the 837 files in loop 2010BA, NM109? Will this number be the Medicare HIC number or the trading partner's contract ID number?**

It will be the Medicare HIC Number. The secondary insurer ID provided on the incoming eligibility file will be found in the 2010BA REF02 with a qualifier of IG.

**17. Is it possible for an EIN number to be reported for a billing provider in an 837 file (loop 2010AA, NM109) with a leading zero followed by the nine-byte EIN? If yes, can a trading partner request that the leading zero be omitted prior to COBC receiving that file? Can the EIN number contain hyphens?**

No.

**18. Will the 837P COB files contain the Medicare carrier's proprietary provider ID for the billing provider in loops 2010AA (billing provider), 2310B (claim level rendering), and 2420A (line level rendering) in REF02? If yes, what qualifier will be used in REF01?**

Yes, that number will be in the REF02 field with a qualifier of 1C.

**19. Our understanding is that we will send each eligibility record with a COBA identifier on it. When claims are received by COBC from a Medicare contractor, they will be assigned a unique claim file based on the COBA identifier.**

▪ **Will we be able to determine the physical number of claim files we'll receive on a specific day based on the number of different COBA identifiers that are sent with the eligibility information?**

You will receive a minimum of three claims files (ANSI x12 Institutional, ANSI X12 Professional, and NCPDP Version 5.0 Batch 1.1). You can elect to receive three per COBA ID (1 per format) or three per all COBA IDs.

▪ **Will each of these physical files have its own ISA – IEA segment?**

Yes. Each physical file will have just one ISA-IEA segment.

▪ **It looks like we can specify different criteria of claims to receive and exclude per COBA identifier. For example, on the three waiver states, we can choose to receive claims that are declined by Medicare for non-covered services, while on other states we may choose not to. Is that correct?**

Yes.

▪ **Do we still have the option to break down the COBA file by Medicare Contractor?**

The physical file is broken down by ST-SE segment, not by Contractor Identification Number. The Carrier Identification Number is in the 1000A Loop.

▪ **The Ascential translator seems to have better thru-put when translating several smaller files than if it were to translate one large file. Our concern is that a single or even a couple of very large files may not translate in a reasonable amount of time. Comments?**

One way for the Trading Partners to control the volume of claims file received from the COBC is to split their eligibility records into two separate Eligibility Files using unique COBA Identification Numbers. In addition, the Trading Partner will need to provide the COBC with unique data set names for receipt of separate claims files by COBA ID.

**20. In the claims file flowchart, there is a right hand comment with the text "*Files that fail business edits will not be processed.*" What happens to these claims? Are they**

**recovered from the Medicare Contractors? Are they discarded? Are they otherwise accounted for?**

The Fiscal Intermediaries/Carrier will be asked to re-transmit the entire file.

**21. Is it correct that there won't be a separate GS-GE group for each Medicare Intermediary, but there will be separate ST-SE groups for each Intermediary and Carrier?**

Yes.

- **Since the ST-SE groups contains only a control number for the group and a segment counter, how will the recipient be able to tell from these segments which intermediary or Carrier was the source of the claim?**

In the 1000A loop.

**22. If a Trading Partner does not have an executed COBA then the NM109 field will contain the ID of the intermediary or Carrier? However, in the Technical Requirements section, it indicated Trading Partners cannot test until a COBA has been received, processed, and executed. From reading those two sections, I'm not sure I understand when if ever the NM109 field would ever contain the ID of an Intermediary or Carrier.**

We assume this question is referring to the 2330B Loop. Trading Partners will not receive Claims Files until they execute a COBA. The primary reason is that the Claims Files contain information that cannot be released without an agreement. If the Trading Partner has executed a COBA with the COBC, then the appropriate COBA Identification Number will be plugged into the NM109 field of the 2330B loop. Otherwise, the NM109 field of the 2330B loop will contain the Identification Number as used by Trading Partners today

**23. How are partial file rejects going to be reported, fixed, and resent? For example, if a file contains 4 ST-SE loops and our translator rejects the 3rd ST-SE loop, how will the COBC expect that information to be reported to them and how will the replacement file be presented? Will the three ST-SE loops that were accepted be sent again?**

You may report partial file rejects to your COBA EDI representative or through the dispute resolution process. Each error will be looked at on an individual basis. If the problem can be corrected the entire file will be retransmitted. This procedure will apply to all file rejects.

**24. The Terms and Conditions section indicates a cancellation of existing TPA must occur prior to implementing COBAs.**

- A. Do all existing agreements need to be terminated or can they be done one at a time?**
- B. How do we establish a confidence level that the Medicare Contractor and COBC have completed testing to be sure the ANSI 837 flat file**

**COBC is receiving from the Medicare Contractor is complete and accurate?**

**C. Who and how is a cutover coordinated so the Medicare Contractor isn't sending a file once to us directly and once to COBC for translation or a file is skipped?**

(a) Trading Partners will need to terminate any existing agreement that is being replaced with the COBA. (b) No Trading Partner will go into production until they have completed a testing period (a parallel production test). (c) The Trading Partners are responsible for having all of their current crossover processes un-plugged with each Medicare contractor with whom they have executed agreements for receipt of Medicare claims. The COBC will assist in the coordination efforts with the Medicare Contractors to terminate Trading Partner agreements.

**25. Is it possible for a single Medicare beneficiary to be listed for multiple Trading Partners? Would all listed receive the claim file?**

a) Yes. b) Yes, subject to the Trading Partner's claims selection options specified in the COBA.

**26. How will providers know that their Medicare claim was automatically crossed over (i.e. is the COB ID and an indicator that the claim has been electronically crossed over sent to the provider in some format from Medicare)? If Trading Partners receive a crossed claim from COBC, as well as a claim directly from the Provider, there will be many duplicates for the Trading Partner to address, which would not be cost effective.**

Providers/physicians/suppliers will be informed about a crossover trading as the result of required HIPAA 835 Electronic Remittance Advice (ERA) specifications. The 835 ERA requires that the name of the entity to which a claim is crossed be present. CWF will return the COBA ID as well as Trading Partner's name via the Beneficiary Other Insurance (BOI) reply trailer (29). Medicare contractors, in turn, will use this information to populate their provider remittance advices and 835 ERA with all required crossover data element, including Trading Partner name.

**27. How will CMS and the COBC communicate/campaign to providers to let providers know about new payers who are capable of receiving crossover claims electronically? Will COBC rely on the intermediaries for this type of communication, or will they update the providers directly? (Which would help avoid confusion amongst providers and their systems vendors and help to eliminate duplicate submission on paper).**

CMS will utilize its internal Provider Outreach area as well as Medicare Contractor's Provider Education and Outreach area to inform and educate providers about the COBA program. CMS will also make information about all Trading Partners that participate in eligibility-based versus claim-based crossover under the COBA process available on a designated portion of the COB website at <http://www.cms.hhs.gov/medicare/cob/coba/coba.asp>.

**28. Which Medicare Contractors will the test data be coming from?**

Effective July 6, 2004, all Medicare Contractors are required to participate in the COBA program.

- 29. How will the COBC handle patients with more than one insurance plan? That is, the patient has both Aetna and BCBS and neither is a Medigap policy. How will the COBC determine who to split the claim to?**

If a beneficiary record is attached to unique COBA IDs, then multiple crossover claims will be created for each COBA ID, per the claims selection criteria specifications in the signed COBA.

- 30. If a beneficiary has two or more policies with a single insurance company, and the insurance company has requested that its name be placed on the MSNs, would the MSN list multiple times that the claim had been crossed over to that particular Trading Partner?**

Yes, if the beneficiary eligibility records are attached to unique COBA IDs.

- 31. We are asked to list the kind of Common Claim Types we wish to exclude. If we exclude #2 on this list (Original Medicare claims paid at 100%), does that exclude the Hospital: Inpatient Part A claims that are paid in full by Medicare? That is what we expect to see, but want to verify. If not, how do we include the Hospital: Inpatient Part A claims where a deductible is applied while excluding those that are paid in full by Medicare?**

Yes.

- 32. In Section IV, Claims Selection Option, E. Common Claim Types, #7 is listed as "Adjustment claims, non-monetary/statistical." Does this mean there is no monetary change for Medicare or no monetary change for the beneficiary? For example, if an inpatient hospital claim is paid by Medicare except for the inpatient deductible, then the hospital rebills the claim with information that causes the DRG to change, Medicare may indeed pay more (or less) on that claim. However, the beneficiary (and therefore the secondary insurer) would still only be liable for the inpatient deductible. This is an "adjustment claim, monetary" for Medicare but an "adjustment claim, non-monetary" for the beneficiary/insurer. If the insurer had checked to exclude #7, would this claim be crossed over or not?**

Adjustment claims, non-monetary/statistical is defined as a claim that is modified for the purpose of correcting dates of service and other non-monetary changes but on which the original financial outcome remains unchanged. Therefore, in the above example, the claim would be included or excluded based on the Trading Partner's selection of #6 "Adjustment claims, monetary."

- 33. There may be times when Medicare's payment does not change, but the beneficiary's responsibility does. In such a case, the claim would be an "adjustment claim, non-monetary" for Medicare, but it would be an "adjustment claim, monetary" for the beneficiary/insurer. Would that claim be crossed over?**

Adjustment claims, monetary is defined as a claim on which the original financial information, such as the amount - approved or allowed or the amount paid, was modified. Therefore, in the above example, the claim would be included or excluded based on the Trading Partner's selection of #7 "Adjustment claims, non-monetary/statistical."

- 34. Are we supposed to mark multiple sections (e.g., 1, 2 and 5) if we are sending a single eligibility file for multiple lines of business? We will not be asking for separate COBAs (at this time), but we were unclear as to whether or not COBC would accept a single attachment with more than one section selected on the Trading Partner Information sheet.**

If you have questions about multiple COBA ID's, please contact the COBC EDI help desk at (646) 458-6740.

- 35. Can you give us some examples of claims that would fall within #10 (National Council for Prescription Drug Programs claims)? We are trying to determine whether we currently receive anything that is NCPDP coded, but we aren't sure which claims would currently even carry this coding.**

Refer to the NCPDP Web site at [www.ncdp.org](http://www.ncdp.org).

- 36. For FEP claims: Section D allows us to exclude claims only by region, not state. FEP claims are to be processed by the insurer within the state in which the services are rendered so we would need to be able to ask for claims solely from our state. Can COBC/CMS change the criteria for section D to either (1) exclude by region or (2) exclude by individual states?**

Section IV D.2 allows for the inclusion/exclusion of DMERC claims by region.

- 37. What validation level do you expect to receive from the Contractors?**

CMS and the COBC have tested with all Medicare intermediaries and carriers to validate their ability to produce COB flat files from which COBC can then produce HIPAA-compliant 837 COB files. That testing has confirmed that these contractors can successfully produce 837 COB flat files.

- 38. Please clarify what level of HIPAA compliance the COBC will be ensuring. To what specific HIPAA 837 transaction specifications will the COBC not adhere?**

The COBC's translator will edit to the level of compliance mandated by the HIPAA 837 Implementation Guide.

- 39. How often will claim files be sent to Trading Partners?**

Daily, weekly, bi-weekly, or monthly depending on what option you specify in the COBA.

- 40. Since the data centers receive Medigap carrier eligibility files as "full file replacements," what happens if a carrier misses the cut off time for submitting a file? Will their old eligibility be used? If not, what procedure will be followed?**

There is no cut off time for submitting the file. Whatever CMS' CWF file has will remain there until it is altered.

**41. Will the COBC accept or expect a 997 acknowledgment?**

No. We will not accept 997 or negative TA1.

**42. If insurance companies will be receiving crossover claims from the COBC soon (possibly as early as late 2004), doesn't it make sense to cease testing with the Medicare contractors that are not currently sending us HIPAA standard transactions (ANSI-X12N 837)? What is the incentive to continue to test with many Trading Partners when very soon we will be testing with the COBC? Also, doesn't this make the implementation of HIPAA compliant crossover claims much easier since the beta test group should work out the HIPAA transaction problems, therefore making everyone else's test effort much less?**

Because testing continues to uncover new problems, we encourage you to keep testing. However, when you begin testing under the COBA process with the COBC, we believe it is appropriate to stop testing with FI's and Carriers at that time.

**43. The only problem that I have regarding the crossover is that Medicare has their own codes, example being G0289 & G0283 that are not recognized by these carriers. It seems that it is a waste to crossover these claims just to be getting a denial and having to resend to the carrier via paper anyway. Does CMS have a resolution to this? Could CMS stop claims with "Medicare codes" from crossing over and letting the others cross?**

CMS will consider adding an exclusion for these types of claims in the future.

**44. Is there going to be a way to identify claims from individual Trading Partners? Is the file going to come in with one interchange and every Trading Partner's claim underneath it or will the claims be separated into functional groups by Trading Partner?**

Claims by individual Trading Partners can be distinguished by COBA IDs that may be referenced in the 1000B Loop within the ST-SE envelope. There will be one functional group per ISA to IEA envelope. Consequently, there will only be one functional group per transmission.

**45. How will multiple providers with the same Medicare number be handled?**

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

**46. How often will addresses be updated?**

The address on the 837 will be the latest address on the Medicare contractor's file.

**47. How will adjusted claims be identified on the claims file?**

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

**48. Will we receive rendering provider name as well as billing provider information? If there is an issue/problem with the file size, does the file get re-run? How are these issues handled?**

If this information is sent on the claim, you should receive both. Right now, we cannot rerun the process; only retransmit the entire file again. Each ST-SE can only have a maximum of 5000 claims; however, there is no limit to how many ST-SE segments a file can contain.

**49. Will this new process also take care of formatting situations? We have claims that cross over to a State Medicaid; however they require other information that is not required by Medicare. Because it's not received in the format they want to see it when they deny the claims and we have to file a paper claim.**

HIPAA requires all claims be transferred in the ANSI 837 (Professional and Institutional) and the NCPDP.

**50. We receive an 837 ASC X12N file, not a flat file. Do you support the X12 file? (I am assuming not.) Will the flat file that you send to us pass compliance?**

Please refer to the COBA Implementation User Guide.

<http://www.cms.hhs.gov/medicare/cob>

**51. What suppression criteria will be available under the new process?**

Please reference section 4 of the attachment to the COB Agreement.

**52. Will Crossover Trading Partners be able to select specific states they want electronic claims from or will they have to take all claims?**

Please reference section 4 of the attachment to the COB Agreement.

**53. Will claims be passed based only on the eligibility file sent by the Medicare Supplemental payer or will other criteria be used to send claims?**

Initially this process will be limited to eligibility based. Carriers and DMERCs will maintain the responsibility for claim-based crossover until October 2005.

**54. How will a supplemental payer be able to track a claim if a beneficiary calls and wants to know the status of the claim? Will they call the COBC or the CMS contractor or both?**

Trading Partners should contact the COBC.

**55. What type of audit trail will exist to be sure all claims are able to be accounted for and are sent to the proper party?**

Several checks and balances have been instituted into the system to ensure all claims from contractors are accounted for and processed accordingly.

**56. We heard that the CMS contractors will send all claims to the COBC, not just the ones that have secondary coverage. What is the purpose of this and doesn't this create a lot more processing that is done in the current process?**

CWF will annotate claims that are to be crossed over. Only these claims will be sent to COBC.

- 57. (a) Our plan currently receives transactions from 5 different Intermediaries. Will we continue to receive claims only from these Intermediaries? (b) If yes, please advise the process for enrolling for other crossover transactions from other Intermediaries. (c) If answer to (a) is yes and Answer to (b) no, are their plans to supply us with the projected increase in claims volume? (This information would be needed for budgeting)**

You will receive claims from all intermediaries, unless you specifically exclude intermediaries by state.

- 58. One Medicaid has experienced crossover testing with an intermediary claiming a unique identifier cannot be created for ISA 13, Interchange Control Number.**

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

- 59. The 837 Institutional and Professional COB Loop 2330D does not support reporting State License Number in the secondary identifier REF segment; however, Loop 2310A does support State License Number and the IG allows for up to 5 iterations of the segment.**

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

- 60. (a) Will Medicare pass along all iterations of the secondary identifier REF segment whether contained in the claim level loops or the COB 2320/2330/2430 Loops?**

If the information comes in on a claim it will be passed to the trading partner.

- (b) If yes, will the 0B qualified REF segment in the 2310A be moved to the 2330? Loop?**

No.

- 61. Will there be any additional exclusionary logic available? We would prefer to never receive a claim that Medicare denies as a duplicate. These come to us as an adjustment (CAS CO 18). Many of the states cannot make this exclusion.**

CWF will not allow duplicate denials to be returned to the contractor. The selection criteria are referenced in Section III of the COBA Attachment, which can be viewed at <http://www.cms.hhs.gov/medicare/cob>.

- 62. Will it be possible to selectively choose the crossover claims? Could I receive Rural Health Clinic claims with out receiving Part A crossover claims?**

Yes, you can choose the type of bill in section IV of the COBA Attachment and exclude all but the Rural Health Clinic. The attachment can be viewed at <http://www.cms.hhs.gov/medicare/cob>.

- 63. Are Rail Road Retirement claims included in this program?**

Yes.

64. **Who will be the contact for questions of requests? When we originally wrote our 837 decode program to create claim records on our system, we only coded for one occurrence of an OI record. Some states send us multiple OI records within a single claim. A single source would be preferable.**  
Contact the COBC's EDI department at 1-646-458-6740 or send an e-mail to [cobva@COBCmedicare.com](mailto:cobva@COBCmedicare.com).
65. **Will there ever be available a Medicare number matching process that would allow the submission of a Medicare number, name, address, birth dates, and gender and return a good or bad status? It is sometimes difficult to track down the real source of why policyholders' claims are not crossing over.**  
Error reports will be sent to inform you that a claim did not crossover. The process does not exist now as to why, but is being considered for a future enhancement.
66. **Will the "automatic" crossover process continue to be timely, or will there be a lag because individual contractors will need to forward the claims to the COBC who will then send on to Medicaids?**  
The automatic process will continue to be timely. All claims will be forwarded after the Medicare payment has been made. The COBA process standardizes this procedure across all contractors. Claims are sent daily to the COBC and transferred to the trading partner according to section III.B.3 of the COBA attachment. This could be daily, weekly, bi-weekly or monthly.
67. **Will all claims crossed over from the COBC be in HIPAA compliant format? If not, will "gap filling" continue to occur?**  
Yes, all claims crossed over from the COBC will be in HIPAA compliant format. "Gap filling" will always occur when mandatory fields do not contain values.
68. **Will the COBC be performing any gap filling to ensure all outbound files are compliant? Or will they simply be acting as a switch and passing the claims to the payers as received from the Fiscal Intermediaries?**  
The Medicare contractors' system will be responsible for producing "gap filling" on the 837 flat files for crossover.
69. **How will the COBC incorporate the individual files from the Carriers and Fiscal Intermediaries into their daily transmission(s)?**  
Files are run through a pre-edit process, then through a translator and then sorted by COBA IDs for submission as indicated by the trading partners.
70. **Will the current Carrier and Fiscal Intermediary Sender ID/Receiver IDs be used by the COBC? If so, how?**  
No.
71. **How will the COBC identify the individual Carriers and Fiscal Intermediaries within an 837 claim transmission?**

From the 1000A Loop.

**72. Will parallel test files be provided to the payers by the COBC?**

If by parallel test files you mean parallel claim files, then yes the actual claim files will be provided.

**73. If the provider completes all required elements and COB information on the 837, but the beneficiary is not found on the secondary payer eligibility tape, will the claim be automatically crossed over? If the required COB elements are not present on the 837, but the beneficiary is found on the secondary payer eligibility tape, will the claim be automatically crossed over?**

All of the claim records will be triggered by information contained on the eligibility file. It is important that the information on the claim is correct. The key identifier of the eligibility file is the HIC number. During phase I, matching will be based on the HIC number on the claim compared to the HIC number on the eligibility file. In October 2005(target date) for claim based crossover all mandatory elements and requirements must continue to be met (Mandated Medigap) in order for claims to be crossed over without an eligibility file.

**74. The ability to be able to suppress by state in electing electronic crossovers is critical. Will separate Trading Partner agreements be required to have different suppression criteria?**

One COBA with multiple attachments would facilitate this objective.

**75. Will separate CMS contractor claims be on the same file or separate files? If same file, how will Trading Partners know which contractor processed the claim?**

Trading partners will receive separate 837 Institutional and Professional claims as well as National Council for Prescription Drug Programs (NCPDP) claims. Trading partners may receive consolidated outbound claims files. There are, however, size limitations for the files. The contractor that processed the claim will be referenced in Loop 1000A. Outbound files can be segregated when there are separate IDs. However, consolidation of the claims file is also available to the trading partner.

**76. Will Medicare enter on the COB for each line item- the Medicare paid amount, any deductible and coinsurance amount applied to the item?**

Yes, Medicare processes claims at the line level.

**77. Will both par and non-par claims (provider accepts Medicare assignment vs. does not) be routed through this new process?**

For the COBA eligibility-based crossover process, trading partners will receive par and non-par claims. Under the future claim-based crossover process (Mandated Medigap), trading partner will only receive par claims.

**78. What will be sent in the ISA06 Interchange Sender ID?**

COBA.

79. **What will be sent in the GS02 Application Sender Code?**  
COBA
80. **Will only one ISA/IEA be sent per transmission?**  
Yes, only one.
81. **If we submit an eligibility file on 10/01/04, what will we receive back? For example, will we receive claims from ALL intermediaries or only those intermediaries we held contracts with? Will all Intermediaries be ready for 10/01/04 date?**  
All intermediaries were tested to be pursuant to this process as of July 7, 2004.
82. **When the COBC returns non-compliant claims to the originating FI or carrier, what procedures will the COBC follow to ensure the timely correction of these claims and to ensure no claim gets lost?**  
Our recovery process is still under development, and CMS will specify its plans for a claim recreate process as part of a future systems release.
83. **When will the Medicare carriers and intermediaries be required to submit COB claims in an 837 format?**  
CMS has no proposed date for lifting the contingency of the 837 outbound. In the mean time, the COBA process will supersede the existing process.
84. **What data will COBC be changing in an 837 COB file prior to sending it to a trading partner?**  
COBC receives an 837 flat file from the Medicare contractor and then converts it to an outbound HIPAA ANSI X12N (version 4010A1) file.
85. **Will the sender source code be populated anywhere on the 837 COB files? If no, is there any way that a trading partner can determine which carrier or intermediary originally submitted the claim to COBC?**  
If by sender source code you mean Medicare contractor, that information will be populated in Loop 1000A of NM109 field.
86. **During the testing phase, what will COBC populate to the ISA-15?**  
“P” for Production.
87. **Can a trading partner specify what time of day they would like to receive the 837 COB files from COBC?**  
Currently, day of the week is an option in the national COBA but not the time of day.
88. **If a trading partner sends a rejected 997 to COBC, will COBC correct the file? How quickly will the file be corrected and retransmitted to the trading partner?**  
The COBC will not accept 997. In place of a 997, the Trading Partner should contact the COBC to discuss the rejections.

**89. How will Medigap issuers be able to identify the originating FI or carrier for each claim crossed over? There is a lot of room for lack of uniformity, even with claims that are fully HIPAA compliant.**

This information may be referenced in Loop 1000A of the NM109 segment.

**90. Is there a limit to how many claims will be submitted in a transaction (ISA to IEA)?**

There will be 1 ISA-IEA transmission, which can contain multiple ST-SE envelopes that can contain up to 5,000 claims per ST-SE envelope.

**91. Will one ST to SE contain claims from more than one Medicare carrier or intermediary?**

There will be separate ST-SE groups for each intermediary or carrier.

**92. How many GS segments will be submitted in a single 837 COB file (ISA to IEA)?**

There will be 1 GS-GE functional group per transmission.

**93. Will the trading partner/payer receiving the 837 COB file from COBC be reported in Loop 2330B?**

Yes.

**94. The CMS Manual System, Pub. 100-04, Medicare Claims Processing Transmittal 48, Change Request 3964, dated December 19, 2003, states that there will only be four detail records per transmission. This sounds like there will be only 4 claims identified by "GI" in the 701 field of the batch detail record. Is this correct?**

No. Each claim for service submission request may contain up to four occurrences of claims/service data.

**95. Based on NCPDP test claims we have received to date from the DMERCs, it appears we will only receive 1 service line per claim. We have been told that we will never get more than 1 service line per claim. Will this still be true when NCPDP claims start coming from the COBC?**

We don't know if this will always be the case. It depends upon the type of transmission.

**96. NCPDP claims do not provide a Medicare Assignment Indicator or Benefits Assignment Indicator. I have been told that all NCPDP claims will be assigned but cannot find any documentation on this. This information is not in any of the Companion Documents I've referenced.**

That is correct. CMS is currently working on a Data Element Request Form (DERF) within the NCPDP to add these data elements.

## **SECTION V – CLAIM BASED**

1. **Currently, we receive claim-based Medigap information on our electronic file along with the eligibility-file based crossover claims information from Medicare contractors that we have an electronic agreement. We are charged the standard rate of .54 per claim. If CMS delays the claim based process until a further release, and all eligibility file based processes are transitioned to the COBC, we will receive the claim-based Medigap information on paper. Therefore, increasing our paper claims and the administrative cost of .54 to approximately \$1.00 per claim. CMS change requests on the COB consolidation states that Supplemental Insurers must terminate their Crossover Trading Partner Agreements with those Medicare Intermediaries and Carriers for which one exists. Am I correct in my interpretation that we will not be able to get the Medigap 4081 claims electronically (until claim-based is implemented)? The delay of the Claim-based crossover has a very large impact on the Supplemental Insurer.**

You should keep your claim-based portion of your agreement in place until we go live with COBA in October 2005.

2. **We thank CMS for streamlining the claim crossover process, but it was interesting to find out that CMS approved of a Trading Partner charge on a per claim basis. If the Trading Partner does not absorb the cost, they will undoubtedly pass it on to the beneficiary either by unknowingly or purchase agreement. This will probably adversely affect electronic COBA claim transmissions for several payers. Thus providers of service will incur the additional cost to submit COB claims to an individual payer not willing to obtain a Trading Partner COBA, when a beneficiary has assigned benefits to the provider. Where is the incentive for the payer who has become electronic for primary submissions, when they will incur additional costs for COBA submissions? Should not a payer be required to obtain a COBA if they are electronic for primary submissions under HIPAA guidelines?**

CMS has always charged on a per claim basis and this fee is staying the same with the COBA process. However, the efficiencies provided by the streamline could decrease the charge in the future.

3. **Typically, clearinghouses charge 16 to 35 cents for claims. Why are CMS fees so much higher? Have claim fees been established for the new process? If so, what are they? Will we continue to be charged a per claim fee? If so, please advise the per claim fee.**

The per claim fee will remain the same as the fee paid to Medicare contractors but will be invoiced by the COBC in the COBA process. It will be for Part B \$0.54 and for Part A \$0.69 for electronic. CMS does not anticipate an increase in the fees associated with the COBA process. The additional clearinghouse charges are not comparable to the cost charged by CMS.

4. **Change requests #3109 and #3218 imply that claim-based Crossover will be sent electronically to the Trading Partner when it is implemented? Is CMS eliminating the paper Medigap transfer process when claim-based crossover is implemented?**

Trading Partners will be encouraged to retain their claim-based agreements. We will not be eliminating claim-based hard copies.

5. **Medicare anticipates creating secondary electronic claims from paper claim submissions. Will Medicare create a crosswalk between Medicare provider ID's and secondary payer ID's or will that be the responsibility of the secondary payers?**  
CMS will not be maintaining a crosswalk between Medicare provider ID's and secondary payer ID's. However, secondary payers may create their own internal crosswalk.

6. **The current OCNA list sometimes shows the same payer multiple times with different addresses or only slightly different spellings in the name or address, but with different OCNA numbers. Neither our carrier nor the payer can tell us which number is correct. Will this problem be corrected with the COBA ID numbers? Will CMS or the carriers supply a crosswalk from the OCNA numbers to the new COBA ID numbers? Will the instructions for putting MEDIGAP in other payer information change?**

The implementation of claim-based crossovers has been delayed until further notification. Prior to the implementation of the claim-based crossover, CMS will provide detailed instructions for providers that include a Medigap directory to replace the existing OCNA and IN-KEY identifiers.

7. **Under the new process, at least initially, claim-based crossovers will continue to be done by the contractors, while the eligibility-based crossovers will be done by the COBC. We need to understand how this will be coordinated. Currently, at a Medigap carrier's request, contractors suppress the claim-based process when the same claim is identified through the eligibility-based process. Will the contractors continue to suppress the claim based process in favor of the eligibility based process in those cases where requested by the Medigap carrier?**

CMS' system instructions indicate that Medicare carriers are not to send claim-based crossover when they receive a CWF trailer that contains a Medigap COBA ID (eligibility-based crossover).

8. **Please confirm that Medigap carriers will not have to execute new TPAs with the Medicare contractors for continuing just the claim-based crossover process, after the eligibility-based claims have been switched to the COBC?**

Where existing crossover agreements cover both eligibility and claim-based crossover, the contractors may need to amend the agreements to allow for continuation of claim-based crossover.

9. **Please review the process (and timing) CMS envisions for a Medigap issuer to modify or end its TPAs with carriers and FIs, and sign the COBA. We have heard that some carriers and FIs are requiring a 60-day advance notice of changes to TPAs.**

CMS is finalizing a joint-signature memo that will require Medicare intermediaries and carriers to terminate existing crossover Trading Partner Agreements (TPAs) in a specified manner. We plan to ask Medigap issuers, like all other eligibility file-based crossover

trading partners, to alert Medicare contractors 10 business days before they will send a null (empty) eligibility file. The sending of the null eligibility file will prevent further claims from being tagged by the Medicare contractor for crossover. Upon receipt of the null eligibility file, the contractor will process the file. Any claims sitting on the claims payment floor would be sent to the Medigap issuer under the existing electronic crossover process. Contractors will have 30 calendar days from the date of the alert received from the trading partner to cancel or amend existing crossover TPAs. Medicare contractors will only amend the TPAs if provisions for both claim-based (mandated Medigap) and eligibility file-based crossover apply and only if the Medigap issuer wishes to continue claim-based Medigap crossover.

**10. What do you mean by Claims based (Phase III) crossover? Will eligibility and claims pieces be in separate phases?**

Claims crossover is triggered by information on a claim, even in the absence of an eligibility record. We're going to start with eligibility files first, but in the absence of an eligibility record, there is another process, whereby the claim is crossed over based on information found solely on the claim. Medicare has an obligation to cross these claims over, if they are coded properly.

**11. What are the plans for claim-based (as opposed to eligibility-based) crossover claims? Will Medicare contractors continue to cross those claims? Currently, at a Medigap issuer's request, contractors suppress the claim-based process when the same claim is identified through the eligibility-based process. Will the contractors continue to suppress the claim-based process in favor of the eligibility based process?**

Medicare contractors will continue to send claim-based crossovers to trading partners until that process is fully consolidated under the COBC. Contractors will continue to suppress the claim-based process in favor of the eligibility file-based crossover process.

**12. Has CMS made arrangements (or initiated the process) for prohibiting providers from viewing the direct data entry screen? This is critically important to Medigap issuers because Medigap issuers will receive the crossed claim some period after Medicare has paid, and physicians/providers will send paper claims to Medigap carriers if they do not receive prompt reimbursement from them. This must be avoided.**

CMS is not prohibiting providers from viewing the direct data entry screen. We are developing provider education materials that will address this issue and advise physicians/suppliers/providers that all claims will be crossed over after they come off the payment floor.

## **SECTION VI - MISCELLANEOUS**

1. **Can you share with me who the 10 Beta testers are and how the testers were chosen, e.g., by crossover claim volume, by contact to CMS?**

The Trading Partners have requested that they not be contacted regarding comments or questions. The Beta testers are: COBC-HMO, Horizon-BCBSNJ, InterPayNet, Life Investors Insurance Company of America, Maryland State Medicaid Agency, MassHealth State Medicaid Agency, Monumental Life Insurance company, Peoples Corporation, Regence Group, Transamerica Financial Life Insurance Company, United Health Care-AARP, Universal Benefits Corporation, WebMD Envoy, Wellmark Blue Cross Blue Shield. Representativeness & volume considerations were taken into account when choosing these partners.

2. **Please describe the status of implementation activity and of the CMS implementation timeline.**

CMS has implemented all internal system changes, and COBC has built all necessary infrastructures to implement the COBA process. After addressing a volume issue in the loading of eligibility files to CWF, the 10 beta trading partners' eligibility files have been loaded and claims have been successfully crossed. We have established connectivity options for electronic transfer of files. We are continuing to work on the HIPAA problems involving the outbound 837 files. The findings in the parallel production period have prompted CMS to change its COBA production implementation date from October 4, 2004, to December 1, 2004. Once we are able to transition the 10 beta testers to production, we will transition the remaining trading partners. Claim-based Medigap crossover will be transitioned all at once to the COBC, following successful conversion of all existing trading partners that participate in eligibility file-based crossover.

3. **We are very interested in receiving a copy (draft or otherwise) of the COBA. Is a copy available, and if so, how can one be obtained?**

The COBA and Implementation User Guide can be found on COBC's website at <http://www.cms.hhs.gov/medicare/cob/coba/coba.asp>

4. **Does CMS contemplate any changes to the COBA, Implementation User Guide and Frequently Asked Questions?**

CMS is in the process of updating the COBA Implementation User Guide. The FAQs will continually be updated as necessary. Minor changes are being made to the Agreement. The final version should be posted on the COB website no later than October 31, 2004.

5. **Who is the COBC? Is this a regional contractor process?**

Group Health Incorporated is our national COB contractor.

6. **Who is authorized to execute the Trading Partner Agreement? Health Plans, Insurers, Clearinghouses? Agents of the preceding entities?**

Please refer to Article I.C of the COBA document. It spells out who is authorized to execute the Trading Partner Agreements.

7. **Who will sign the agreement on behalf of CMS?**  
The COBC.
8. **What is the purpose of the changes to the Medicare crossover process?**  
To realize greater efficiency and simplification via consolidation.
9. **What is the COBC test and transition plan for Supplemental Insurers, specifically those that have multiple current Crossover Trading Partner Agreements?**  
Trading Partners with an existing agreement will be given priority.
10. **It is my understanding that the current Medicare Carriers and FI's will continue to process Medicare claims. Payers will send a universal eligibility file to the COBA and the COBA will go to a common working file to pull claims for the individuals identified in the eligibility file. If Carriers and FI's do not have eligibility information at the time they process and pay Medicare claims, they will not know if the claim is going to be forwarded to a supplemental insurer. In this scenario, providers will not be notified that the information is being forwarded to a supplemental insurer as they are now. Without this notification we believe that providers may begin to drop claims to paper and submit them manually since they will have no way of knowing if the claim was electronically submitted on their behalf to a supplemental insurer. Are we missing something? Is there some mechanism to trigger a message to the providers at the time of payment? Will the FI's and Carriers have access to eligibility files and if so, will they be required to utilize them for this purpose? If not, isn't this a serious concern?**  
The fact that the claim was sent to COBC for crossover will be annotated for the provider on the remittance advice.
11. **Will the new Crossover procedure impact pharmacy providers in any way?**  
Not at this time.
12. **Since COBC is the vendor that handles the Medicare Secondary Process (MSP), will the consolidation affect the current MSP process?**  
No.
13. **How can a Medigap issuer find out approximately when it will be contacted by the COBC to initiate the transition? Is the phone number that COBC provide at the June 17, 2004 open door forum still relevant? It was 646-45-9740.**  
The COBC will alert all prospective trading partners 60 days in advance of their selection to begin testing the COBA process with the COBC. Considerations such as crossover volume and readiness to test with the COBC in the HIPAA 837 and NCPDP formats will influence where a particular trading partner falls on the transition schedule. Entities that are interested in participating in the COBA process should contact 646-458-6740. The COBC would also be interest in learning about a trading partner's contingencies that could negatively impact its transition schedule.

14. **Is there a requirement for parallel processing with the Intermediaries when consolidating? Parallel testing- in the web site documentation it is noted that 6 months of testing needs to be completed prior to implementing. Does this apply to intermediaries or Trading Partners?**

The entire implementation process may span 60-90 business days (including parallel testing). The COBC will work with the Trading Partners to provide a production implementation date coordination purposes in terminating eligibility-based agreements with Intermediaries and Carriers. The COBC and the Trading Partner will mutually decide when the Trading Partner will make the final step to move to production. Each trading partner will continue to receive production crossover claims via the existing process while testing the COBA process with the COBC.

15. **Training plans appear to be aggressive in the COBA Implementation User Guide. What has the experience of the beta sites been?**

Experience to date shows that the 60-90 day time frame is realistic.

16. **I have serious concerns, especially with the time line for testing. The establishment of communications through Connect: Direct (NDM) was estimated at 5 business days. Based on our experience, this is wildly unrealistic. We at Utah State Medicaid have gone through the difficult process of establishing NDM communications, through the AT&T network, to three Medicare contractors and it has never taken less than 2 months to complete and test these links. How do you justify this time estimate? For us, one of the real benefits of the Medicare COBA program will be that we only have to go through this laborious process one more time. I would like to know that the COB Contractor has the experience and expertise to actually make this a more reasonable process. This unreal estimate makes me very concerned that the experience necessary to succeed is not in place.**

In an effort to address your concern, we have discussed with the COBC its processes for establishing AGNS Connect: Direct using NDM. Based on our experiences with our COBA pilot test Trading Partners, in those instances where a Trading Partner already had an existing AGNS and NDM account, connectivity was established in most instances in fewer than 10 business days. Basically, as you may know, the NDM set-up process amounts to establishing an "IP" address. What drives the timeframe are issues that arise in terms of security on the part of the trading partner as well as the MDCN approval process. Per the COBC's EDI Department the process to establish and test Connect: Direct NDM connectivity should never take 2 months.

We at CMS are highly confident that the COBC possesses both the requisite experience and expertise for the COBA program to succeed, and we look forward to participating with you in your future migration to the new consolidated crossover process.

17. **If a trading partner determines that it cannot meet the specified implementation date to convert to the new COBA consolidated process, what are the alternatives?**

The COBC will work with the trading partner to identify a date that would better meet its needs within the established COBA implementation timeline.

18. **Can the start of the COBA with COBC overlap with the termination of an existing agreement with an individual Medicare carrier or intermediary?**  
There will be an overlap while in the testing period. Once all parties agree that the trading partner is ready to go live, the existing agreement must be terminated.
19. **Is there a limit to the number of invoices we can receive? When can we expect to receive our Trading Partner Agreements? What is the best way for us to stay connected to updates, changes etc?**  
You will receive one invoice for each billing location. That invoice could contain multiple COBA IDs. You will be contacted by the COBC to negotiate a COBA. To stay connected, refer to the COBC website at <http://www.cms.hhs.gov/medicare/cob>.
20. **Will there also be a list of eligibility payers that have successfully tested, versus those that we should expect to use the 5 digit COBA number for when we bill Medicare Part B?**  
CMS will provide, on the website, a listing of the eligibility based Trading Partners that are in production (<http://www.cms.hhs.gov/medicare/cob>). Claim based COBA IDs will not be published until July 2005, for implementation in October 2005. Until that time you should continue using your contractor assigned ID.
21. **Help me understand your implementation schedule. My understanding is that you will start converting contractors to COBC on October 1, 2004, and complete conversions of all contractors by April 1, 2005. Is this correct?**  
These are our target dates.
22. **Do you create the COBA file based on an application form that we fill out? Do carriers need to send the COBA file to you? Likewise, do you send the BOI trailer record to the intermediary? Do carriers have any responsibility?**  
Please refer to the COBA Implementation User Guide.  
<http://www.cms.hhs.gov/medicare/cob>.
23. **Requirement 3.4 in Transmittal 29 confused me. If BCBSKC converts both our Medigap and supplemental business to COBC, this scenario should not occur, should it? This scenario as described, results in BCBSKC receiving a Medigap claim from both the intermediary and COBC?**  
The beneficiary could have policies with multiple insurers.
24. **Will local Medicare contractors be provided with beta-test data?**  
Yes, and testing is currently underway.
25. **Providers will be notified that the beneficiary claim has been submitted via COBC to a Trading Partner with a COBA under a separate RA. How will we track claim submission issues with a payer - through a local Medicare contractor or through the COBC?**  
Providers and Beneficiaries should contact the local Medicare contractor.

26. **In reference to Pub. 100-04 Transmittal 28 dated November 27, 2003, the COBC will be looking for the COBA ID in 2010BC:NM109 and 2330B:NM109, but our interpretation of the IG - NM109 was reserved for NPI and we were looking to use REF02 for COBA ID - when NPI is mandated. What are CMS's plans about addressing this issue with the COBC?**

When NPI is instated, COBC will address the issue. However, for now, they are mandatory fields and we will be completing them using the COBA ID. The field can be used for this purpose until NPI is mandated. At that time, COBC will follow HIPAA conventions.

27. **What will happen if a Trading Partner has not taken action to transition to the COBC by 4/30/2005?**

CMS will require all Trading Partners to eventually utilize the new COBA process. Eventually Medicare Contractors authority to use the current crossover process will be withdrawn.

28. **How will the new process work?**

The process is fully explained in the user COBA Implementation User Guide at our website <http://www.cms.hhs.gov/medicare/cob>.

29. **Will Medicare Supplemental payers and others still be able to utilize a third party to interface with the COBC?**

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

30. **How many Medicare claims are processed each day and how many are estimated to have secondary coverage?**

Well over 1 billion claims are processed annually. Approximately 600 million of those are crossed over to other payers, including 200 million to Medicaid.

31. **Will all Medicare secondary claims be edited for balancing purposes at both the line level and claim level?**

Yes, this is a Medicare function, not a COBA function.

32. **We are not currently a COBA Trading Partner but want to be one ASAP. What steps should we be taking to be able to go live shortly after 10/1/04? How will priority be given to Trading Partners? When should we expect to have a Trading Partner agreement with the COBC in place and begin testing? Will there be any prerequisites to being able to begin testing? How will CMS determine the schedule for beginning the migration of a specific Medigap carrier to the new system? Will employer-sponsored supplemental claims be migrated to the COBC process on the same schedule as Medigap eligibility file crossovers?**

If you wish to be a trading partner, call COBC's EDI department at 1-646-458-6740, send an e-mail to [cobva@COBCmedicare.com](mailto:cobva@COBCmedicare.com), or visit the COBC website at <http://www.cms.hhs.gov/medicare/cob>. Potential/existing trading partners should determine their state of readiness and ability to implement the requirements by

referencing the <http://www.cms.hhs.gov/medicare/cob>, particularly the COBA Implementation User Guide.

- 33. When CMS proposed the standardization of Trading Partner Agreements for Medicare Crossover Claims in 2003, the proposal was to require that the party ultimately responsible for payment enter into the Trading Partner agreement. The practical implication of this approach was that 1) insurance companies and 2) self insurer employee group health plans (as opposed to their third party administrator) would each have to directly enter into such agreements with each Medicare Carrier and Intermediary.**

Although the new approach being proposed by CMS is to require that payers only enter into one agreement with the new crossover claims administrator, it is unclear as to who is going to be required to entering into the agreement. This is an important issue since self-insured employers often look to their third party administrators to handle issues such as Trading Partner agreements on their behalf. I would also think that this is an important question for CMM since the difference between having to contract with a few thousand health plans as opposed to hundreds-of-thousands of self funded employer groups is significant. It would be our hope that you permit third party administrators to enter into one Trading Partner agreement with the crossover carrier on behalf of all of the self-funded groups for whom they provide services. Please advise as to who will be the contracting entities for these agreements.

Only a trading partner can sign agreements. Refer to Section I of the COBA Attachment, which can be viewed at <http://www.cms.hhs.gov/medicare/cob>, for the definition of who is defined as a trading partner. A third party can sign trading partner agreements directly, only if that third party adjudicates claims for insurers or State Medicaid Agencies.

- 34. What is the process for escalating problems with crossover data content if the FI and the secondary payer disagree on the COBA Implementation User Guide interpretation?**

The trading partners should contact the EDI representative at COBC.

- 35. How will the testing phase be structured for transition to the COBC? When will the test plan and time line to support the transition be available to payers?**

Your test phase will commence upon full execution of the COBA.

- 36. Is there a standard agreement on the Internet for us to use?**

Yes. It can be viewed at <http://www.cms.hhs.gov/medicare/cob>.

- 37. Who can we contact regarding testing and implementation?**

The COBC marketing coordinator will contact all existing trading partners.

- 38. Will a standard problem resolution and change process be included in the new agreement?**

Yes, this is provided in the national COBA and may also be referenced in the COBA Technical Implementation User Guide, both of which are available on the COB website.

**39. Will Trading Partners be able to customize the agreement in any way other than to prescribe frequency and bill type options?**

CMS has developed a standard agreement that will be used by all COBA trading partners.

**40. Medigap carriers need a minimum of a six-month testing period running parallel files to assure that the new system can handle issues that arise with different types of claims. We would like confirmation from CMS that the migration plans will provide for a 6-month parallel file-testing period.**

The parallel testing period will take as long as CMS, the COB Contractor, and the trading partner believe is necessary. The trading partner will move to production when the trading partner, CMS, and the COB Contractor mutually agree to do so.

**41. While CMS has indicated that the beta testers will parallel test, CMS has also indicated that the files will never match. How will we be able to determine that the process is working effectively (both accurately and timely)?**

The parallel production process was never intended to allow for a one-for-one match. Trading partners will, however, be able to compare the results received via the 837 outbound COB crossover process. Any variances would result from differing frequencies, claims selection criteria, and other variables.

**42. In the new process, Medigap carriers will be a Trading Partner of the COBC. Why, then, are we testing with each contractor? CMS has indicated that this is required as the back up to the COBC process if it does not work, but it seems to be a major burden for all the carriers to have to test with all contractors.**

If possible, we would like you to continue testing. Through this testing, errors have been detected that would previously not have been found.

**43. If you will be transitioning your current Medicare COB partners between October 1, 2004 and April 30, 2005, when will the COBC be able to work with new crossover claims partners? Would this be after a specified date in 2005?**

There may be a window of opportunity for new trading partners to join the COBA process at an earlier interval. The CMS marketing plan allows for three (3) extra slots per month for moving trading partners to the national COBA process.

**44. Is there a coordinator at the COBC for new trading partners? How do you make contact with that individual?**

Contact the EDI Department at 646-458-6740. The appropriate EDI representative will then contact you.

**45. We process claims for NC, TN and ID for Part B and DMERC Region D. Currently, we are responsible for billing and collection of these crossover claims. Under this new process, we will not be invoicing the Trading Partners, but will we still receive**

**crossover credits for our contracts? Will we still receive the cash payments or will the COB direct those to CMS instead?**

As recently communicated by CMS through the Budget and Performance Requirements (BPRs) for FY 2005, Medicare contractors will receive the complementary credits for claims crossed over by the COB Contractor. CMS issued a joint-signature memorandum (JSM) to request banking information for purposes of depositing the credits in the Medicare contractor's account.

**46. How are we supposed to budget for crossover claims for FY 05 if our Trading Partners will be migrating to the COB at different times?**

As answered through the BPR questions, contractors should budget as if they were still handling crossover operations as done during FY 2004.

**47. Who is going to be responsible for collection efforts of outstanding invoices, the COB or the contractor?**

Medicare contractors will be responsible for invoices they sent prior to the start of the COBA process, and COBC will be responsible for invoices sent after the initiation of the COBA process.

**48. What is the implication of non-compliance with a 90-day termination clause with our current intermediaries?**

CMS is currently drafting instructions to all FI's and carriers that will give them guidance on relaxing this requirement, if necessary.

**49. If we are ready to go live, have terminated our current contracts with our intermediaries, and a problem arises and our implementation date is pushed, would that result in paper claims being sent to us?**

Extensive parallel production testing would mitigate these problems. In other words, we would have already successfully done it, before we actually do it.

**50. What support will be available from COBC and how does that compare to the current services our intermediaries provide today?**

We will have staff available at COBC from 8:00 AM to 5:00 PM EST. Each trading partner will be assigned an EDI rep as their primary contact, and backups will be established in their absence.

**51. Does the 15 day lead time to change a COB Agreement mean that 15 days after the change is requested that it will be operational?**

Yes.

**52. How will confirmation of the changes be communicated?**

We will send a profile report anytime there is an attachment change. See the COBA section of the COBA Implementation User Guide for an example of a profile report.

**53. Is there a date when the Medicare carriers and intermediaries will no longer be permitted to send COB files to existing trading partners?**

When all existing trading partners are transitioned to the COBA process, Medicare carriers and intermediaries will have no need to send COB files to existing trading partners.

**54. Is E-billing required?**

Yes E-billing is required; however, the trading partner does not have to pay electronically. We envision that E-billing will be used to generate, review, pay, and dispute bills.

**55. Will a parallel test be done prior to implementation with a particular trading partner?**

Yes

**56. When will existing trading partners be required to transition to the new COBA consolidated process?**

By current estimates, all eligibility file-based trading partners should at least be in testing mode by end of fiscal year 2005.

**57. Please describe disaster recovery and system failure back-up plans that you are putting into place, and the timeline for completion.**

## **COBC Government Programs Business Contingency Plan Overview**

**Plan Scope:** COBC and its Government Programs Division have active Disaster Recovery and Business Contingency programs. The Coordination of Benefits (COB) program at COBC Government Programs is included in the Government Programs Business Contingency Plan (BCP). The COBC Disaster Recovery Plan (DRP) covers the General Support Systems (Mainframe, Distributed Systems, and Voice & Data) that the COB System relies on.

**Recovery Sites:** COBC utilizes SunGard for its Disaster Recovery site for both Mainframe, Distributed Systems and Voice & Data recovery, and alternate workspace. SunGard provides numerous recovery sites should the primary location be unavailable. Disaster Recovery testing at SunGard facilities is conducted twice a year.

**Contingency Planning Methodology:** The COBC Government Programs BCP is developed, maintained and tested in accordance with NIST-800 guidelines and the Centers for Medicare & Medicaid Business Partners Systems Security Manual.

**Audits:** Government Programs conducts a self-assessment annually that includes Service Continuity. COBC Internal Audit conducts an Annual Compliance Audit that included Service Continuity in 2004. Government Programs and COB are also subject to numerous external audits.

**Testing:** Contingency and DR plans are only reliable if tested. COBC conducts at least two DR tests annually at varying SunGard locations. The COB program participates in at least one of these tests annually. The COB program has participated in the last two DR tests conducted in April and July 2004.

**Plan Maintenance:** Contingency and DR plans must be kept up to date as businesses and technologies evolve. The COBC Government Programs BCP is updated at least annually and incorporates changes due to DR test results, Business Impact Analysis and Risk Assessments that are conducted as production systems are modified.

58. **Where can we find the NCPDP Companion Document from the COBC? The CMS web-site lists Program Memorandum (Carriers), Transmittal B-03-067, Change Request 2839, dated August 22, 2004. Also, the CMS Manual System, Pub. 100-04, Medicare Claims Processing, Transmittal 38, Change Request 2963, dated December 19, 2003, provides documentation. Should we use either of these documents and assume the COBC will follow them as well?**

CR 2964 is the latest NCPDP Companion Document that has been written. COBC will follow CMS' conventions for NCPDP.

59. **The NCPDP lists the National Supplier Clearinghouse (NSC) number as the only way to identify the provider of service. We currently get the NSC from one of the DMERCs. Once we transition to the COBC, will we then get a file sent to us from the COBC on a monthly basis?**

Your information is not accurate. The service provider ID is a mandatory data element in the Transaction Header Segment and may be referenced there.