Coordination of Benefits Agreement (COBA)
Companion Guide for

Health Insurance Portability and Accountability Act (HIPAA) 837 Institutional and Professional Medicare Coordination of Benefits (COB)/Crossover Version 5010 Claim Transactions

For Use by
All COBA Trading Partners

Developed by
The Division of Medicare Secondary Payer Program Operations (DMPO) at the Centers for Medicare & Medicaid Services (CMS)

Rev. 2014/ September Version 5.2

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Revision History

Date	Version	Reason for Change
November 2010	5.0	Previous publication date
February 3, 2014 (January Release B)	5.1	Branded for the Benefits Coordination & Recovery Center
September 2014	5.2	To include updates for systems changes made during 2013 and 2014 as well as a future change that will be effective in January 2015. To make other general modifications as needed. Also, to note an example of another field that Medicare will not produce as part of version 5010 837 COB claims.

I. Introduction

The Coordination of Benefits Agreement (COBA) Companion Guide for Health Insurance Portability and Accountability Act (HIPAA) Accredited Standards Committee (ASC) 837 X12N Institutional and Professional Medicare Coordination of Benefits (COB)/Crossover Version 5010 Claim Transactions provides all COBA trading partners with critical technical information concerning the Medicare HIPAA 5010 COB claim transactions they will receive from the Benefits Coordination & Recovery Center (BCRC). This guide includes eleven sections. Referenced documents and forms are available for download at http://www.cms.hhs.gov/COBAgreement/01_overview.asp.

The Centers for Medicare & Medicaid Services (CMS) and BCRC COBA teams recognize that differences in how employer retiree group health plans, third party administrators, Medigap plans, and Title XIX Medicaid agencies price crossover claims will impact how they calculate Medicare's allowed amount. The CMS and BCRC COBA teams have done our best to take these differences into account, as shall be seen under Section III.A. We trust all the information presented herein will prove helpful to our COBA trading partners.

Summary of Changes to this COBA HIPAA 5010A1 and A2 COB Companion Guide:

- Modified the title of Companion Guide on the Title Page and as referenced in the "I. Introduction" section, to ensure greater clarity.
- Modified the language in the "I. Introduction" section to promote greater clarity.
- Modified Section II "Getting Started" to remove references to "pre-Errata" (i.e, pre-April 4, 2011) version HIPAA 837 COB claims and the ability to test with the BCRC on this format.
- Updated reference link to the Technical Readiness Assessment Document in "Section II. Getting Started."
- In the concluding section of "II. Getting Started," we added a note to indicate that all COBA trading partners have been under the HIPAA 837 COB version 5010 format since July 1, 2012.
- Added a clarifying note to "III. Overview of Important Changes between 4010A1 and HIPAA 5010 (Pre-Errata) Medicare COB Transactions" to explain why this section is being retained in this Guide.
- Adjusted position of information regarding 2300 AMT*F5 (Patient Paid Amount) within Section III.
- Changed the term "Medicare contractor" to the most current naming convention used by CMS; this change is reflected throughout the document.
- Under "V. 837 Institutional Claims" and "VI. 837 Professional Claims," we made the following changes:
    - Modified version number to ensure that current Errata version is reflected.
    - Included a note concerning use of the 23rd byte of the BHT03 identifier as of April 4, 2011.
    - Updated the listing of possible 23rd byte BHT03 identifier values to include C, E, and V.
    - Modified the guidance for 2000B SBR09 to indicate that, effective January 7, 2015, and after, this field will contain "CI" if the destination payer is non-Medicaid; if the destination payer is Medicaid, the field will continue to reflect "MC."
    - Added clarifying statement for 2300 CLM05-3 for "void/cancel only" claims.
    - **(NOTE: Unique to Section V. 837 Institutional Claims only)** Updated the 2300*HI Value Code section to reflect guidance regarding the Model 4 Bundled Payments for Care Improvement (BPCI) pilot project.

  - Modified the guidance for 2320 SBR09 (specific to all destination payers and ***not*** Medicare) to account for the January 7, 2015 change to reflect "CI" rather than "ZZ" as a qualifier for commercial payers. The value "MC" will continue to be reflected for Medicaid.
  - Included a note about discontinuance of the practice of including National Drug Code (NDC) reporting in NTE (NOTE) segments effective with the implementation of HIPAA 837 COB version 5010 claims.

- Added an important note concerning the values that will be reflected in 2300 CLM09 and 2320 OI06 at the conclusion of "Section IX. Helpful Information for COBA Trading Partners…" as of January 7, 2015.

II. Getting Started—Preparing to Test Medicare HIPAA 5010 Claims

As a COBA trading partner representative that is preparing your organization for testing the Errata versions of the HIPAA 5010 institutional and professional coordination of benefits (COB)/crossover claims with CMS's BCRC, your first step is to complete the "Technical Readiness Assessment Document." This document may be referenced at:

http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/COBA-Trading-Partners/Downloads/5010_TECH_READINESS.pdf .

This will help you and CMS to gauge your readiness and indicate when you expect to begin testing the HIPAA 5010 837 (Errata version) COB claim transactions with the BCRC.

COBA trading partners that already have existing COBA IDs will most likely ***not*** need to obtain new COBA identifiers (IDs) to test HIPAA 5010 Errata version COB transactions with the BCRC. Your designated BCRC electronic data interchange (EDI) representative should be able to assist you with set-up for HIPAA 5010 Errata version testing.

Questions concerning what connectivity options are available to you in connection with HIPAA 5010 COB testing may be referenced in the COBA Implementation User Guide. At this point in time, CMS is offering the same options that were available to COBA trading partners as part of the former version 4010A1 837 COB claims crossover process.

COBA trading partners that have questions about available claims selection criteria should consult Chapter 2 of the COBA Implementation User Guide.

As has always been the case, COBA trading partners should not make payment on Medicare-transmitted HIPAA 5010 "test" 837 institutional or professional claims. They should, however, use these claims to gauge the possible need for front or back-end systems changes that will enable them to receive HIPAA 5010 COB claims in production mode.

IMPORTANT: Effective July 1, 2012, all COBA trading partners have moved to the HIPAA 5010 COB claim Errata version in production.

III. Overview of Important Changes between HIPAA 4010A1 and HIPAA 5010 (Pre-Errata) Medicare COB Transactions

NOTE: The following section speaks to issues that would have been of concern to COBA trading partners prior to the July 1, 2012, mandated switch to HIPAA ASC X12N version 5010 837 COB claim formats in production mode. This section may be of minimal interest to new COBA trading partners.

A. Removal of Numerous AMT Segments

The HIPAA X12 Committee has determined that the HIPAA ASC X12N 837 version 4010A1 institutional and professional claims transactions contained numerous redundancies in terms of "AMT" segments. As a covered entity under HIPAA, Medicare must abide by the new ASC X12 Standards for Electronic Data Interchange Technical Report Type 3 (TR-3) requirements. One of the most important changes that COBA trading partners will notice under HIPAA 5010 is the elimination of all allowed and approved amounts, formerly qualified by AMT*B6 or AMT*AAE within the 837 institutional and professional claim formats.

IMPORTANT: As CMS has mentioned on many occasions during individual or group conference calls with COBA trading partners, currently, the Medicare Part A shared system maps the "total submitted allowable charges" to the AMT*B6 on 837 institutional 4010A1 crossover claims. COBA trading partners that formerly wished to determine Medicare's actual allowed amount on version 4010A1 837 institutional inpatient hospital crossover claims would have needed to take the total submitted Medicare charges, qualified by T3, at the 2320 claim level and subtract the CO*45 if present from that figure or add the CO*94 amount {or CO*45 amount if it has a negative symbol (-) beside it} to that figure to determine Medicare's "actual" approved amount. If attempting to determine Medicare's allowed amount on version 4010A1 837 institutional outpatient-oriented crossover claims, the COBA trading partner would have needed to use the suggested formula provided directly below for version 5010 837 institutional outpatient-oriented and 837 professional claims to determine the Medicare allowed amount on version 4010A1 837 institutional outpatient-oriented claims.

Possible Methodology for Determining Medicare's Allowed/Approved Amount

As a result of some detailed input received from our commercial Medigap payer community, CMS has learned that COBA trading partners that are interested in determining Medicare's allowed or approved amount will find, in the majority of instances, they can derive this amount for 837 professional or 837 institutional outpatient-oriented claims, which Medicare adjudicates at the service line level, by:

Taking the Medicare paid amount, as may be found in 2430 SVD02, and adding the following CAS*PR elements, PR*1 (deductible applied), PR*2 (co-insurance), PR*66 (blood deductible) **[see Special Note directly below relative to PR*66],** and PR*122 (psychiatric reduction), as applicable as well as CAS*CO*B4 (late filing penalty) if reflected).

SPECIAL NOTE: In comparing their 837 professional version 4010A1 production claims with their version 5010A1 (Errata) test claims, several COBA trading partners noted that inclusion of PR*66 in the formula to derive Medicare's allowed amount inflates the calculation. Therefore, CMS cautions COBA trading partners to try to include the PR*66 amount in calculating Medicare's allowed amount on 5010A1 test professional COB claims and then compare the results with the allowed amount reflected in the AMT*B6 or AMT*AAE of their 4010A1 production claims. If over time the amounts continue to match, then inclusion of PR*66 would likely be feasible as part of any systematic formula used to determine Medicare's allowed amount on Part B physician-oriented claims. Otherwise, it would probably not be feasible to include the PR*66 amount.

IMPORTANT: For non-assigned claims, COBA trading partners would **not** want to include CAS*PR*45 (the amount of the limiting charge by which the non-participating physician is bound) as part of their formula to derive the Medicare approved amount. **[SPECIAL NOTE:** Though the limiting charge is the most that a physician/practitioner may hold a beneficiary liable for, it is not Medicare's physician fee schedule (MPFS) allowed amount. It is the MPFS amount that is currently reflected in AMT*B6 or AMT*AAE on version 4010A1 outbound 837 professional claims.] For such claims, the COBA trading partner can derive the approved amount by taking the Medicare paid amount in 2430 SVD02 and adding the following, if present on the claim, to that amount: PR*1 (deductible amount owed), PR*2 (co-insurance amount), PR*66 (blood deductible amount) **[Note: same**

qualification as reflected above concerning the blood deductible would apply], and PR*122 (psychiatric reduction), if applicable, as well as CO*B4 (late filing penalty) if reflected.

COBA trading partners that are interested in determining Medicare's allowed or approved amount will find, in the majority of instances, they can derive this amount for Part A 837 institutional inpatient-oriented claims, which Medicare adjudicates at the claim level, by:

Taking the Medicare paid amount, as reflected in 2320 AMT*D, and adding any CAS*PR elements, such as PR*1 (deductible), PR*2 (co-insurance), and PR*66 (blood deductible) if reported, and any instance of CAS*CO*B4 (late filing penalty) if reported.

SPECIAL NOTE: Based upon feedback from testing COBA trading partners during 2011, failure to include the PR*66 when reported on 837 institutional claims in a formula to determine Medicare's allowed amount will result in an inability to calculate that amount accurately.

For balancing purposes, COBA trading partners should note that amounts reflected as CAS*CO*94 most often represent instances where Medicare's inpatient prospective payment system (IPPS) paid amount is greater than the amount billed.

IMPORTANT: CMS learned in September 2011 that the Part A shared system cannot guarantee that it will always reflect the amount in excess of billed charges through reporting of a claim adjustment reason code (CARC) 94. Until a future CMS systems change is made, there will be times that the amount in excess of billed charges, as happens often with IPPS claims, will be reflected as CARC 45. The key is that the amount will always be reflected with a negative symbol (-) beside it. Thus, regardless of whether CARC 94 or 45 is reflected, if the amount is shown with a negative symbol (-) beside it, this means this amount needs to be added as part of the balancing formula rather than subtracted. COBA trading partners will want to subtract from the Medicare total billed amount any instance of CAS*CO*45 <u>where a negative symbol (-) is NOT reflected</u> as well as any instance of CAS*PR to arrive at the Medicare paid amount.

Medicare will be creating the following AMT segments within the HIPAA 837 pre-Errata and Errata versions of the 5010 institutional and professional claim formats:

- 2300 AMT*F5 (Patient Paid Amount) [unchanged from HIPAA 4010A1]
- 2320 AMT*D (COB Payer Amount Paid) [now standard for all claim formats]

NOTE: As previously indicated, Medicare will also reflect the total amount paid in association with 837 professional and 837 institutional outpatient-oriented claims in 2430 SVD02. This will **not** be true for 837 institutional inpatient-oriented claims, which are adjudicated at the claim level.

NOTE: For claims that Medicare adjudicates at the service line level, such as Part B physician (837 professional) and outpatient-oriented facility (837 institutional) claims, COBA trading partners will continue to see total Medicare paid amounts reported in the 2430 SVD02. Such information is needed for balancing the claim at the service line level as compared to the claim level (2320 AMT02).

Within the HIPAA 5010 Technical Report Type 3 (TR3) Guide, the numerous 2320 level AMT segments for COB Total Submitted Charges (qualified by T3), Medicare Paid Amount—100% (qualified by KF), Medicare Paid Amount—80% (qualified by PG), COB Medicare A Trust Fund Paid Amount (qualified by AA), COB Medicare Part B Trust Fund Paid Amount (qualified by B1), and COB Total Denied Amount (qualified by YT) are discontinued on 837 institutional claims. The HIPAA 5010 TR3 also eliminates the 2300 loop AMT segment for Payer Estimated Amount Due.

SPECIAL NOTE: Medicare is planning to create 2400 level AMT segments tied to service tax amounts, qualified by GT, associated with 837 institutional version 5010 claims if this information is received on incoming electronic claims. At this time, Medicare is not planning to create 2400 level AMT segments tied to facility tax amounts, qualified by N8.

B. Creation of New Present on Admission (POA) Indicator Fields

With HIPAA 837 institutional version 4010A1 claims, Medicare had been reporting POA indicators within the 2300 K3 (File Information) segment. The X12 Committee agreed to the creation of new fields within the 2300 HI segment for POA indicators for HIPAA 5010. Thus, COBA trading partners will find POA indicators reported within the 2300 HI segments of their version 5010 837 institutional COB/crossover claims as indicated:

- Within 2300 HI01-9 (Principal Diagnosis Code)
  Valid values, as per the TR3 Guide, are as follows:
  N—condition not present at admission;
  U—unknown;
  W—not applicable; and
  Y—condition was present at admission.
- Within 2300 HI01-9 through HI12-9 (External Cause of Injury), as applicable.
  POA indicators will be listed in accordance with number of diagnosis codes.

C. Limited Use of Secondary Provider Reference Identifier (REF) Segments

Most COBA trading partners have been accustomed to Medicare's inclusion of a very limited range of "non-legacy" secondary provider identifiers within the various REF segments of outbound 837 institutional and professional version 4010A1 crossover claims. The Centers for Medicare & Medicaid Services (CMS) had been following this practice due to the HIPAA 4010A1 Implementation Guides' language concerning primacy of the National Provider Identifier (NPI) within the NM109 segment.

Similarly, all COBA trading partners should note that the CMS has taken the TR3 Guide's statements concerning non-validity of various secondary provider REF segments once the use of the NPI is mandated very seriously. Given that the NPI became mandatory on all Medicare claims as of May 23, 2008, the only REF segment that Medicare will create within HIPAA 5010 COB claims is the 2010AA (Billing Provider) REF01 and REF02, with the latter containing either the billing provider's employer identification number (EIN) or social security number (SSN), where appropriate, as derived from the A/B Medicare Administrative Contractor (MAC) or Durable Medical Equipment Medicare Administrative Contractor's (DME MAC) internal provider file.

D. Removal of Restrictions on Provider Taxonomy Codes

With HIPAA 837 4010A1 professional claims, Medicare did not allow the provider to report a taxonomy code at both the 2000A PRV and the 2310B PRV. In addition, from Medicare's perspective, the "NOTES" accompanying 2000A PRV did not permit provider group taxonomy to be reported at the 2000A PRV level. Under HIPAA 5010, these restrictions are removed. The provider's taxonomy code may be reported at any level without restriction for both 837 institutional and professional claims.

E. Requirements for Balancing of HIPAA 837 5010 Claims

The CMS, through its Medicare program, acknowledges that the TR3 Guide establishes claim balancing as mandatory. Therefore, COBA trading partners should always encounter claims where the **total charges less** any **claim adjustment segment (CAS) amounts results in the Medicare paid amount.**

COBA trading partners should note that because providers are not allowed to modify 835 Electronic Remittance Advice (ERA) payment data as received from insurers that pay before Medicare, they will be required to "force-balance" Medicare Secondary Payer (MSP) claims that they transmit to Medicare. COBA trading partners may identify forced-balancing by the presence of CAS*OA*A7 within either the 2320 or 2430 loops of the outbound claim. The forced-balance monetary amount fits

into the above referenced balancing formula appropriately, thereby ensuring that Medicare's outbound 837 COB version 5010 claims balance as required.

F. Changes for Reporting of Anesthesia Timed Values

Through specific notes provided within the TR3 Guide, our A/ B MACs (Part B) will now be required to generate anesthesia timed units exclusively in terms of minutes rather than in terms of units. Under HIPAA 4010A1, Medicare created 837 professional crossover claims with units represented for anesthesia timed values based upon Medicare's adjudication of anesthesia claims. This was changed for HIPAA 5010 COB, in accordance with the TR3 Guide.

G. Discontinuance of "QTY" Segments

Under the HIPAA 4010A1 format, the A/ B MACs (Part A and Home, Health, & Hospice (HH&H)) reflected actual covered days, co-insurance/co-insured days, life-time reserve (LTR) days, and non-covered days within loop 2300 QTY ("Claim Quantity") in QTY02, with QTY01=CA (covered-actual), CD (co-insurance/insured-actual), LA (LTR-actual), and NA (non-covered actual), as applicable. The TR3 Guide eliminated usage of the 2300 QTY segments. Therefore, effective with CMS's implementation of the 5010 Errata version for the 837 institutional claim on April 4, 2011, Medicare now reflects day count information within the 2300 Health Insurance (HI) portion of the 837 institutional claim as follows:

2300 HI*BE (denoting value code)

2300 HI01-2=

80 (for covered days)

81 (for non-covered days)

82 (for co-insurance days)

83 (for LTR days)

The accompanying 2300*HI01-5 reflects the day count associated to 2300 HI01-2 as a whole number.

SPECIAL NOTE: For HIPAA 5010, when there are zero (0) covered days associated with a given Medicare Part A institutional stay, Medicare reflects this within the 2320 MIA01 segment and **not** within the 2300 HI01-2, qualified by 80.

IV. Overview of Important Changes Between HIPAA 5010 (Pre-Errata) and HIPAA 5010 (Errata) Medicare COB Transactions

A. Admission Type Code Now Required

Through changes made within version 005010X223A2 of the Technical Report 3 (TR3), the Admission Type Code element within loop 2300 CL101 is now required. Previously, this element was situational. For instances where Medicare is taking incoming 837 institutional version 4010A1 or other claim format content and building a 5010 Errata claim, the Part A shared system will need to gap-fill the value "9" (Information Not Available) when this element needed for the creation of a compliant 5010 Errata 837 institutional claim was not present on the incoming claim to Medicare.

B. Certain City, State, and Zip Code (N4) Elements Made Situational

As a result of changes made within versions 005010X223A2 (837 institutional) and 005010X222A1 (837 professional) of the TR3, the 2010BA, 2330A, and 2330B N401, N402, and N403 segments are now situational. Previously, these elements were required.

C. Loop 2430 SVD Becomes Situational

Under the pre-Errata 5010 claim formats, loop 2430 SVD was required, which meant all composite elements was also required. The CMS elected not to temporarily gap-fill various elements within the 837 pre-Errata institutional claims that were required for HIPAA compliance. Thus, CMS will remain unable to transmit pre-Errata 5010 837 "test" institutional claims where the 2430 SVD composite does not contain a CPT-4 or HCPCS per claim service detail line.

The changes made within version 005010X223A2 of the TR3, which make the 2430 SVD situational, brought the HIPAA compliance rules for the 2430 SVD composite into alignment with those formerly in force under the HIPAA 4010A1 Implementation Guide for 837 institutional claims.

V. 837 Institutional Claim Elements, Including Possible Gap-Fill Values

As the result of Medicare Part A shared system coding for HIPAA 837 version 5010, CMS, through its BCRC, will be passing the elements indicated below on outbound 837 institutional claims. **IMPORTANT:** Where specific loops and segments are not cited, this means that the Part A shared system will create any HIPAA 5010 pre-Errata and Errata required loops and segments with the singular values prescribed by the TR3 Guide or referenced code source within the Guide. Please also consult Section VI of this Companion Guide to determine Medicare's policy concerning non-creation of certain situational loops.

SPECIAL NOTES: As was true of HIPAA version 4010A1 837 institutional COB claims, COBA trading partners will note the presence of CAS reporting at the 2320 claim level when the Medicare claims are considered "inpatient" (e.g., type of bill=11x, 12x, 21x). Medicare outpatient-oriented claims (e.g., 13x, 34x, 71x, 72x, 77x, 74x, 75x, 79x, and 85x) will continue to feature CAS reporting at the 2430 service line level.

IMPORTANT: Data for the NM103 segment within the 2310A, 2310B, 2310C, 2310E, and 2310F loops are derived directly from the incoming claim as submitted by the provider to Medicare. Thus, if, for example, a provider's billing vendor inputs "X" in 2310A NM103 on the incoming claim to Medicare, the Part A shared system will literally map that same value out for the 5010A2 837 institutional COB claim.

A. ST– Transaction Set Header

ST01 – 837;

ST02 – Will begin with 000000001 and increment with each interchange; and

ST03 – 005010X223A2 [Errata version] (Note: This value will change if additional Errata updates are made in the future.)

B. BHT – Beginning of the Hierarchical Transaction

BHT01 – 0019;

BHT02 – Normally will be 00; for cases of claim repairs, the value will be 18; and

BHT03 – Unique 23- byte indicator (effective since April 4, 2011).

1. For normal COBA crossover claim files, the BHT03 will be formatted as follows:

   Bytes 1-9 – A/B MAC (Part A, HH&H) contractor ID (5 bytes, left-justified, followed by 4 spaces);

   Bytes 10-14 – Julian date (5 bytes, expressed as YYDDD);

   Bytes 15-19 – Sequence number (5 bytes, starting with 00001, incremented for each ST-SE);

Bytes 20-21 – Claim version indicator (2 bytes; valid values for 837 institutional COB claim = 50 [for 5010]);

Byte 22 – Test/Production indicator (1 byte; valid values=T (test) or P (production); and
Effective April 4, 2011: Byte 23 – claim adjustment indicator (will apply to all claims herein).

Valid values=
O – Original claims;
P – ACA/ other congressional imperative mass adjustments;
M – Non-ACA mass adjustments ties to Medicare Physician Fee Schedule (MPFS);
S – Mass adjustment claims-all others;
R – RAC adjustment claims;
A – Routine adjustment claims, not previously classified;
C—CMS-directed mass adjustment action (use specified by CMS);
E—For reprocessed claims that formerly included an electronic prescribing (E-Rx prescribing) negative adjustment amount; and
V--Void/Cancel only claim (3rd byte TOB frequency code/2300 CLM05-3 = value of 8 or appropriate alpha code (e.g., G))

2. For COBA claims recovery files, the BHT03 will be formatted as follows:

Bytes 1-9 – A/B MAC (Part A, HH&H) contractor ID (5 bytes, left-justified, followed by 4 spaces);
Bytes 10-14 – Julian date (5 bytes, expressed as YYDDD);
Bytes 15-19 – Sequence number (5 bytes, starting with 00001, incremented for each ST-SE);
Bytes 20-21 – Claim version indicator (2 bytes; valid values = 50 [for 5010]);
Byte 22 – COBA recovery indicator (1 byte; indicator=R);

As of April 4, 2011: Byte 23 – Claim Adjustment Indicator (possible values reflected above);
BHT04 – Transaction set creation date expressed as CCYYMMDD;
BHT05 – Time; will be expressed as HHMM; and
BHT06 – Will always be CH.

C. 1000A NM1 – Submitter Name

NM101 – Will always be 41;
NM102 – Will always be 2 (non-person);
NM103 – Name of the A/B MAC adjudicating the incoming claim;
NM108 – Will always be 46; and
NM109 – Will always be the 5-byte contractor number of the A/B MAC (Part A, HH&H) that adjudicated the claim (e.g., 14001); this alpha-numeric value will be left- justified with no trailing spaces.

D. 1000A PER (Submitter EDI Contact Information)

PER01 – Will always be **IC**;
PER02 – Will always be BCRC EDI Department;
PER03 – Will always be TE; and
PER04 – Will be 6464586740, unless telephone number changed with appropriate notice.

E. 1000B NM1 (Receiver Name)

NM101 – Will always be 40;
NM102 – Will always be 2 (non-person entity);
NM103 – Will be the COBA trading partner's name, as specified in the executed COBA Attachment;

NM108 – Will always be 46; and
NM109 – Will be the 5-byte COBA ID for the trading partner.

F. 2000A HL – Billing Provider Hierarchical Level

HL01 – Will be 1;
HL03 – Will be 20; and
HL04 – Will be 1.

G. 2000A PRV and 2310A PRV– Billing Provider Specialty Information (Provider Taxonomy Codes) [Should be reported even on "skinny" 5010A2 COB claims.]

Loop 2000A PRV01=BI;
Loop 2310A PRV01=AT;
PRV02=PXC; and
PRV03= Provider taxonomy code as received on incoming claim.

NOTE: The Part A shared system will transfer these values**, unchanged,** from the incoming Medicare claim to the outbound 837 institutional COB claim as long as the taxonomy code values are syntactically correct

H. 2010AA NM1 (Billing Provider Name)

NM101 – Will always be 85;
NM102 – Will always be 2 (non-person entity);
NM103 – Facility name;
NM108 – Will always contain XX; and
NM109 – Will be the provider's national provider identifier (NPI), as derived from the incoming claim.

I. 2010AA N3 and N4 (Billing Provider Address, City, State, Zip Code)

Derived from A/B MAC (Part A, HH&H)'s internal provider files, based upon provider's completion of CMS Form 855 for provider enrollment in the Medicare program.

Special Notes: 1) For the N403, where 9-digit zip code is required, as in the case of this loop's N403 segment, our Medicare Part A shared systems will output the complete zip code as obtained from the internal provider files. If only a base-5 zip code is available (which would be very infrequently), the Part A shared system will output an additional 9998 to realize HIPAA compliance for the 9-byte zip code **when required** for specified provider loops and associated N403 segments (See item K within "Section VIII. Gap-Filling Standards" for more information); 2) for N404 (Country Code), the Part A shared system will only populate a 2-digit code when the beneficiary is traveling in Canada or Mexico and requires urgent medical attention and a Canadian or Mexican facility is the closest one available. **NOTE:** This kind of scenario will be rare.

J. 2010AA REF – Billing Provider Tax Identification (ID)

REF01 – Will always be EI; and
REF02 – Will be the Billing Provider's Tax ID, as derived from the A/B MAC (Part A, HH&H)'s internal provider files.

K. 2010AA PER – Billing Provider Contact Information

PER01=**IC**;
PER02= Billing Provider Contact Name;
PER03=Created based upon what Medicare has on file; and
PER04=Element to be mapped from Medicare provider file.

SPECIAL NOTE: The shared system will **only** create the above 2010AA PER elements if the provider has supplied Medicare with complete contact information. No attempt will be made to gap-fill telephone numbers or other billing provider contact information for COB purposes.

L. 2010AB NM1 – Pay-to Address Name

NM101=87; and
NM102= 2 (non-person entity).

M. 2010AB N3 & N4 segments

Elements created from A/B MAC's internal provider files.

SPECIAL NOTE: In accordance with the TR3 Guide, Medicare will only create the 2010AB loop when the address information in the 2010AB N3 and N4 segments differs from that in the 2010AA N3 and N4 segments.

N. 2000B – SBR – Subscriber Information [Destination Payer After Medicare]

SBR01 – Will be U;
SBR02 – Will always be 18;
SBR03 – Populated as situation may require; and
SBR09 – [**Crossover claims transmitted prior to January 7, 2015]** Will be ZZ, unless the COBA trading partner is Medicaid; then it will be MC.
[Crossover claims transmitted on and after January 7, 2015] Will be CI, unless the COBA trading partner is Medicaid; then it will be MC.

O. 2010BA NM1 – Subscriber Name And Attendant Elements

NM101 – Will always be IL;
NM102 – Will always be 1;
NM103 – Surname of beneficiary as determined by Medicare's internal entitlement records;
NM104 – First name of beneficiary as determined by Medicare's internal entitlement Records;
NM105 – Middle name of beneficiary, as applicable, as determined by Medicare's internal entitlement records, if available;
NM108 – Will be MI; and
NM109 – Will be the member's identification number, as provided to the BCRC via the COBA eligibility file; otherwise, the Medicare Health Insurance Claim Number (HICN) will be populated.

2010BA N3 – Subscriber Address

N301– Line 1 of beneficiary's address, as derived from Medicare's entitlement records.
SPECIAL NOTE: If the address line 1 on file is incomplete, the Part A shared system will map "Xs" to satisfy the minimum field length requirement.
N302 – Line 2 of beneficiary's address, as applicable, as derived from Medicare's internal entitlement records.

2010BA N4 – City, State, Zip Code

Elements N401, N402, N403, and N407 will be derived from Medicare's internal entitlement records.

SPECIAL NOTE: With Medicare's implementation of the 5010 Errata changes, the elements comprising the N4 will ***not*** be gap-filled. If the Medicare shared system cannot create a full-content N4 segment, it will likewise not create the N3 segment. This is because, effective with the Errata changes, both segments are now situational.

P. 2010BA–DMG – Subscriber Demographic Information

DMG01 – Will be D8;
DMG02 – Will be expressed as CCYYMMDD, as derived from internal beneficiary entitlement records; and
DMG03 – Will be F, M, or U, as appropriate, based upon internal beneficiary entitlement records.

Q. 2010BB NM1 – Payer Name and Attendant Elements

NM101 – Will always be PR;
NM102 – Will always be 2;
NM103 – COBA trading partner's organizational name;
NM108 – Will be PI; and
NM109 – Will be 5-byte COBA ID of trading partner.

2010BB N3 & N4 – (Payer Address, including City, State, Zip Code)
Derived from information provided by COBA trading partner via executed COBA contract.

R. 2300–CLM – Claim Information

CLM01 – Created, as per TR3 IG;
CLM02 – Created, as per incoming Medicare claim;
CLM05 – 1 through CLM05-3 – Created based upon type of claim.
For CLM05-3, the value designates original (value=1) versus adjustment/replacement (value=7) or some other NUBC-prescribed alpha code) versus void/cancel only (value=8 or other permitted alpha value);
CLM07 – Will always be A (provider accepts assignment under **Medicare**), as derived by Medicare's claims adjudication;
CLM08 – Mapped based upon incoming claim; and
CLM09 – See Section IX.C of this Guide for specifics.

S. 2300 – DTP-Discharge Hour

Created only for all final inpatient-oriented claims, as per the TR-3 Guide.

DTP01 – Will always be 096;
DTP02 – Will always be TM; and
DPT03 – Will be expressed as HHMM.

T. 2300 DTP – Statement Dates

DTP01 – Will be 434;
DTP02 – Will be RD8; and
DTP03 – Range of dates expressed as CCYYMMDD – CCYYMMDD.

U. 2300 DTP- Admission Date/Hour

DTP01 – Will always be 435;
DTP02 – Will be DT in association with inpatient hospital claims; and
DPT03 – Will be expressed as CCYYMMDDHHMM, with true hour and minute reflected as received on the incoming claim. **(**See item K within the "VIII. Standards" section of this Guide for more information about the gap-filling of admission hour and minute values that may appear on 837 institutional version 5010 claims when this required information cannot otherwise be derived from incoming UB04 paper claims or DDE screen entry data. **)**

V. 2300 REF – Demonstration Project Identifier

REF01 – Will always be P4; and
REF02 – The demonstration project identifier (e.g., 64)

W. 2300 HI – Value Codes (BE-Qualified)

Co-insurance amounts relating to covered skilled nursing facility (SNF) types of bills and of Medicare life-time reserve days (LTR) will be reported with BE-qualified value codes. Value codes 08, 09, 10, and 11 are applicable for these two scenarios.

In addition, the Part B co-insurance for the physician component portion of the Model 4 Bundled Payments for Care Improvement (BPCI) [demo code 64] pilot claims is reported within the 2300 HI with the BE-qualified value code of Y3. This amount will also be carried in the 2320 CAS with Claim Adjustment Reason Code (CARC) 248 reflected.

Special Note: Part B deductible amounts owed on Model 4 BPCI claims will be reported in 2300 HI with the BE-qualified value code of Y5. This amount will also be carried in the 2320 CAS with CARC 247 reflected.

X. 2320–MIA – Inpatient Adjudication Information and MOA-Outpatient Adjudication Information

Remark code MA18 and/or N89 will be noted within MIA20 through MIA23 and within MOA04 through MOA07. Typically other remark codes will precede MA18 or N89. Each of these remark codes indicates that Medicare selected the affected claim for crossover to a COBA trading partner. Remark code N89 is used when Medicare simultaneously crosses a claim to multiple payers, while remark code MA18 is used to designate claims crossover to an individual COBA trading partner.

As aforementioned, under HIPAA version 5010A2, when there are zero (0) covered days associated with a given Medicare Part A institutional stay, Medicare will reflect this within the 2320 MIA01 segment and ***not*** within the 2300 HI01-2, qualified by 80.

Y. 2320 SBR (Subscriber Information – Medicare's Payment Loop)

SBR01—Will always be P or S (Medicare is either the primary or secondary payer for the claim);
SBR02—Will always be 18 (self);
SBR03—Will always be populated as the situation may require; and
SBR09—Will always be MA (Medicare Part A).

Z. 2320 SBR (Subscriber Information – All Destination Payers After Medicare)

SBR01 – Will always be U (unknown);
SBR02 – Will always be 18 (self);
SBR03 – Will always be populated as the situation may require; and

SBR09 – **[Crossover claims transmitted prior to January 7, 2015]** For commercial payers, this value will always be ZZ (mutually defined); for Medicaid COBA payers, this element will always reflect MC.
[Crossover claims transmitted on/after January 7, 2015] For commercial payers, this value will always be "CI" (commercial insurance); for Medicaid COBA payers, this element will always reflect MC.

AA. 2330–A NM1 – Other Subscriber Name

NM101 – Will always be IL;
NM102 – Will always be 1;
NM103 – NM105 – Elements will be derived from the A/ B MAC's internal Medicare eligibility records;
NM108 – Will always be MI; and
NM109 – Will be the Medicare beneficiary's HICN.

2330A–N3 and N4 segments – Information derived from the A/B MAC's internal Medicare eligibility records.

NOTE: When the beneficiary's line 1 address is incomplete, the Medicare shared systems will map all "Xs" to satisfy the minimum requirements of 2330A N301.

SPECIAL NOTE: With Medicare's implementation of the 5010 Errata changes, the elements comprising the N4 will not be gap-filled. If the Medicare shared system cannot create a full-content N4 segment, it will likewise not create the N3 segment. This is because, effective with the Errata changes, both segments are now situational.

BB. 2410-LIN – Drug Identification

For HIPAA 5010 claims, Medicare will place the national drug code (NDC) in the 2410 LIN03, with LIN02=N4, for COB purposes irrespective of the format.

SPECIAL NOTE: The past practice of mapping an NDC from an incoming hard-copy 1450 (UB-04) claim to a 2300 NTE segment for outbound COB mapping for the benefit of ensuring this information was transferred on to Medicaid COB receivers was discontinued with the implementation of HIPAA 837 5010 COB claims in production (effective July 1, 2012).

VI. 837 Professional Claim Elements, Including Possible Gap-Fill Values

Through A/B MAC (Part B) and DME MAC shared system coding changes for HIPAA 837 version 5010, CMS, via its BCRC, will be passing the elements indicated below on outbound 837 professional claims. **IMPORTANT:** Where specific loops and segments are **not** cited, this means that the Part B or DME MAC shared systems will create any HIPAA 5010 pre-Errata or Errata required loops and segments with the singular values prescribed by the TR3 Guide or referenced code source within the Guide. Please also consult Section VI of this Companion Guide to determine Medicare's policy concerning non-creation of certain situational loops.

Special Note: As is true currently with HIPAA 4010A1 COB claims, COBA trading partners will note the presence of CAS reporting for 837 professional claims at the 2430 service line level. Medicare always adjudicates such claims at the service line level.

[October 2011] IMPORTANT: Data for the NM103 segment within the 2310A, 2310B, 2310C, and 2310D loops come directly from the incoming claim as submitted by the provider to Medicare. Thus, if, for example, a physician/practitioner's billing vendor inputs "X" in 2310B NM103 on the incoming claim to Medicare, the Part B shared system will map this same value out for the 5010A1 837 professional COB claim.

A. ST– Transaction Set Header

ST01 – 837;

ST02 – Will begin with 000000001 and increment with each interchange; and
ST03 – 005010X222A1 [for Errata version] (Note: This value will change if additional Errata updates are made in the future.)

B. BHT – Beginning of the Hierarchical Transaction

BHT01 – 0019;
BHT02 – Normally will be 00; for cases of claim repairs, value will be 18; and
BHT03 – Unique 23- byte indicator (effective April 4, 2011).

1. For normal COBA crossover claim files, the BHT03 will be formatted as follows:

   Bytes 1-9 – A/B MAC (Part B) or DME MAC contractor ID (5 bytes, left-justified, followed by 4 spaces);
   Bytes 10-14 – Julian date (5 bytes, expressed as YYDDD);
   Bytes 15-19 – Sequence number (5 bytes, starting with 00001, incremented for each ST-SE);
   Bytes 20-21 – Claim version indicator (2 bytes; valid values = 50 [for 5010] and 20 [for NCPDP version D.0, batch 1.2]);
   Byte 22 – Test/Production indicator (1 byte; valid values=T (test) or P (production); and
   Effective April 4, 2011: Byte 23 – Claim Adjustment Indicator (will apply to all claims herein).

   Valid values=

   O—Original claims;
   P—ACA/ other congressional imperative mass adjustments;
   M—Non-ACA mass adjustments ties to Medicare Physician Fee Schedule (MPFS);
   S—Mass adjustment claims-all others;
   R—RAC adjustment claims;
   A—Routine adjustment claims, not previously classified;
   C—CMS-directed mass adjustment action (use specified by CMS);
   E—For reprocessed claims that formerly included an electronic prescribing (E-Rx prescribing) negative adjustment amount; and
   V—Void/cancel only claim, as applicable (Identified by the value 8 in 2300 CLM05-3)

2. For COBA claims recovery files, the BHT03 will be formatted as follows:

   Bytes 1-9 – A/B MAC (Part B) or DME MAC contractor ID (5 bytes, left-justified, followed by 4 spaces);
   Bytes 10-14 – Julian date (5 bytes, expressed as YYDDD);
   Bytes 15-19 – Sequence number (5 bytes, starting with 00001, incremented for each ST-SE);
   Bytes 20-21 – Claim version indicator (2 bytes; valid values = 50 [for 5010] and 20 [for NCPDP version D.0, batch 1.2]);
   Byte 22 – COBA recovery indicator (1 byte; indicator=R);
   Byte 23 – Claim Adjustment Indicator (possible values reflected above);
   BHT04 – Transaction set creation date expressed as CCYYMMDD;
   BHT05 – Time; will be expressed as HHMM; and
   BHT06 – Will always be CH.

C. 1000A NM1– Submitter Name

NM101 – Will always be 41;
NM102 – Will always be 2 (non-person);

NM103 – Name of A/B MAC (Part B) or DME MAC adjudicating the incoming claim;
NM108 – Will always be 46; and
NM109 – Will be the 5-byte contractor number of the A/B MAC (Part B) or DME MAC that adjudicated the claim (e.g., 14002 or 16003); value will be left-justified followed by spaces.

D. 1000A PER (Submitter EDI Contact Information)

PER01 – Will always be **IC;**
PER02 – Will always be BCRC EDI Department;
PER03 – Will always be TE; and
PER04 – Will be 6464586740, unless telephone number changed with appropriate notice.

E. 1000B NM1 (Receiver Name)

NM101 – Will always be 40;
NM102 – Will always be 2 (non-person entity);
NM103 – Will be the COBA trading partner's name, as specified in the executed COBA Attachment;
NM108 – Will always be 46; and
NM109 – Will be the 5-byte COBA ID for the trading partner.

F. 2000A HL-Billing Provider Hierarchical Level

HL01 – Will be 1;
HL03 – Will be 20; and
HL04 – Will be 1.

G. 2000A PRV, 2310B PRV, and 2420A PRV– Billing Provider Specialty Information (Provider Taxonomy Codes) [NOTE: Will only be mapped out on non-skinny 837 professional version 5010A1 COB claims.]

Loop 2000A PRV01 value=BI;
For Loops 2310B and 2420A, the PRV01 value=PE;
PRV02=PXC; and
PRV03= Provider taxonomy code as received on the incoming Medicare claim.

NOTE: The shared systems will transfer these values**, unchanged**, from incoming claims to outbound COB claims as long as the taxonomy code values are syntactically correct.

H. 2010AA NM1 (Billing Provider Name)

NM101 – Will always be 85;
NM102 – Will be 1 (person) **or** 2 (non-person entity);
NM103 – Facility name;
NM108 – Will always contain XX; and
NM109 – Will be the provider's NPI, as derived from Medicare's claims adjudication system.

I. 2010AA N3 and N4 (Billing Provider Address, City, State, Zip Code)

Derived from the A/B MAC (Part B) or DME MAC's internal provider files, based upon the physician/practitioner or supplier's completion of CMS form 855.

Special Notes: 1) For the N403, where 9-digit zip code is required, as in the case of this loop's N403 segment, our Medicare Part B and DME MAC shared systems will output the complete zip code as

obtained from the internal provider files. If only a base-5 zip code is available, the Medicare Part B and DME MAC systems will output an additional 9998 to realize HIPAA compliance for the 9-byte zip code **when required** in association with specified provider loops and associated N403 segments (See item K within "Section VIII. Gap-Filling Standards" for more information); 2) for N404 (Country Code), the Part B and DME MAC shared systems will only populate a 2-digit code when the physician or supplier is located outside the United States (e.g., Mexico or Canada. **NOTE:** This will be extremely rare).

J. 2010AA REF – Billing Provider Tax Identification (ID)

REF01 – Will either be EI or SY for physician-oriented claims; will be "EI" for DME MAC supplier oriented claims; and
REF02 – For 837 professional physician claims, the shared system will map the physician's EIN if available in lieu of his/her SSN. For DME MAC supplier-oriented claims, the shared system will map the supplier's EIN/TAX ID.

K. 2010AA PER – Billing Provider Contact Information

PER01=**IC**;
PER02= Billing Provider Contact Name;
PER03=Created based upon what Medicare has on file; and
PER04=Element to be mapped from Medicare provider file.

SPECIAL NOTE: The shared systems will **only** create the above 2010AA PER elements if the provider has supplied Medicare with complete contact information. No attempt will be made to gap-fill telephone numbers or other billing provider contact information for COB purposes.

L. 2010AB NM1 – Pay-to Address Name

NM101=87; and
NM102= 1 (person) **or** 2 (non-person entity).

2010AB N3 & N4 segment
******Elements created from the A/B MAC (Part B) or DME MAC's internal provider files.

SPECIAL NOTE: Medicare Part B and DME MAC shared systems will only create the 2010AB loop for COB purposes when the Pay-to address elements (N3 and N4 segments) for the physician or supplier differ from the 2010AA loop N3 and N4 information.

2000B – SBR – Subscriber Information [Destination Payer After Medicare]
SBR01 – Will be U;
SBR02 – Will always be 18;
SBR03 – Populated as situation may require; and
SBR09 – **[Crossover claims transmitted prior to January 7, 2015]** Will be ZZ, unless the COBA trading partner is Medicaid; then it will be MC.

[Crossover claims transmitted on/after January 7, 2015] Will be CI, unless the COBA trading partner is Medicaid; then it will be MC.

M. 2010BA NM1– Subscriber Name And Attendant Elements

NM101 – Will always be IL;
NM102 – Will always be 1;
NM103 – Surname of beneficiary as determined by Medicare's internal entitlement records;
NM104 – First name of beneficiary as determined by Medicare's internal entitlement records;
NM105 – Middle name of beneficiary, as applicable, as determined by Medicare's internal

entitlement records, if available;
NM108 – Will be MI; and
NM109 – Will be the member's identification number, as provided to the BCRC via the COBA eligibility file, with the exception of Medigap claim-based crossovers.

For non-Medigap claim-based crossover situations, if the supplemental payer does **not** provide the member's identification number via the COBA eligibility file, the BCRC will map the beneficiary's Medicare HICN to this field.

SPECIAL NOTE: For Medigap claim-based crossovers, Medicare will send the beneficiary's policy number, as derived from item 9-D of the paper CMS-1500 or 2330A NM109 of the incoming 837 professional claim, in 2010BA NM109.

2010BA N3 – Subscriber Address
N301 – Line 1 of beneficiary's address, as derived from Medicare's entitlement records.

SPECIAL NOTE: If the address line 1 on file is incomplete, the Part B and DME MAC shared systems will map "Xs" to satisfy the minimum field length requirement.

N302 – Line 2 of beneficiary's address, as applicable, as derived from Medicare's internal entitlement records.

2010BA N4 – City, State, Zip Code
Elements N401, N402, N403, and N407 will be derived from Medicare's internal entitlement records.

SPECIAL NOTE: With Medicare's implementation of the 5010 Errata changes, the elements comprising the N4 will not be gap-filled. If the Medicare shared system cannot create a full-content N4 segment, it will likewise not create the N3 segment. This is because, effective with the Errata changes, both segments are now situational.

N. 2010BA-DMG – Subscriber Demographic Information

DMG01 – Will be D8;
DMG02 – Will be expressed as CCYYMMDD, as derived from internal beneficiary entitlement records; and
DMG03 – Will be F, M, or U, as appropriate, based upon internal beneficiary entitlement records.

O. 2010BB NM1-Payer Name and Attendant Elements

NM101 – Will always be PR;
NM102 – Will always be 2;
NM103 – COBA trading partner's organizational name;
NM108—Will be PI; and
NM109—Will be 5-byte COBA ID of trading partner.

2010BB N3 & N4—(Payer Address, including City, State, Zip Code)
Derived from information provided by the COBA trading partner via executed COBA contract.

P. 2300-CLM – Claim Information

CLM01 – Created, as per TR3 IG;
CLM02 – Created, as per incoming Medicare claim;
CLM05-1 through CLM05-3 – Created based upon type of claim.

For CLM05-3, the value designates original (value=1) versus adjustment/replacement (value=7) versus void/cancel, as applicable (value=8);
CLM07 – Will be mapped based upon Medicare's adjudication of the claim;

CLM08 – Mapped based upon incoming claim; and
CLM09 – See Section IX.C of this Guide for more specifics.

Q. 2300-REF – Mandatory Medicare (Section 4081) Crossover Indicator

REF01 – Will always be F5; and
REF02 – Will be N when the COBA trading partner sends an eligibility file to trigger crossover claims; the value will be Y when the COBA trading partner is a Medigap plan that participates in the Medigap claim-based crossover process (COBA ID=55000 to 59999).

R. 2320 – MOA-Outpatient Adjudication Information

Remark code MA18 and/or N89 will be noted within MOA04 through MOA07. Typically other remark codes will precede MA18 or N89. Each of these remark codes indicates that Medicare selected the affected claim for crossover to a COBA trading partner. Remark code N89 is used when Medicare simultaneously crosses a claim to multiple payers, whereas remark code MA18 is used to designate crossover to an individual COBA trading partner.

S. 2320 SBR (Subscriber Information – Medicare's Payment Loop)

SBR01 – Will always be P or S (Medicare is either the primary or secondary payer for the claim);
SBR02 – Will always be 18 (self);
SBR03 – Will always be populated as the situation may require; and
SBR09 – Will always be MB (Medicare Part B).

T. 2320 SBR (Subscriber Information – All Destination Payers After Medicare)

SBR01 – Will always be U (unknown);
SBR02 – Will always be 18 (self);
SBR03 – Will always be populated as the situation may require; and
SBR09 – **[Crossover claims transmitted prior to January 7, 2015]** For commercial payers, this value will always be ZZ (mutually defined); for Medicaid COB payers, this value will always be MC.

[Crossover claims transmitted on/after January 7, 2015] For commercial payers, this value will always be CI (commercial insurance); for Medicaid COB payers, this value will always be MC.

U. 2330-A NM1 – Other Subscriber Name

NM101– Will always be IL;
NM102 – Will always be 1;
NM103 – NM105—Elements will be derived from the A/B MAC (Part B) or DME MAC's internal Medicare eligibility records;
NM108 – Will always be MI; and
NM109 – Will be the Medicare beneficiary's HICN.

V. 2330A– N3 and N4 segments

Information derived from the A/B MAC (Part B) or DME MAC's internal Medicare eligibility records.

NOTE: When the beneficiary's line 1 address is incomplete, the Medicare shared systems will map all "Xs" to satisfy the minimum requirements of 2330A N301.

SPECIAL NOTE: With Medicare's implementation of the 5010 Errata changes, the elements comprising the N4 will not be gap-filled. If the Medicare shared system cannot create a full-

content N4 segment, it will likewise not create the N3 segment. This is because, effective with the Errata changes, both segments are now situational.

W. 2410-LIN – Drug Identification

For HIPAA 5010 claims, Medicare will place the national drug code (NDC) in the 2410 LIN03, with LIN02=N4, for COB purposes irrespective of the format.

SPECIAL NOTE: The past practice of mapping an NDC from an incoming hard-copy CMS-1500 claim to a 2300 NTE segment for outbound COB mapping for the benefit of ensuring this information was transferred on to Medicaid COB receivers was discontinued with the implementation of HIPAA 837 5010 COB claims in production (effective July 1, 2012).

VII. Reverse Mapping (5010 Errata or Pre-Errata Mapped to 4010A1) Considerations

Once physicians/suppliers/providers begin to bill Medicare in the HIPAA 5010 Errata claim versions, there will be many situations, prior to January 1, 2012, where COBA trading partners have not as yet moved into production on the HIPAA 5010 Errata COB claim versions (versions 005010X223A2 for 837 institutional claims or 005010X222A1 for 837 professional claims) with the BCRC. For the most part, COBA trading partners will find strong degrees of correlation between their 4010A1 production claims received prior to testing and the "skinny" 4010A1 production claims created while testing the pre-Errata or Errata 5010 COB claims with the BCRC. Below are two (2) noted exceptions.

Differences in AMT Allowed Amounts Created on the 4010A1 "Skinny" Claim

Scenario: On June 1, 2011, hospital A sends a HIPAA 837 5010 Errata version institutional claim to its A/B MAC (Part A, HH&H), known as contractor XYZ. As contractor XYZ adjudicates the claim and transmits it to the Common Working File (CWF) for payment authorization, CWF returns a 5010 "T" indicator and a 4010A1 "P" indicator to A/B MAC (Part A)'s claims system via the 29-trailer. Since the 29-trailer contained a "T" value for 5010 and a "P" value for 4010A1, contractor XYZ takes the incoming 5010 Errata claim and reverse maps it to a 4010A1 "skinny" claim format for claims crossover purposes.

Question: Since the outbound claim is 4010A1, how will the AMT allowed amounts on the claim be reflected?

Answer: The Part A shared system will create only one (1) instance of an allowed amount within the 2320 AMT*B6. This is all that is required to satisfy HIPAA 4010A1 compliance requirements.

Creation of the 2010AB Loop N3 and N4 Elements

SPECIAL NOTE: As we know, the TR3 makes it clear that the 2010AB N3 and N4 segments are only to be created when the provider's Pay-To Address differs from the physical address present within the 2010AA (Bill-To Provider) N3 and N4 segments. The usage of the 2010AB loop within the 5010 pre-Errata and Errata claim version varies considerably as compared to its prior usage as outlined within the 4010A1 Implementation Guides. Under 4010A1, the entity within the 2010AB NM101 may itself be different from that present within the 2010AB NM101. Indeed, the differences under 4010A1 were not necessarily limited to address.

Scenario: On June 1, 2011, a physician or provider submits an Errata version 5010 claim to Medicare that includes 2010AA and 2010AB segments, which signifies that the Pay-to Address for the physician or provider differs from the Bill-to Address. The COBA trading partner is still testing 5010 with the BCRC. Therefore, the Medicare shared system will create a 4010A1 production claim for transmission to the BCRC.

Question: Within the 4010A1 "skinny" 837 institutional or professional claim, what will be created in terms of 2010AA and 2010AB N3 and N4 segments?

Answer: The Medicare shared systems will only be able to create the 2010AA loop and related N3 and N4 segment address information.

VIII. Gap-Filling Standards Applied to 837 "Skinny" COB Claims

During the transitional period, where providers could submit claims to Medicare either in the 4010A1 or in the 5010 pre-Errata or Errata formats, CMS created outbound 837 COB files based upon the COBA trading partner's test or production status with respect to these transactions. For example, if a provider submitted a pre-Errata 5010 claim to Medicare in February 2011, but COBA trading partner A was **not** in 5010 COB claim production at that time, the Medicare shared system outputted to the BCRC: 1) a production "skinny" 4010A1 COB claim and 2) a full-content 5010 test COB claim. If, by contrast, the provider submitted a 4010A1 claim to Medicare in June 2011, and the COBA trading partner has moved to 5010 Errata version production, the Medicare shared system outputted to the BCRC: 1) a production "skinny" 5010 Errata version COB claim and 2) nothing in terms of the 4010A1 claim.

The term "skinny claim" means that Medicare takes the incoming claim down the same path that it would normally follow if the physician/supplier/provider had submitted the claim to Medicare as in a hard-copy/paper UB04 or CMS-1500 format. Since Medicare takes the claim down the hard-copy/paper COB path, the shared system will frequently map "Submitted but not Forwarded" for required fields to satisfy compliance requirements for elements that normally could be retrieved from Medicare's store-and-forward repository (SFR) had the claim gone down the electronically submitted path.

COBA trading partners may reference CMS' previous direction for HIPAA 4010A1 gap-filling by activating the following link: http://www.cms.hhs.gov/Transmittals/downloads/R83OTN.pdf. This document is termed "CMS' Medicare Companion Document," but theoretically it has served as a scaled-down Companion Guide for 4010A1 COB transactions. **NOTE:** Medicare will apply these gap-fill standards during the transitional period, prior to January 1, 2012, in cases where Medicare creates a "skinny" 4010A1 claim format for COBA trading partners that have **not** moved to HIPAA 5010 production.

IMPORTANT: COBA trading partners should note that even after the January 1, 2012, mandatory cutover date, if Medicare adjusts a claim that it originally processed in version 4010A1, it will create an outbound 5010 "skinny" claim for COB purposes. This would occur because as of January 1, 2012, Medicare and all other health care plans would have cut over to the HIPAA 5010 claims transactions.

The following gap-fill standards will be applied to "skinny" 837 5010 COB claims:

A. For all instances of the N403 (Postal/Zip Code) segment, **where required, as specified in the TR-3 Guide,** the Medicare shared systems shall populate a 9-byte zip code. If only 5 core zip code bytes are available, the remaining 4 digits will be gap-filled/system-filled with 9998**, when required**, **as per the TR-3. IMPORTANT NOTE:** There should be very few occasions where this kind of gap-filling will be necessary. When it does become necessary, the following loops are the only ones where the "9998" will be reported as the +4 component of the N403 segment to fulfill the requirements specified in the TR-3 Guide:

   For 837 Institutional Claims: Will only be present in the N403 segment of the 2010AA and 2310E loops.

   For 837 Professional Claims (Affecting Physician Claims as well as Claims for DMEPOS): Will only be present in the N403 segment of the 2010AA, 2310C, and 2420C.

B. For the rare occasions where there is not a valid zip code available to complete an N403 segment when required, the shared system will default to a base 5-digit zip code 96941. **IMPORTANT NOTE:** When the base 5-digit zip code cannot be obtained for the N403 segment within the 2010AA and 2310E loops of the 837 institutional claim and for the 2010AA, 2310C, and 2420C loops of the 837 professional claim, Medicare will report 9998 as the gap-filled +4 zip code component**, but only for those specific loop segments.**

C. If the incoming claim to the A/B MAC or DME MAC contractor is paper **or** entered via DDE, as applicable, and the dosage information necessary to populate 2410 CTP05-1 is not available, the shared system will always map F2 for outbound 837 institutional and professional COB claims.

D. For Medicare institutional version 5010 COB claims, if the incoming claim to Medicare is paper, the shared systems shall map "non-specific procedure code" in 2400 SV202-7 if a non-specific procedure code description is required.

E. For Medicare professional COB claims, the Part B shared system shall map "not otherwise classified" within loop 2400 SV101-7 (composite medical procedure—description) if the physician submitted the claim to Medicare on a hard copy/paper CMS-1500 form and the needed information is not otherwise obtainable.

F. The DME MAC shared system will the value "X" to the field corresponding to 2430 SVD03-2 when the value for this segment on the incoming claim is missing or invalid. (**NOTE:** This should be extremely rare, as Medicare will require valid HCPCS at the point that suppliers submit claims for Medicare adjudication.)

G. For instances where the date of admission, when required, must be gap-filled, the Part B system will use the claim's earliest service date to satisfy the 2330 DTP03 requirement when the claim's place of service (loop 2300 CLM05-1 on the 837 professional claim) is 21, 41, 51, or 61.

H. For outbound 837 professional claims, place of service 99 will be mapped to CLM05-1 as a gap-fill measure.

I. Special requirements for **ambulance claims** when the ambulance supplier submits the claim to Medicare as 837 professional version 4010A1 but the COBA trading partner has moved to 5010 production for 837 professional claims are as follows:

1. The Part B shared system will map the 2310E and 2310F N3 and N4 segments as follows:
   a. For the required N301 segment, the shared system will map all "Xs" to meet the minimum required standard.
   b. For the N4 segments, the shared system shall map the following values:

      N401 (City)---will contain Cityville;
      N402 (State Code)—will contain MD; and
      N403 (Postal Zone/Zip Code)—will contain 96941 (**NOTE:** The +4 zip code is **not** required for this segment loop.)
2. The Part B shared system will map "LB" in the field corresponding to 2400 CR101 when the patient's weight is indicated on the incoming Medicare claim in 2400 CR102. The Part B shared system will **not** map LB in 2400 CR101 if 2400 CR102 on the incoming Medicare claim contains spaces.

J. If providers submit claims to Medicare via UB-04 paper claim or DDE screen that do **not** contain minutes in association with Admission Date/Hour, the Part A shared system internally defaults to "00" for minutes for adjudication purposes. If, however, the incoming paper or DDE claim also contains "00" for the admission hour, the Part A system will output the Admission Date/Hour DTP03 segment as CCYYMMDD0001, where minutes will be gap-filled as "01." Otherwise, if the incoming paper or DDE claim contains a true hour but does not contain minutes, the Part A shared system will gap-fill the minutes portion of the DTP03 with "00."

K. If an institutional provider submits a 837 institutional 4010A1 claim or other Part A claim format to its A/B MAC (Part A, HH&H) but the COBA trading partner is requesting the 5010 Errata claim (version 005010X223A2) from the BCRC for crossover purposes, the Medicare shared system shall gap fill "9" (Information Not Available) to 2300 CL101 (Admission Type Code) when the incoming claim to Medicare did not contain this required information. {**NOTE:** This gap-fill convention is specific to version 005010X223A2 [HIPAA Errata 5010] claims only.}

L. With the adoption of the HIPAA 5010 Errata changes, in situations where Medicare is the secondary payer but the institutional provider included a qualifier in 2330A NM108 segment but did not populate 2330A NM109 with a payer identification code, the Medicare Part A shared system will gap-fill the 2330A NM109 segment with all Xs to satisfy the minimum bytes requirement (e.g., XX).

M. With the adoption of the HIPAA 5010 Errata changes, in situations where Medicare is the secondary payer but the institutional provider included a qualifier in the 2330B NM108 segment but did not populate 2330B NM109 with a payer identification code, the Medicare Part A shared system will gap-fill the 2330B NM109 segment with all Xs to satisfy the minimum bytes requirement (e.g., XX).

N. **IMPORTANT:** In such situations where Medicare is the secondary payer, the Medicare Part A shared system will ensure that the value reflected in the 2330B NM109 segment matches the value populated in the 2430 SVD01, as required.

O. For situations where the Medicare Part B shared system (MCS/HPES) is unable to produce a valid N4 segment (including city, state, and postal code), it will create the following for outbound 837 professional physician/practitioner claims:

P. N401 (City) – Will contain Cityville;

Q. N402 (State Code) – Will contain MD; and

R. N403 (Postal Zone/Zip Code) – Will contain 96941, along with 9998, if a zip code +4 is required for the loop(s) in question.

IX. HELPFUL INFORMATION FOR COBA TRADING PARTNERS IN COMPARING THEIR 4010A1 PRODUCTION CLAIMS TO THEIR 5010 ERRATA COB TEST CLAIMS [October 2011]

A. Provider Address Differences Between 2010AA and 2010AB N3 and N4

In comparing their 4010A1 837 professional claims to their 5010A1 837 professional test COB claims, COBA trading partners will note the following relative to address information within the 2010AA and 2010AB N3 and N4 segments:

1. Typically, the Part B shared system now reflects a physician/practitioner's Pay-to Address in the N3 and N4 segments of loop 2010AA on current 4010A1 production claims and does not create a 2010AB (Pay-to Provider) loop. There are times, however, when the Part B system does create a separate 2010AB loop for version 4010A1 837 professional COB claims.
2. Contrastingly, in creating test 5010A1 837 professional claims, the Medicare Part B shared system will always populate the N3 and N4 segments in 2010AA with the physician or practitioner's practice or "master" address, which is on file with Medicare. And, for test 5010A1 COB claims, the Medicare Part B shared system will only create the 2010AB ("Pay-to Provider") loop if the physician/practitioner has supplied Medicare with a differing address for remittance or check payment purposes. **(NOTE:** The same results may be expected if Medicare created the 837 professional COB claims for trading partners in 5010A1 production mode.**)**

B. Situational Loops and Segments That Will Not Reflected on 5010 Errata Skinny Claims

In comparing their 4010A1 837 professional claims to their 5010A1 837 professional "skinny" test COB claims, COBA trading partners will notice that the following situational loops and/or segments will **not** be created:

- Loops 2420A, 2420B, 2420C, 2420D, 2420E, and 2420F.
- Provider taxonomy (PRV) segments, regardless of where
- The taxonomy code is reported on the incoming claim to Medicare.
- Family Planning (or Early and Periodic Screen for Diagnosis and Treatment of Children [EPSDT] involvement) Indicator in segment
- SV111 of loop 2400.
- For 5010A2 837 institutional "skinny" test COB claims, COBA trading partners will notice that the following situational loops and/or segments will **not** be created:
- Loops 2420A, 2420B, 2420C, and 2420D.

SPECIAL NOTE: The above situational loops and segments will be reflected on 5010 Errata (versions A1 or A2) COB/crossover claims if the provider, physician, or supplier reported them on incoming 5010 claims to Medicare.

C. 2300 CLM09 (Release of Information Code) Value Mapped

In comparing their 4010A1 837 institutional production claims with their 5010A2 837 institutional test COB claims, COBA trading partners will notice the following relative to value reflected within the 2300 CLM09:

- The Part A shared system will always map "Y" for 5010A2 837 institutional claims. (**NOTE**: This will be true regardless of the claim format that the provider submitted to Medicare.)

For 5010A1 "skinny" mapping, the Part B shared system will proceed as follows relative to the value reflected in 2300 CLM09:

- If the incoming 4010A1 2300 CLM09=A and the inbound 4010A1 2300 CLM10 (Signature Source) = B, C, S, or P, the Part B shared system will map "Y" to 2300 CLM09.
- If the incoming 4010A1 2300 CLM09=A, and the inbound 4010A1 2300 CLM10= M, then the Part B shared system will map "I" to 2300 CLM09.

In terms of DMEPOS (DME and retail drug store) claims, the DME MAC shared system will create 2300 CLM09 in accordance with the appropriate scenario depicted below.

- If the incoming claim to the DME MAC is version 5010A1, and the 2300 CLM09 information is available from the DME MAC's internal store-and-forward repository (SFR), the DME MAC shared system will map the value from the incoming 5010A1 claim to the 5010A1 COB claim.
- If the incoming claim to the DME MAC was 4010A1 or was version 5010A1 but the SFR information is not otherwise available, the DME MAC would map "Y" to 2300 CLM09.

IMPORTANT: As of January 7, 2015, Medicare will always map the same value in 2300 CLM09 and in 2320 OI06 for all outbound 837 COB claim transactions.

X. Segments That Will Not be Created on Medicare 837 COB Claims

Medicare will never create the segments indicated below on HIPAA 837 5010 pre-Errata and Errata version COB claims. This is because Medicare will **not** accept incoming claims that contain these segments.

- 2000A CUR (Foreign Currency Information), unless the claim contains monetary amounts expressed as foreign currency, which should be non-applicable to Medicare claims;
- 2010BB REF – Payer Secondary Identifier;
- 2010BB REF – Billing Provider Secondary Identifier;
- 2000C HL– Patient Hierarchical Level;
- 2000C PAT – Patient Information --NOTE: For Medicare, the subscriber and patient are always the same;
- 2010CA – Patient Name;
- 2300 PWK – Claims Supplemental Information for COB purposes; and
- 2320 AMT (COB Total Non-Covered)

Specifics for 837 Institutional COB Claims

In addition, the Part A shared system governing institutional and facility claims will not map the following:

- 2320 AMT (Remaining Patient Liability) for COB purposes;
- 2420E N3 and N4 segments if the information on the incoming claim is either incomplete or missing [**note:** applicable to 5010 Errata claims only.]; and
- 2300 AMT (Patient Estimated Amount Due), which is designated by qualifier "F3."

Specifics for 837 Professional DMEPOS COB Claims

In addition, the VMS system governing DMEPOS claims will **not** create the following segments on outbound 837 professional COB claims:

- 2300 DTP–Date – Repricer Received Date;
- 2320 AMT Remaining Patient Liability; and
- 2420E N3 and N4 segments if the information on the incoming claim is either incomplete or missing [**note:** applicable to 5010A1 (Errata) claims only.]

XI. Other Helpful Information

IMPORTANT: As previously mentioned in Section II of this Guide, the Medicare shared systems will only create secondary provider identifier values within the various REF (Reference Identification) segments that represent the provider's EIN/TAX ID or SSN, with the latter only being allowed on 837 professional claims. Thus, the Medicare shared systems will only create the 2010AA REF within all outbound HIPAA 5010 pre-Errata and Errata version COB claims.