CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 448

Department of Health & Human Services
Center for Medicare and &
Medicaid Services
Date: JANUARY 21, 2005
Change Request 3658

SUBJECT: Timeframe for Continued Execution of Crossover Agreements and Update on the Transition to the National Coordination of Benefits Agreement (COBA) Program

I. SUMMARY OF CHANGES: Through this change request, CMS is modifying language from Transmittal 138 in the manual sections indicated below. This change will update the timeframes for execution of new crossover Trading Partner Agreements (TPAs) and transition of trading partners from their existing crossover process to the national COBA program.

NEW/REVISED MATERIAL :
EFFECTIVE DATE : February 22, 2005
IMPLEMENTATION DATE : **February 22, 2005**

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

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

R/N/D	CHAPTER/ SECTION/ SUBSECTION/ TITLE
R	24/70/ Crossover Claims Requirements 24/70.1/ FI Requirements 24/70.2/ Carrier/DMERC Requirements
R	28/70.6/ Consolidation of the Claims Crossover Process 28/80/ Electronic Transmission - General Requirements 28/80.2/ ANSI X12N 837 COB Transaction Fee Collection
R	28/80.3/ Medigap Electronic Claims Transfer Agreements 28/80.3.1/ Intermediary Crossover Claim Requirements 28/80.3.2/ Carrier/DMERC Crossover Claims Requirements

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2005 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Unless otherwise specified, the effective date is the date of service.

Attachment - Business Requirements

Pub. 100-04	Transmittal: 448	Date: January 21, 2005	Change Request 3658

SUBJECT: Timeframe for Continued Execution of Crossover Agreements and Update on the Transition to the National Coordination of Benefits Agreement (COBA) Program

I. GENERAL INFORMATION

A. Background: Through the issuance of Transmittal 138, you were informed that you could execute new Trading Partner Agreements (TPAs) with prospective trading partners if those entities would be converted to full crossover production with you by August 1, 2004. A subsequent joint signature memorandum (JSM), entitled, "Medicare Contractor Crossover Processes Prior to the Implementation of the COBA Initiative," alerted you to a process you or your prospective trading partners could follow to seek a waiver of the August 1, 2004, deadline.

On October 18, 2004, the Centers for Medicare & Medicaid Services (CMS) issued JSM-05018, entitled, "Alert Regarding Existing Crossover Processes and the Larger-Scale Implementation of the Consolidated Crossover Process," which extended the date for execution of new TPAs and modified the earliest date by which CMS would begin moving trading partners into crossover production with the Coordination of Benefits Contractor (COBC). CMS is issuing this Change Request to modify the language in Transmittal 138 regarding timeframes for execution of new crossover TPAs and earliest transition date to begin moving trading partners from the existing crossover process to the national COBA program.

B. Policy: Contractors shall use this instruction for purposes of gauging timeframes for continuance of the existing eligibility file-based crossover process. Carriers and Durable Medical Equipment Regional Carriers (DMERCs) shall not use this instruction as a tool for planning the transition of mandated Medigap crossover (or claim-based crossover) from their operations to the COBC.

C. Provider Education: None.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3658.1 Ch. 28, Sec. 70.6	Contractors shall execute new TPAs only with trading partners that will be converted to full crossover production by April 1, 2005. Therefore, CMS expects contractors to cease execution of new crossover TPAs by January 31, 2005.	X	X	X	X					
3658.2	In light of requirement 1, contractors shall cease the filing of waiver requests, as specified in JSM-211. Contractors shall, however, notify Brian Pabst of CMS about any new crossover TPAs (including information such as trading partner's name, address, contact name, telephone number, and e-mail address) that they execute. Such information should be e-mailed to bpabst@cms.hhs.gov. Contractors may have already begun to submit this information in accordance with JSM-05018, issued October 18, 2004. If so, they shall continue to provide this information through January 31, 2005.	X	X	X	X					
3658.3 Ch. 28, Sec. 70.6 and Sec. 80.3.1	Contractors shall note that CMS will not move trading partners into crossover production with the COBC any earlier than December 2004. Consequently, the COBA parallel production period, which involves participation by ten trading partners that serve as beta-site testers, will be extended until CMS, the COBC, and the trading partners conclude that the testing results demonstrate a high level of confidence. Contractors shall note that the larger-scale COBA process, where additional trading partners are first identified as testing participants with the COBC and then are moved to crossover production with the COBC following the successful completion of testing, may be activated at any time during the COBA parallel production process. Activation of the larger-scale COBA process will most likely not	X	X	X	X					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	occur before the early months of calendar year 2005.									
3658.4 Ch. 24, Sec. 70.1 and Sec. 70.2; Ch. 28, Sec. 70.6, Sec. 80, Sec.80.2, Sec. 80.3, Sec. 80.3.1, and Sec. 80.3.2.	Contractors shall operate under the assumption that all of their current eligibility file-based crossover trading partners will at least be in test mode with the COBC by the end of fiscal year 2005 (i.e., by September 30, 2005). Therefore, trading partners will not be fully transitioned from the existing eligibility file-based crossover process to the national COBA program by April 30, 2005, as previously indicated in Transmittal 138.	X	X	X	X					

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: February 22, 2005 **Implementation Date:** February 22, 2005 **Pre-Implementation Contact(s):** Brian Pabst (410-786-2487) **Post-Implementation Contact(s):** Brian Pabst (410-786-2487)	**Medicare contractors shall implement these instructions within their current operating budgets.**

***Unless otherwise specified, the effective date is the date of service.**

70 - Crossover Claims Requirements

(Rev. 448, Issued: 01-21-05, Effective: 02-22-05, Implementation: 02-22-05)

Prior to HIPAA, each supplemental insurer specified criteria related to the claims it wanted the carrier or FI to transfer. Examples of claims most frequently excluded from the crossover process are:

- Totally denied claims;
- Claims denied as duplicates or for missing information;
- Adjustment claims;
- Claims reimbursed at 100 percent; and
- Claims for dates of services outside the supplemental policy's effective and end dates.

The supplemental insurer will provide an eligibility file no less frequently than monthly, preferably weekly.

*Until a trading partner has signed a national Coordination of Benefits Agreement (COBA), t*he carrier or FI will *continue to* provide the claim payment information in either the UB-92 or NSF COB flat file or ANSI X12N COB format. This information will be transferred no less frequently than weekly.

Under HIPAA the carrier or FI will provide only the ANSI X12N COB format.

On July 5,2004,CMS will begin to transfer claims crossover responsibilities from intermediaries and carriers to a national claims crossover contractor, the Coordination of Benefits Contractor (COBC). This initiative is termed the Coordination of Benefits Agreement (COBA) process. Under this process, intermediaries and carriers will receive confirmation via a Common Working File (CWF) Beneficiary Other Insurance (BOI) auxiliary reply trailer that a trading partner has selected a beneficiary's claim for crossover. Upon receipt of a BOI reply trailer, the intermediary or carrier will transfer the processed claim to the COBC via an 837 COB flat file or National Council for Prescription Drug Programs (NCPDP) file to be crossed over to the trading partner.

Refer to Pub. 100-4, Chapter 28, Section 70.6 for further details about specific intermediary and carrier responsibilities under the consolidated crossover (or COBA) claims process.

70.1 - FI Requirements

(Rev. 448, Issued: 01-21-05, Effective: 02-22-05, Implementation: 02-22-05)

A - Shared system Claim/COB flat file

If the shared system detects an improper flat file format/size (incorrect record length, record length exceeding 32,700 bytes, etc.), the flat file will be rejected back to the file's submitter (FI or data center) by the shared system with an appropriate error message. If a

syntax error occurs at the standard level, FIs must return the entire transmission (ISA to IEA) to the submitter via the ANSI X12N 997.
The date of receipt is to be generated upon receipt of a claim, prior to transmission of the data to the data center. The FI has the responsibility to ensure the correct date of receipt is populated onto the Medicare Part A Claim/Coordination of Benefit (COB) flat file (flat file) **before** the file gets to the shared system. The shared system will process the date of receipt reported in the flat file. If the flat file contains an incorrect date of receipt (e.g., all zeros), the flat file will be rejected back to the flat file's submitter (FI or data center) by the shared system with an appropriate error message.

Intermediary responsibilities related to the COB flat file will be significantly modified under the COBA process beginning with July 5, 2004. Refer to Pub.100-4, Chapter 28, Section 70.6 for details.

E - Outbound COB
The outbound COB transaction is a post-adjudicative transaction. This transaction includes the incoming claim data as well as COB data. FIs are required to receive all possible data on the incoming 837 although they do not have to process non-Medicare data. However, the shared system must store that data in a *store-and-forward repository (*SFR*)*. This repository file will be designed and maintained by the shared system. This data must be re-associated with Medicare claim and payment data in order to create an IG compliant outbound COB transaction using the Medicare Part A Claim/COB flat file as input. The shared system is to use post-adjudicated Medicare data (data used from history and reference files to adjudicate the claim) instead of data received when building the outbound COB transaction. The shared system must retain the data in the SFR for a minimum of 6 months.

The Medicare Part A Claim/COB flat file is the format to be used to re-associate all data required to map to the COB transaction. The translator will build the outbound COB transaction from the Medicare Part A Claim/COB flat file. FIs are not required to process an incoming ANSI X12N 997. They may create and use their own proprietary report(s) for feedback purposes.

The shared system maintainer must accommodate the COB transaction.

The flat file creation process and responsibility for sending outbound COB files to crossover trading partners will change appreciably once CMS' COBA process is implemented. The implementation of COBA is scheduled to begin July 5, 2004, and conclude by January 31, 2005. Refer to Pub.100-4, Chapter 28, Section 70.6 for details regarding intermediary versus Coordination of Benefits Contractor (COBC) responsibilities under the COBA process.

H - Summary of Process
The following summarizes all FI steps from receipt of the incoming claim to creation of the outbound COB:

- FI's translator performs syntax edits, IG edits, and Medicare edits and maps incoming claim data to the Medicare Part A Claim/COB flat file;

- Medicare data on the Medicare Part A Claim/COB flat file is mapped to the core system by the shared system.
  NOTE: No changes are being made to core system data fields or field sizes;
- Non-Medicare data (and Medicare data elements where field sizes are in excess of the core system) are written to the SFR by the FI's shared system; and
- Adjudicated data is combined with SFR data to create the outbound COB transaction.

For specifics on how the claims crossover process will change, as early as July 5, 2004, under the COBA initiative, refer to Pub.100-4, Chapter 28, Section 70.6.

70.2 - Carrier/DMERC Requirements

(Rev. 448, Issued: 01-21-05, Effective: 02-22-05, Implementation: 02-22-05)

E - Outbound Coordination of Benefits (COB)

The outbound COB transaction is a post-adjudicative transaction. This transaction includes incoming claim data as well as COB data. Carriers are required to receive all possible data on the incoming ANSI X12N 837 although they do not have to process non-Medicare data. However, they must store that data in a store-and-forward repository (SFR). This repository will be designed by the shared system. This data must be reassociated with Medicare claim and payment data in order to create an outbound ANSI X12N 837 COB transaction. The shared systems maintainer is to use post-adjudicated Medicare data (data used from history and reference files to adjudicate the claim) instead of data received when building the outbound COB transaction. Carriers must retain the data in the SFR for a minimum of six months.

The ANSI X12N-based flat file is the format to be used to reassociate all data required to map to the outbound ANSI X12N 837 (HIPAA version). The translator will build the outbound ANSI X12N 837 COB from the ANSI X12N-based flat file.

The shared system maintainer must create the outbound ANSI X12N 837.

The flat file creation process and responsibility for sending outbound COB files to crossover trading partners will change appreciably once CMS' COBA process is implemented. The implementation of COBA is scheduled to begin July 5, 2004, and conclude by January 31, 2005. Refer to Pub.100-4, Chapter 28, Section 70.6 for details regarding intermediary verses Coordination of Benefits Contractor (COBC) responsibilities under the COBA process.

H - Summary of Process

The following summarizes all the steps from receipt of the incoming claim to creation of the outbound COB:

- Carrier's translator performs syntax edits and maps incoming claim data to the ANSI X12N flat file;

- Shared system creates implementation guide and Medicare edits for the flat file data;
- Medicare data on ANSI X12N flat file is mapped to the core system;
  NOTE: No changes are being made to core system data fields or field sizes.
- Non-Medicare data (and Medicare data elements where field sizes are in excess of the core system) are written to the store-and-forward repository; and
- Adjudicated data is combined with repository data to create the outbound COB.

For specifics on how the claims crossover process will change, as early as July 5, 2004, under the COBA initiative, refer to Pub.100-4, Chapter 28,Section 70.6.

70. 6 – Consolidation of the Claims Crossover Process

(Rev. 448, Issued: 01-21-05, Effective: 02-22-05, Implementation: 02-22-05)

The CMS has decided to streamline the claims crossover process to better serve our customers. *Beginning with July 6, 2004, approximately ten* COBA trading partners will participate in the beta-site testing of the consolidated claims crossover or Coordination of Benefits Agreement (COBA) process. During this time, the COBA beta-site testers will participate in a parallel production crossover process (a pilot for only COBA trading partners using production/live data). During the parallel production period, the *ten* COBA trading partners will receive consolidated crossover claims as part of the COBA process. In addition, if the *ten* COBA trading partners have individual Trading Partner Agreements (TPAs) executed with Medicare contractors, they will receive crossover claims based on the terms and conditions of those TPAs. The Coordination of Benefits Contractor (COBC) will not charge the COBA beta-testers for crossed over claims during the parallel production period. Intermediaries and carriers will, however, continue to charge these partners for claims that they continue to cross over to them during the beta-testing period.

Under the consolidated claims crossover process, trading partners will be transitioned from the current TPA process with intermediaries and carriers to new agreements called Coordination of Benefits Agreements (COBAs). These agreements, which will be negotiated on behalf of CMS by the COBC, will be entered into directly between CMS and the COBA trading partners. Through the COBA process, each COBA trading partner will send one national eligibility file that includes eligibility information for each Medicare beneficiary that it insures to the COBC. The COBC will transmit the beneficiary eligibility file(s) to the Common Working File (CWF) via a maintenance transaction. The transaction is known as the Beneficiary Other Insurance (BOI) auxiliary file. (See chapter 27, §80.14, of Publication 100-4, Medicare Claims Processing Manual, for more details about the contents of the BOI auxiliary file.)

The CWF is being modified so that it will apply each COBA trading partner's claims selection criteria against processed claims with service dates that fall between the effective and termination date of one or more BOI records. After applying the claims selection options, CWF will return a BOI reply trailer (29) to the intermediary or carrier only in those instances when the COBA trading partner expects to receive a Medicare processed claim from the COBC. Upon receipt of a BOI reply trailer (29) that contains (a) COBA ID (s) and other crossover information required on the HIPAA 835 Electronic Remittance Advice (ERA), Intermediaries and Carriers will send processed claims via an 837 COB flat file or National Council for Prescription Drug Programs (NCPDP) file to the COBC. The COBC, in turn, will cross the claims to the COBA trading partner. The CWF is also being modified in preparation for future receipt of claim-based Medigap and/ or Medicaid COBA IDs in field 36 of the HUBC or HUDC query. For claim-based crossover, CWF will also be equipped to search the Coordination of Benefits Agreement Insurance File (COIF) to locate a matching COBA IDs; apply the Medigap claim-based trading partner's claims selection criteria; and return a Claim-based reply trailer 37 to the carrier or DMERC if a claim-based COBA ID has been located and the claim is to be sent to the COBC to be crossed over.

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

The effort to consolidate the claims crossover function will be implemented via a phased-in approach, beginning with a small-scale implementation on July 6, 2004, involving approximately *ten* COBA trading partners that will serve as beta-site testers.

CMS will not move trading partners into crossover production with the COBC any earlier than December 2004. Consequently, the COBA parallel production period will be extended until CMS, the Coordination of Benefits Contractor (COBC), and the participating beta-testing trading partners conclude the testing results demonstrate a high-level of confidence.

Contractors shall operate under the assumption that all of their existing eligibility file-based crossover trading partners will at least be in test mode with the COBC by the end of fiscal year 2005 (i.e., by September 30, 2005).

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

1. BOI Reply Trailer Process

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

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

Larger-Scale Implementation of the COBA Process

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

MSN Crossover Messages

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

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

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

(For all COBA ID ranges other than Medigap)

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

(For the Medigap COBA ID range)

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

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

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

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

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

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

Beginning with the October 2004 release, when contractors receive a BOI reply trailer (29) that contains a "P" Test/Production Indicator, they shall use the returned BOI trailer

information to take the following actions on the provider's 835 Electronic Remittance Advice:

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

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

- NM101 [Entity Identifier Code]—Use "TT," as specified in the 835 Implementation Guide.
- NM102 [Entity Type Qualifier]—Use "2," as specified in the 835 Implementation Guide.
- NM103 [Name, Last or Organization Name]—Use the COBA trading partner's name that accompanies the first sorted COBA ID returned to you on the BOI reply trailer.
- NM108 [Identification Code Qualifier]—Use "PI" (Payer Identification)
    - NM109 [Identification Code]—Use the first COBA ID returned to you on the BOI reply trailer. (See line 24 of the BOI aux. file record

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

G. Transition to the National COBA and Customer Service Issues

1. Maintenance of Current Crossover Processes, Including Entry into New Claims Crossover Agreements (also known as Trading Partner Agreements or TPAs)

Intermediaries and carriers shall keep their present crossover process in place, including invoicing for claims crossed to current trading partners, as described in Pub. 100-6, Financial Management, chapter 1, §450 and §460, until each of their present trading partners has been transitioned to the COBA process. *Once CMS has fully consolidated the claims crossover process under the COBC, the COBC will have exclusive responsibility for the collection of crossover claim fees for those Medigap and non-Medigap claims that are sent to the COBC to be crossed over to trading partners. The COBC will also have responsibility for distribution of the collected crossover fees to Medicare intermediaries and carriers. (See also Pub.100-06, Chapter 1, §450.)*

As trading partners are signed on to national COBAs, they will be advised that it is their responsibility to simultaneously cancel current agreements with intermediaries and carriers and to cease submission of eligibility files. (NOTE: During the parallel production period, the COBA trading partner will be instructed by CMS to not cancel current TPAs with you.) By current estimates, CMS expects to *at least have all current*

eligibility file-based trading partners in test mode by end of fiscal year 2005 (September 30, 2005).

Intermediaries and carriers shall execute new TPAs only with trading partners that will be converted to full crossover production by April 1, 2005. Therefore, CMS expects contractors to cease execution of new crossover TPAs by January 31, 2005.

Trading partners that either wish to go into live crossover production after *January 31, 2005,* or have current questions regarding the COBA process shall be referred to the COBC at *1-646-458-6740.*

80 - Electronic Transmission - General Requirements

(Rev. 448, Issued: 01-21-05, Effective: 02-22-05, Implementation: 02-22-05)

Until an intermediary or carrier receives notice from a Medigap plan that it has signed a national Coordination of Benefits Agreement (COBA) with CMS's Coordination of Benefits Contractor (COBC) and thus has requested cancellation of its existing Trading Partner Agreement with the Medicare contractor (see § 70.6 of this chapter for more information), intermediaries and carriers will continue to enter into formal agreements with individual Medigap insurers for the transmission of claim information electronically (see §80.3). The agreement should specify whether the Medigap insurer will submit an eligibility file. If the Medigap insurer wants to send a periodic eligibility file the agreement must specify how Medicare costs are to be paid by the Medigap insurer.

The CMS requires that the outbound format for the transfer of *h*ealth *c*are claim information is the ANSI X12N 837 COB, or for transmissions before the required implementation date for X12N, the NSF or UB-92 outbound format may be used. Also, if the recipient wants electronic attachments, attachment data must be furnished in UB-92 or NSF format because X12N does not support electronic attachments (e.g., UB-92 RTs 74, 75, 76). Only the attachment records will be furnished in UB-92 or NSF format after X12N becomes mandatory. Other data will be in the X12N format. The recipient must coordinate any attachments received with the claim record.

Detailed specifications on the electronic formats can be obtained at http://www.cms.hhs.gov/providers/edi/edi3.asp.

The outbound COB transaction is a post-adjudicative transaction. This transaction includes the incoming claim data as well as the COB data. The intermediary or carrier is required to receive all possible data on the incoming 837, although they do not have to process non-Medicare data. However, the shared system must store that data in a store-and-forward repository (SFR). This repository file is designed and maintained by the shared system. This data must be re-associated with the Medicare claim and payment data in order to create a compliant outbound COB transaction using the Medicare Claim/COB flat file as input. The shared system is to use post-adjudicative Medicare data (data used from history and reference files to adjudicate the claim) instead of data received when building the outbound COB transaction. This is to show any changes in data element values as a result of claims adjudication. The shared system must retain the data in the SFR for a minimum of six months.

The Medicare Claim/COB flat file is the format to be used to re-associate all data required to map to the COB transaction. *Until all trading partners have executed national COBAs and been moved into production with the COBC, t*he *intermediary or c*arrier's translator will *continue to build its* outbound COB transaction from the Medicare Claim/COB flat file.

The CMS recommends *that* the *intermediary or carrier* send the outbound COB transaction over a wire connection. However, tape or diskettes may be sent to those trading partners that do not wish to receive transmissions via wire. The *intermediary or c*arrier and *its* trading partners will need to reach agreement on telecommunications

protocols. It is the *intermediary or c*arrier*'s* choice as to whether *it* wish*es* to process the X12N 997 Functional Acknowledgment from *its* COB trading partners.

Data on claims that the intermediary or carrier receives from its keyshop or image processing systems may not be included on the SFR, depending on the shared system design. The *intermediary or carrier* will create the Medicare claim/COB flat file using data available from claims history and reference files. Since some data will not be available on these "paper" claims, the outbound COB transaction will be built as a "minimum "data set. It will contain all "required" COB transactions segments and post-adjudicative Medicare data. For a Medicare Claim/COB flat file layout see http://www.cms.hhs.gov/providers/edi/hipaadoc.asp.

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

- Contractor's translator performs syntax edits and maps incoming claim data to the X12N flat file;
- Standard system creates implementation guide and Medicare edits for the flat file data;
- Medicare data on ANSI X12N flat file is mapped to the core system;

NOTE: There are no changes in core system data fields or field sizes.

Non-Medicare data (and Medicare data elements where field sizes are in excess of the core system) are written to the SFR; and *a*djudicated data is combined with repository data to create the outbound COB. *Under the COBA process, the COBC will receive flat files containing processed Medicare claims. The COBC will then convert the flat files into the appropriate HIPAA outbound COB format and transmit the claims to the COBA trading partner. Implementation of this process will begin on July 6, 2004, with a small-scale parallel production period. Refer to §70.6 of this chapter for more details.*

80.2 - ANSI X12N 837 COB Transaction Fee Collection

(Rev. 448, Issued: 01-21-05, Effective: 02-22-05, Implementation: 02-22-05)

The intermediary or carrier charges Medigap and other complementary insurers (but not Medicaid) for the cost of preparing and sending COB transactions. The transfer agreement must include a description of data elements on the invoice (bill). (See §70.3 above.) *Once CMS has fully consolidated the claims crossover process under the COBC, the COBC will have exclusive responsibility for the collection of crossover claim fees for those Medigap and non-Medigap claims that are sent to the COBC to be crossed over to trading partners. The COBC will also have responsibility for distribution of the collected crossover fees to Medicare intermediaries and carriers. (See also Pub.100-06, Chapter 1, §450 and Pub.100-04, Chapter 28, §70.6.)*

If a Medigap insurer refuses to pay or does not pay it regularly and completely, the *c*arrier should notify the appropriate State insurance commission that the Medigap insurer is not complying with the payment provisions of §4081 of OBRA 1987 *(also found at §1842(h)(3)(B) of Title XVIII of the Act)*. First, the *c*arrier should contact the insurance department of the State in which the policyholder resides. If that State insurance department does not accept jurisdiction, the *carrie*r informs the appropriate RO. The RO contacts CMS Central Office for assistance in determining the department of jurisdiction. If, after contacting the insurance department recommended by CMS, the problem is unresolved, the carrier treats it as a CMS debt under 42 CFR 401.601-401.625. (***NOTE:*** *This responsibility shall cease once all Medigap insurers, including those that presently participate in mandatory Medigap [also known as "claim-based"] crossover as well as those that participate in eligibility file-based crossover, have been transitioned to the COBC).*

The requirements in §§20 - 30.1 do not supplant existing agreements which the intermediary or carrier may have with any other insurer to exchange complementary insurance information except for possible amendment to recognize the beneficiary's right to assign Medigap payment to participating physicians and suppliers on a claim-by-claim basis. The intermediary or carrier should modify these agreements to state that it is the beneficiary's right to designate a particular insurer to receive a notice for payment. If the *intermediary or carrier has* transmitted an ANSI X12N 837 COB *t*ransaction to a designated Medigap insurer based on a properly executed assignment, that insurer should send claims information to other insurers under complementary arrangements.

80.3 - Medigap Electronic Claims Transfer Agreements

(Rev. 448, Issued: 01-21-05, Effective: 02-22-05, Implementation: 02-22-05)

For electronic transfers occurring on a frequent basis, Medigap and other insurers must enter into agreements with the intermediary or carrier. These agreements may alter the procedures applying to existing agreements with complementary insurers, including Medigap assignment provisions.

At a minimum, all transfer agreements include:

- Functions of the carrier;
- Functions of the Medigap insurer;
- Fees and payment schedules;
- Confidentiality/Disclosure of information furnished;
- Office of Inspector General (OIG) review access;
- Contract periods and automatic renewal provisions;
- Contract termination provisions; and
- Dated signatures of authorized carrier/Medigap insurer representatives

Intermediaries or carriers can negotiate other provisions that the Medigap insurer may want but are not required to by §§20 - 80. The standard formats as described by these sections must be used.

By current estimates, effective with the end of fiscal year 2005 (i.e., September 30, 2005), all electronic transfer agreements [formally known as Coordination of Benefits Agreement (or COBAs)] will be negotiated and administered by the COBC, working on behalf of CMS. The COBAs will be executed between health insurers and health benefits programs that pay after Medicare and CMS rather than between intermediaries/carriers and these entities. Refer to §70.6 in this chapter for more details.

80.3.1 - Intermediary Crossover Claim Requirements

(Rev. 448, Issued: 01-21-05, Effective: 02-22-05, Implementation: 02-22-05)

D - Outbound COB

The outbound COB transaction is a post-adjudicative transaction. This transaction includes the incoming claim data as well as COB data. Intermediaries are required to receive all possible data on the incoming ANSI X12N 837 although they do not have to process non-Medicare data. However, the shared system must store that data in a SFR. This repository file will be designed and maintained by the shared system. This data must be re-associated with Medicare claim and payment data in order to create an IG compliant outbound COB transaction using the Medicare Part A Claim/COB flat file as input. The shared system is to use post-adjudicated Medicare data (data used from history and reference files to adjudicate the claim) instead of data received when building

the outbound COB transaction. The shared system must retain the data in the SFR for a minimum of six months.

The Medicare Part A Claim/COB flat file is the format to be used to re-associate all data required to map to the COB transaction. The translator will build the outbound COB transaction from the Medicare Part A Claim/COB flat file.

Intermediaries are not required to process an incoming ANSI X12N 997. They may create and use their own proprietary report(s) for feedback purposes.

The shared system maintainer must accommodate the COB transaction.

The flat file creation process and responsibility for sending outbound COB files to crossover trading partners will change appreciably once CMS' COBA process is implemented. The small-scale implementation of COBA will begin July 6, 2004, with a parallel production period involving ten beta-tester trading partners. This parallel production process will continue until CMS, COBC, and the trading partners conclude the testing results demonstrate a high level of confidence. The larger-scale COBA process, where additional trading partners are first identified as testing participants with the Coordination of Benefits Contractor (COBC) and then are moved to crossover production with the COBC following the successful completion of testing, may be activated at any time during the COBA parallel production process. Activation of the larger-scale COBA process will most likely not occur before the early months of calendar year 2005.

G - Summary of Process

The following summarizes all intermediary steps from receipt of the incoming claim to creation of the outbound COB:

Intermediary's translator*/edit process* performs syntax edits, IG edits, and Medicare edits and maps incoming claim data to the Medicare Part A Claim/COB flat file;

Medicare data on the Medicare Part A Claim/COB flat file is mapped to the core system by the shared system.

NOTE: No changes are being made to core system data fields or field sizes;

Non-Medicare data (and Medicare data elements where field sizes are in excess of the core system) are written to the SFR by the intermediary's shared system; and

Adjudicated data is combined with SFR data to create the outbound COB transaction.

For specifics on how the claims crossover process will change on a small-scale as early as July 6, 2004, under the COBA initiative, refer to §70.6 in this chapter.

80.3.2 - Carrier/DMERC Crossover Claim Requirements

(Rev. 448, Issued: 01-21-05, Effective: 02-22-05, Implementation: 02-22-05)

E - Outbound Coordination of Benefits (COB)

The outbound COB transaction is a post-adjudicative transaction. This transaction includes incoming claim data as well as COB data. Carriers are required to receive all possible data on the incoming ANSI X12N 837 although they do not have to process non-Medicare data. However, they must store that data in a store-and-forward repository (SFR). This repository will be designed by the shared system. This data must be re-associated with Medicare claim and payment data in order to create an outbound ANSI X12N 837 COB transaction. The shared systems maintainer is to use post-adjudicated Medicare data (data used from history and reference files to adjudicate the claim) instead of data received when building the outbound COB transaction. Carriers must retain the data in the SFR for a minimum of six months.

The ANSI X12N-based flat file is the format to be used to re-associate all data required to map to the outbound ANSI X12N 837. The translator will build the outbound ANSI X12N 837 COB from the ANSI X12N-based flat file.

The shared system maintainer must create the outbound ANSI X12N 837.

The flat file creation process and responsibility for sending outbound COB files to crossover trading partners will change appreciably once CMS' COBA process is implemented. The small-scale implementation of COBA will begin July 6, 2004, with a parallel production period involving ten beta-tester trading partners. This parallel production process will continue until CMS, COBC, and the trading partners conclude the testing results demonstrate a high level of confidence. The larger-scale COBA process, where additional trading partners are first identified as testing participants with the Coordination of Benefits Contractor (COBC) and then are moved to crossover production with the COBC following the successful completion of testing, may be activated at any time during the COBA parallel production process. Activation of the larger-scale COBA process will most likely not occur before the early months of calendar year 2005.

H - Summary of Process

The following summarizes all the steps from receipt of the incoming claim to creation of the outbound COB:

- Carrier's translator performs syntax edits and maps incoming claim data to the ANSI X12N flat file;
- Standard system creates implementation guide and Medicare edits for the flat file data;
- Medicare data on ANSI X12N flat file is mapped to the core system;

  NOTE: No changes are being made to core system data fields or field sizes.
- Non-Medicare data (and Medicare data elements where field sizes are in excess of the core system) are written to the store-and-forward repository; and

- Adjudicated data is combined with repository data to create the outbound COB.

For specifics on how the claims crossover process will change on a small-scale as early as July 6, 2004, under the COBA initiative, refer to §70.6 in this chapter.