

THE MEDICARE CROSSOVER (COBC Update)

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Medicare Crossover Breakout Session

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History

- CMS is the Centers for Medicare and Medicaid Service, formerly known as the Health Care Financing Administration (HCFA). CMS is the federal agency responsible for administering a number of health programs, among them, Medicare. CMS also oversees the Coordination of Benefits process. Information regarding CMS and its programs can be found at <http://www.cms.hhs.gov/>.
- The Coordination of Benefits (COB) Contractor consolidates the activities that support the collection, management, and reporting of other insurance coverage for Medicare beneficiaries. The purposes of the COB program are to identify the health benefits available to a Medicare beneficiary and to coordinate the payment process to prevent mistaken payment of Medicare benefits. The COB Contractor does not process claims, nor does it handle any mistaken payment recoveries or claims specific inquiries. The Medicare intermediaries and carriers are responsible for processing claims submitted for primary or secondary payment.^[1]
- GHI – Group Health Incorporated is located in New York, NY, and is the CMS Coordination of Benefits Contractor (COBC).
 - The COBC assigns an EDI representative to each Trading Partner.
 - The EDI Representative answers questions, coordinates testing, and production related activities.


[1] COB General Information, Centers for Medicare & Medicaid Services, <http://www.cms.hhs.gov/COBGeneralInformation>, Accessed March 11, 2009.

What is COBA ?

“The Centers for Medicare & Medicaid Services (CMS) developed a model national contract, called the Coordination of Benefits Agreement (COBA), which standardizes the way that eligibility and Medicare claims payment information is exchanged. COBAs permit other insurers and benefit programs (also known as trading partners) to send eligibility information to CMS and receive Medicare paid claims data for processing supplemental insurance benefits for Medicare beneficiaries from CMS’ national crossover contractor, the Coordination of Benefits Contractor (COBC).”^[2]

[2] Coordination of Benefits Agreement, COBA Implementation User Guide, Centers for Medicare & Medicaid Services, <http://www.cms.hhs.gov/COBAgreement/Downloads/COBAguide.pdf>, Accessed March 23, 2009.


The Current COBA Process Starting the Process



Centers For Medicare & Medicaid Services Coordination of Benefits Agreement (COBA) was developed as a standard national contract. – Current version: COBA001-5.1, August 2008

- COBA Attachment – Current version: COBA002-4.1, December 2007. One Attachment is completed for each COBA ID requested. A separate COBA Attachment is required for each line of business (Medigap, Supplement, TRICARE, Medicaid Agency, Federal Employee Program, Third Party Administrator, etc.)
- COBA Addendum – Current version: February 2009, Revision 2. COBA Trading Partners are now provided the opportunity to complete an Addendum to the Coordination of Benefits Agreement requesting additional COBA IDs in the range of 89000 – 89999 to uniquely identify RAC Adjustments. This will provide the COBC with the ability to crossover the RAC Adjustments at no charge to the Trading Partner.
- Complete the Technical Readiness Survey. The survey is important as it helps determine your technical readiness. Spend time reviewing the COBA Implementation User Guide to ensure the technical requirements specifically outlined in the Guide are met. The Technical Readiness Survey and the User Guide can be found using the following URLs.
<http://www.cms.hhs.gov/COBAgreement/Downloads/COBASurv.pdf>
<http://www.cms.hhs.gov/COBAgreement/Downloads/COBAguide.pdf>

The Current COBA ProcessThe COBA Profiles



- The COBC will process the COBA, Attachments, and Addendums. When processing has completed successfully, the COBC will generate profiles reports. This is done with any Attachment changes as well.
- The COBA Profile Report provides the information the Trading Partner/Payer requested on the Attachment as well as the COBA ID assigned by the COBC. Validate the COBA Profiles for each COBA ID.
- The COBA ID is used when sending test/production eligibility files and Dispute Files. The COBA ID is sent to the Trading Partner/Payer on all Claim Transactions.

The Current COBA Process...Testing

- Connectivity Test – Coordinate the connectivity test and the test date with the EDI Representative.
- Complete and return the transmission form to the EDI Representative.
- Eligibility File Testing – COBA Eligibility File Format
 - ☑ Mini test - Transmit no more than 100 eligibility file "Add" records for each assigned COBA ID. A second mini transmission includes "Change Records" only
 - ☑ Verify the receipt of the EFA and ERF for each COBA ID
 - ☑ Receive approval to send full eligibility file
 - ☑ Send full "Add" eligibility file(s); validate receipt and record acceptance through the EFA and ERFs
 - ☑ The EFA is the Eligibility File Acknowledgement and confirms the receipt of the eligibility file.
 - ☑ The ERF is the Eligibility Response File and is sent by COBC after each Eligibility File has been processed. The ERF provides a one-to-one response to each eligibility record sent using a disposition code response process.

The Current COBA Process...Testing

- Claim File Testing – HIPAA 837/NCPDP File Formats
 - ☑ Verify the receipt of claims files for each COBA ID.
 - ☑ Verify the Claims received match accepted eligibility records and match the Claims Selection Criteria selected in the Attachment and Addendum.
 - ☑ Validate the claims received are compliant for the applicable format
 - ☑ Validate Internal system EDI routing and processing for any pre-processing edits.
 - ☑ Test Mapping validation if your system maps the HIPAA or NCPDP to a legacy format.
 - ☑ Verify the claims are delivered to the back-end systems and are accurately adjudicated.

The Current COBA Process The Dispute File

Online Dispute Resolution

- With db-eBills, dispute resolution can now be handled more efficiently online. A trading partner may dispute either whole invoices or specific line items.
- Standardized dispute codes simplify the process, enabling the trading partner to state the nature of the dispute (e.g., item count, claim type or fee) and identify a reason for the dispute (over-billed, records not received, claim type, etc.).

Partial File Rejects

- Partial file rejects may be reported 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.

The Current COBA Process The Dispute File continued

Dispute Reason Codes
The following table lists all the dispute reason codes currently available. This is the code that is used to populate the Dispute or Error Reason field in the Detail Records.

Reason Code	Dispute Reason
000100	Duplicate Claim
000110	Duplicate Claim (within the same ISA-IEA loop)
000120	Duplicate Claim (within the same ST-SE loop)
000200	Reserved for future use
000300	Beneficiary not on eligibility file
000310	Beneficiary record in transition
000400	Reserved for future use
000500	Incorrect claim count
000600	Claim does not meet selection criteria
000700	HIPAA Error
009999	Other

The Current COBA Process The Dispute File continued

WellPoint Inc.

- Edit all incoming COBC Claim files.
- Daily produce by COBA ID, dispute files on claims that do not meet HIPAA compliance (dispute code 00700). Invalid claim and code with description are listed on dispute.
- Dispute files are transmitted to GHI daily.
- GHI returns an automated email that file has been received.
- GHI then researches the dispute and, if agreed, will submit as credit to our COBA ID via dB e-bill.

**Issue discussion

The Current COBA Process... dB e-bills

dB e-bill Quick Reference Guides

Inquiry – invoice, credit notes, payments, disputes

Payer Administration – admin certificate, user Id set up, assign user roles, authorize certificate

Payment – authorization and payment preparation

Invoice Processing – approve invoice, dispute approval/denial, reallocate invoice line items, reassign invoice

Implementation

Common Issues Payers Encounter After Implementation

- Communications - CMS and the COBC provide critical communication through the COBVA list serve. Make sure you are on the distribution list for the COBVA notifications.
- Disputes not being credited – Payers have experienced delays in approved disputes being credited.
- Duplicate claims submitted within later claims files – Payers experience the receipt of duplicate claims embedded in later claim files which the batch duplicate check cannot detect.
- Claims not crossing over when the Payer believes they should have- Payers receive calls from providers/subscribers indicating their claims have not crossed over when they should have.
 - Eligibility Add/Update/Delete may not have processed on CWF as the payer expected preventing claims from being selected for crossover.
 - Eligibility File is out of synch.
- Claims cross over when the Payer believes they should not have- Payers receive calls from providers/subscribers indicating their claims crossed over when they should not have.
 - Eligibility Update/Delete may not have processed on CWF as the payer expected selecting claims for crossover when they not have been.
 - Eligibility File is out of synch.

Re-synch Eligibility File (CWF download review)

Eligibility out of sync?

What we have for membership per a specific COBA ID at our plan is not matching completely at CMS Common Working File (CWF.) Membership missing or incorrect at CWF.

Reason's why this may have occurred:

- Electronic Response Files (ERF) not worked completely
- There could be an issue at Medicare Beneficiary Database (MBD). For example, They cross referenced Husband's HICN as Wife's new HICN. GHI had to contact MBD to correct the information on the system.
- Internal issue with how our backend systems were generating changes "updates" and delete on bi-weekly eligibility files.

Re-synch Eligibility File (CWF download review)

Steps to take to complete a re-sync:

- Request from your GHI representative the COBA ID to be downloaded.
- You will need to give GHI a location delivery address for the full CWF file to be delivered
- Once the file is received at the plan, you will need to compare it to your full membership file for that COBA ID.
- All mismatches need to be add to separate A/U/D eligibility.
- When the file is ready to be sent to GHI, contact your GHI representative to advise that you are sending a file off schedule (this is a re-sync file).
- You must hold your normal bi-weekly eligibility A/U/D file until you receive back you ERF on the re-sync and work those error.

Implementation

Lessons Learned

Blue Cross and Blue Shield of Minnesota requested separate COBA IDs for adjustment/cancel claims. The separate COBA IDs were requested so adjustment/cancel claims would be gathered and sent on separate files from original claims files. The decision to request separate COBA IDs for adjustment/cancel claims was done for a number of reasons and has proven to be a valuable decision.

- ✓ We wanted to maintain control of incoming adjustments (mass adjustments, Medicare Contractor system issues, etc).
- ✓ The business wanted the ability to monitor volumes quickly, easily, and react swiftly without a lot of IT intervention.
- ✓ We wanted to be able to isolate adjustments by entire files rather than claim by claim.
- ✓ We believed this would allow us to implement internal system changes in an efficient manner.
- ✓ We believed being able to isolate adjustments, especially large volumes, would not hinder system performance since we could redirect entire files as needed.

What is in the Future for COBC?

.....Cost for Crossover claims

- 837I, 837P and NCPDP claims currently (.48)
- RAC claims (.00)
- CMS is revisiting fee structure for COBC electronic claims

What is in the Future for COBC?

..... Recovery Audit Contractor (RAC)

Background :

- In Section 306 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Congress directed DHHS to conduct a 3-year demonstration using RACs to detect and correct improper payments in the Medicare FFS program. Congress gave CMS the authority to pay each RAC on a contingency fee basis, which is a percentage of the improper payments corrected by the RACs.

CMS designed the RAC Program to:

- Detect and correct *past* improper payments in the Medicare FFS program; and
- Provide information to CMS and Medicare contractors that could help protect the Medicare Trust Funds by preventing *future* improper payments thereby lowering the Medicare FFS claims payment error rate.

What is in the Future for COBC?

..... Recovery Audit Contractor (RAC) Adjustments

Permanent program will begin by August 2009

- Medicare will adjust claims based on the RAC findings when applicable.
- CMS has conducted provider outreach in some states and by RAC Region.
- Once the provider outreach is completed by state, the RAC will begin reviewing data.
<http://www.cms.hhs.gov/RAC/>
- Providers have the right to appeal the adjusted RAC claim.
- Medicare will send to the appropriate secondary payer the RAC adjusted claims.

RAC Phase In Schedule



Region A: Diversified Collection Services (DCS)
 Region B: CGI
 Region C: Connolly Consulting, Inc.
 Region D: HealthDataInsights, Inc.

What Steps Did WellPoint Take to Prepare?



EDI Steps:

- Completed updates to all current attachments to EXCLUDED RAC claims
 ***Addendum to Exclude RAC claims – completed.
- Completed request to Jim Brady for new COBC RAC IDs (52 New IDs)
 Complete new COBC Attachments/Addendum for new RAC IDs
 - Sign Attachments/Addendum
 - Send to Jim Brady at GHI when completed
 - Receive new Profile report from GHI (listing all new RAC IDs)
- Completed SR for new COBA IDs set up in EDI Gateways
 - Complete 52 new RAC ID transmission forms (due date March 31, 2009)
 - Set up the 52 RAC IDs on the EDI Gateways (due date April 15, 2009)
- Completed SR for new COBA IDs set up in Clearinghouse (EEG)
 - Mercator/Assencial ID set up
 - Reject/Dispute file
 - Routing
 - Testing
 - Reporting Set up

RAC STEPS..... Continued

- Complete SR Backend system eligibility files.
 - Need to duplicate current eligibility files for corresponding RAC IDs
 - Need to send a full file all adds that match your current COBA ID for corresponding RAC ID
- Work with GHI on new GS control number sequencing for all RAC IDs (complete and send spreadsheet with the 52 RAC IDs and individual GS control numbers in April)

System	State/Region	COBA ID	New RAC COBA ID
FACETS	CENTRAL (SUPP)	00001	88001
	MISSOURI (SUPP)	00002	88002
	CENTRAL (Medigap)	30001	88003
	MISSOURI (Medigap)	30002	88004

RAC Lessons Learned...



- Full files can only be uploaded to production at GHI on Friday evenings. However Full files should be submitted to GHI no later than Wednesday end of business to insure they make the run on Friday.
- Make sure you review your profile reports even if they were copied from current COBA IDs. We found discrepancies that GHI had to correct.
- GS control number sequencing with in new COBA IDs are set up after 1st production file is transmitted.

CMS COBC Update:

- **HIPAA 5010 and NCPDP COB Transition Updates**
 - CMS is planning to offer testing of HIPAA 5010 and NCPDP D.0 to all interested trading partners during June to December 2010. Participation is voluntary.
 - Contrary to what CMS stated during its June 2009 Open Door Forum, following COBA trading partner cut-over to 5010 or NCPDP D.0, the insurer will be expected to accommodate two weeks' worth of 4010-A1 and NCPDP 5.1 run-out claims.
 - CMS will inform providers when the claims held in suspense or paper claims that happen to be pending on the payment floor are not crossed over. CMS Medicare contractors will utilize a series of new N22226-N22233 codes for this purpose. These will appear on the provider notification letters that Medicare generates to advise providers that claims will not be crossed over.
 - Without exception, effective with January 1, 2012, all COBA trading partners must be cut-over to the new 5010 and NCPDP D.0 formats.
 - Claims where the Common Working File (CWF) tagged for crossover in the 4010-A1 or NCPDP 5.1 formats prior to January 2012 and that remain on the payment floor through or shortly after January 1, 2012, will be transmitted by the COB Contractor (COBC) to the COBA trading partners in the HIPAA 5010 and NCPDP D.0 formats.

CMS COBC Update continued:

Medigap Plan N Update

- CMS is working collaboratively with America's Health Insurance Plans (AHIP) on the implementation of the new Medigap plan N offering, which becomes effective in June 2010.
- The CMS focus is on identifying affected CPT-4 office visit services, including those rendered by specialty providers, for AHIP and informing providers about the new offering and their associated responsibilities.
- Under the new offering, the physician's or specialty physician's billing staff needs to collect a standard \$20.00 co-payment from the beneficiary for any "office visits" at the time of service.
- There should be no negative impacts to the CMS COBA crossover process arising from this new policy.

CMS COBC Update continued:

ACE Demonstration Project Claims Update

- All payers that accept 837 institutional claims via the COBA crossover process need to be able to identify and pay the co-insurance resulting from the physician component of these claims. This may be found in 2300 HI, qualified by value code Y3.
- CMS will share more details regarding possible further expansion in terms of number of participating providers within this demonstration project via future COBVA.
- Crossover Contact information
 EDI Department
 COB/Medicare
 cobva@ghimedicare.com
 Tel # 646-458-6740
 Fax # 646-458-6761
- References: Centers for Medicare & Medicaid Services (CMS) - www.cms.hhs.gov/TransactionCodeSetsStandards/02_TransactionsandCodeSetsRequisitions.asp

CMS COBC Update continued:

Recovery Audit Contractor (RAC) Adjustment Claims Update

- Under current directives, the RAC program must be operational by calendar year 2010.
- As of August 2009, the CMS COBA team has no new information concerning when RAC-initiated adjustment claims will start to flow.
- When these adjustments start to flow, the current plans are for DME MAC claims to be targeted first.
- All commercial COBA Trading Partners should communicate their decision on receipt (for free) or non-receipt of RAC-initiated adjustment claims by completing the COBA Addendum.
- If no action is taken, with respect to completing the COBA Addendum, COBA Trading Partners will receive RAC-initiated adjustments under their existing COBA IDs at cost (paying the current per claim crossover rate).

Current concerns raised by Blues

Transmittal 521 – Missing CAS segments

- CMS has determined that the Part A shared system does **not** reliably include Claims Adjustment Segment (CAS) information in association with the fully denied 837 institutional flat file claims that it generates to the Coordination of Benefits Contractor (COBC) on a daily basis.
 - Fixed scheduled for Jan 2010
- COBC has contacted Highmark - concerning claims not crossing.
- GHI Eligibility files issue – Not matching CWF
 - Member displays multiple HICN's on GHI records.
 - Member displays no HICN on GHI eligibility records.

Questions and Answers

