Medicare-Coordination of Benefits

Coordination of Benefits Agreement (COBA)
Companion Guide for

National Council for Prescription Drug Programs (NCPDP)
Batch Version D.0 COB Claims

For Use by
All COBA Trading Partners

Developed by
The Division of Medicare Benefits Coordination within the
Centers for Medicare & Medicaid Services (CMS)

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I. Getting Started—Preparing to Test Medicare NCPDP D.0 COB Claims

As a COBA trading partner representative that is preparing your organization for testing NCPDP D.0 COB claims with the Coordination of Benefits Contractor (COBC), your first step is to complete the "Technical Readiness Assessment Document." This document may be referenced at: < http://www.cms.gov/COBAgreement/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 pre-Errata or Errata versions of the COB transactions with the COBC. If you already completed this document in association with your testing of HIPAA 5010, you would only need to complete it again if you neglected to address your planned NCPDP D.0 testing timeframes when previously completing the form.

COBA trading partners will most likely not need to obtain new COBA identifiers (IDs) to test NCPDP D.0 COB transactions with the COBC. Potential reasons for needing to obtain "test" COBA IDs may include the COBA trading partner's desire to vary claims selection criteria for receipt of NCPDP D.0 COB claims as compared with the criteria selected for NCPDP 5.1 crossover claims. **SPECIAL NOTE:** It remains true that trading partners are not required to accept NCPDP claims via the COBA crossover process.

Your designated COBC Electronic Data Interchange (EDI) representative should be able to assist you with set-up for NCPDP D.0 COB claims testing. Questions concerning what connectivity options are available to you in connection with NCPDP D.0 COB testing may be referenced in the COBA Implementation User Guide. At this point in time, CMS is offering the same options available to COBA trading partners as part of their current NCPDP 5.1 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 NCPDP D.0 COB "test" 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 these claims in production mode.

II. High-Level Overview of Changes

A. New Field for Medigap Identifier

The Committee responsible for modifying the National Council for Prescription Drug Programs telecommunication batch and real-time claims formats has accommodated a long-standing Medicare need through its version D.0, batch 1.2 changes. Specifically, in those instances where the Medigap insurer does not provide an eligibility file to the COB Contractor to trigger crossover claims but instead allows the retail pharmacy to input necessary information on the incoming NCPDP D.0 claim to trigger claims crossover, the retail chain pharmacy will now place the Medigap policy number within element 359-21 in the Transmission Insurance Segment. As indicated in Section III below, the Medigap insurer's 5-byte Medigap claim-based COBA ID will continue to be reflected in element 301-C1 ("Group ID") within the same segment.

B. New Provider Accepts Assignment Indicator

Under NCPDP version 5.1, Medicare did not reflect the provider assignment indicator independently on the COB/crossover claim. The NCPDP D.0 has added a provider accept assignment indicator field as element 361-2D in the Transmission Insurance Segment. As indicated below, Medicare will always populate this field.

C. New Field for Qualifying Deductible and Co-Insurance Amounts Remaining and Indication Where These Monetary Amounts Will Appear

Under NCPDP version D.0, any co-insurance or deductible amounts remaining after Medicare's payment of the claim for Part B drugs will no longer be qualified by 98 or 99, respectively. These amounts previously were reflected within the 342-HC and 338-5C Transaction COB/Other Payments Segment. The NCPDP X-12 Committee has now created a new field for the deductible and co-insurance qualifiers for use within the NCPDP D.0 batch transaction. Therefore, Medicare will now qualify the Part B deductible and/or co-insurance amounts as follows within a brand-new field 351-NP ("Other Payer-Patient Responsibility Amount Qualifier") created within the NCPDP D.0 batch claim:

- 01=Deductible amount owed;
- 07=Co-insurance amount owed.

These amounts will also appear within the Transaction COB/Other Payments Segment.

In addition, the actual monetary amount(s) for the Part B deductible and/or co-insurance attributable to Part B drugs billed via the NCPDP D.0 claim will now be reflected within 352-NQ ("Other Payer Patient Responsibility Amount"), which is also within the Transaction COB/Other Payments Segment.

D. New Values Used to Qualify Medicare's Allowed and Paid Amounts

Under NCPDP version D.0, Medicare will now qualify its allowed amount with 07 and its paid amount with 06 within the 342-HC element ("Other Payer Paid Qualifier") within the Transaction COB/Other Payments Segment.

III. NCPDP D.0 COB Mapping

A. General

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

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

B. Transmission/Transaction Header Segment

The Medicare Durable Medical Equipment Medicare Administrative Contractor (DME MAC) shared system will format this segment as follows:

1) The claims version release number will be populated in 102-A2 within the Transmission/Transaction Header Segment.
2) The appropriate transaction code will appear in 103-A3; the process control number will appear in 104-A1; and the transaction count value will appear in 109-A9.
3) The provider ID qualifier corresponding to the national provider identifier (NPI) will be populated in 202-B2.
4) The supplier's NPI will appear in 201-B1 ("Service Provider ID").
5) The date of service shall be taken from the incoming claim and populated in 401-D1.

6) Element 110-AK ("Software Vendor/Certification ID") shall be mapping from the incoming claim.

IMPORTANT: For "skinny" NCPDP claim scenarios, where the incoming claim is NCPDP 5.1 but the COBA trading partner is seeking an NCPDP version D.0 claim for crossover purposes, the shared system shall map "unknown" in 110-AK.

C. Transmission Insurance Segment

The Medicare DME MAC shared system will format this segment as follows:

1) Map the beneficiary's Health Insurance Claim Number (HICN) in 302-C2 ("Cardholder ID").
2) Map 312-CC and 313-CD ("Cardholder's First and Last Names") using information from the DME MAC's internal eligibility file.
3) For Medigap claim-based crossover purposes only, the shared system shall continue to populate the Medigap claim-based COBA ID (range 55000-55999) in the flat file field corresponding to 301-C1 (Group ID), as derived from the incoming claim.
   In addition, the shared system shall populate the Medigap policy ID in the newly created 359-2A ("Medigap ID") element, as derived from the incoming claim.
4) Map an "A" value for element 361-2D ("Provider Accept Assignment Indicator").

D. Transmission Patient Segment

The Medicare DME MAC shared system will format this segment as follows:

1) Element 307-C7 ("Place of Service") will be derived from the incoming claim.
2) The HICN will always be mapped to 332-CY ("Patient ID").
3) Map elements 304-C4, 305-C5, 310-CA, and 311-CB from the DME MAC's internal beneficiary eligibility file.
4) Map elements 322-CM, 323-CN, 324-CO, and 325-CP from the DME MAC's internal beneficiary eligibility file. (--See Gap Filling Requirements section to address situations where the beneficiary's line-1 address, as derived from the DME MAC's internal beneficiary eligibility file, is blank or incomplete.)
5) Map 326-CQ ("Patient Phone Number") and 350-HN ("Patient E-mail Address") from incoming claim if received.
6) Map any one (1) of the following values, as derived from the incoming Medicare claim for "patience residence," in element 384-4X:

0=Not Specified

1=Home

2=Skilled Nursing Facility

3=Nursing Facility

4=Assisted Living Facility

5=Custodial Care Facility

6=Group Home

7=Inpatient Psychiatric Facility - Not applicable to Pharmacy Benefits

8=Psychiatric Facility – Partial Hospitalization - Not applicable to Pharmacy Benefits

9=Intermediate Care Facility/Mentally Retarded

10=Residential Substance Abuse Treatment Facility - Not applicable to Pharmacy Benefits

11=Hospice

12=Psychiatric Residential Treatment Facility - Not applicable to Pharmacy Benefits

13=Comprehensive Inpatient Rehabilitation Facility - Not applicable to Pharmacy Benefits

14=Homeless Shelter - Not applicable to Pharmacy Benefits

15=Correctional Institution

E. **Transaction Prescriber Segment**

The Medicare DME MAC shared system will format this segment as follows:

1) Map element 466-EZ (“Prescriber ID Qualifier”) from the incoming claim.
2) Always map “01” for element 468-2E (“Primary Care Provider ID Qualifier”).
3) Map the NPI, as derived from the incoming claim, in element 421-DL (“Primary Care Provider ID”).

4) Map the supplier's name, as derived from the DME MAC's internal supplier files, for 470-4E ("Primary Care Provider Last Name").
5) Map 411-DB based upon adjudicated claim data.
6) Map 427-DR ("Prescriber Last Name") and 364-2J ("Prescriber First Name") from the DME MAC's internal supplier files.
7) Map 365-2K ("Prescriber Address"), 366-2M ("Prescriber City"), 367-2N ("Prescriber State"), 368-2P ("Prescriber Zip"), and 498-PM ("Prescriber Phone Number") based upon the availability of these elements in the SFR. **(See Gap-Filling Requirements Section for those requirements that will come into play for NCPDP skinny mapping.)**

F. Transaction COB/Other Payments Segment

IMPORTANT NOTE: By contrast to the 837 COB transactions, NCPDP D.0 does not accommodate all future COB payers within this equivalent segment. As each payer adjudicates the claim, each will add its payment information as an additional occurrence. All values set apply to Medicare's payment occurrence only.

The Medicare DME MAC shared system will format this segment as follows:

1) Map element 337-4C from the incoming claim.
   NOTE: The DME MAC system will increase this number by 1 when applying the Medicare payment amounts.
2) Prepare element 342-HC with qualifier "7" for Allowed Amount" and "6" for Paid Amount. (**NOTE:** Medicare will also use "7" as a qualifier for the primary payer's obligated to accept as payment in full [OTAF] amount in situations where Medicare is the secondary payer. Medicare will reflect the monetary amount of the OTAF within element 431-DV.)
3) Map "1" within 351-NP to qualify the Medicare Part B deductible applied; and map "7" to qualify the Part B co-insurance amount owed. **NOTE:** If both deductible and co-insurance are owed on the claim, the Medicare DME MAC shared system shall create 2 occurrences of the 351-NP for reflect the qualifiers for each.
4) Reflect the Medicare Part B deductible amount and/or Part B co-insurance amount within 352-NQ. **NOTE:** If both deductible and co-insurance are owed on the claim, the Medicare DME MAC shared system shall create 2 occurrences of the 352-NQ.
5) Map value "05" for element 339-6C in relation to Medicare's role as payer of the claim.
6) Map the DME MAC's workload identifier (e.g., 16003) in element 340-7C.
7) Map the Internal Control Number (element 993-A7) as received from CEDI and as a result of claim adjudication.
8) Map the following out on the COB flat file only if received on the incoming claim: 443-E8, 341-HB, 342-HC, 431-DV, 471-5E, 472-6E.

When filling in the fields/elements listed for Medicare's payment, the DME MAC shared system will:

A. Place the cycle payment date within element 443-E8.
B. Count the number of payment types it will be reporting and place this amount within element 341-HB.
C. Complete the code value in element 342-HC, with its associated amount reflected in element 431-DV for each payment amount reported.

SPECIAL NOTE: Under NCPDP D.0 COB, the DME MAC shared system will qualify the Medicare allowed amount within element 342-HC with value 07. The DME MAC shared system will qualify the Medicare paid amount within element 342-HC with value 06.

D. Complete the total number of rejects being reported by Medicare in element 471-5E, with each reject code being listed within element 472-6E.

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

G. Transaction Claim Segment

The Medicare DME MAC shared system will format this segment as follows:

1) Map 343-HD, 344-HF, and 345-HG based upon availability of the data on the incoming claim.
2) Create 455-EM and 402-D2 as required, without gap-filling, as derived from the incoming claims data.
3) Create 403-D3, 405-D5, 406-D6, and 407-D7 as required, without gap-filling, as derived from the incoming claims data.
4) Create all of the following if received on the incoming claim: 408-D8, 414-De, 415-DF, 418-DI, 419-DJ, 420-DK, 453-EJ, 445-EA, 446-EB, and 457-EP. (NOTE: Gap-filling of 453-EJ with spaces is acceptable if the shared system is also concurrently gap-filling 445-EA with spaces.)
5) Create procedure modifier count (458-SE) based upon claim adjudication.
6) Create procedure modifier code as appropriate.
7) Map 442-E7 and 436-E1 as required, without gap-filling.
8) Create 456-EN, 420-DK, and 429-DT to the COB file if received on the incoming claim.
9) For element 308-C8, VMS shall map "02" to this element when the paid amount on the adjudicated claim is greater than zeroes. VMS shall, however, map "04" to this element when the paid amount is equal to zeroes.
10) Map 600-28 if received on the incoming claim.

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

H. **Transaction Compound Segment**

The Medicare DME MAC shared system will format this segment as follows:

1) Create all of the following required elements without gap-filling: 447-EC, 448-ED, 449-EE, 450-EF, 451-EG, 488-RE, and 489-TE.
2) Create the following if received on the incoming claim: 490-UE, 362-2G, and 363-2H.

I. **Transaction Pricing Segment**

The Medicare DME MAC shared system will format this segment as follows:

1) Create the following required elements without gap-filling: 409-D9 and 430-DU
2) Create the following based upon claims adjudication: 412-DC, 423-DN, 426-DQ, 433-DX, 438-E3, 478-H7, 479-H8, and 480-H9.

J. **Narrative Segment**

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

IV. Elements That Will Not Appear on NCPDP D.O COB Claims

The CMS and its Medicare contractors have determined that they will **not** create the following elements, shown in accordance with segment placement, on their outbound NCPDP D.0 COB claims:

A. Transmission Insurance Segment

- 336-8C ("Facility ID"), even in "skinny" claim situations
- Elements 115-N5, 116-N6, 314-CE, 303-C3, and 306-C6

B. Transmission Patient Segment

- Element 335-2C ("Pregnancy Indicator")

C. Transaction COB/Other Payments Segment

- Elements 392-MU, 393-MV, and 394-MW, as these are not used for Medicare purposes
- The Transaction Workers' Compensation Segment

D. Transaction Claim Segment

- Elements 461-EU, 462-EV, 463-EW, 464-EX, 354-NX, 357-NV, 995-E2, 996-G1, and 147-U7

E. Transaction Pricing Segment

- Elements 482-GE, 483-HE, and 484-JE

F. Transaction Prior Authorization Segment – Not created

G. Transaction Clinical Segment

- "Transaction Additional Doc" segment or Additional Documentation Type ID (369-2Q)

V. Gap-Filling Requirements

The gap-filling requirements listed below will be applied, as necessary, by the DME MAC shared system when creating outbound NCPDP D.0 COB claims.

A. For all instances of the 325-CP element within the Transmission Patient Segment, the DME MAC shared system (VMS) shall populate a 9-byte zip code. If only 5-bytes of the zip code can be obtained, the shared system shall populate "9998" after the concluding character of the 5-byte zip code that is available (e.g., 211019998).

B. When there is not a valid zip code available to complete a 325-CP element, VMS shall populate "96941" within the field corresponding to that segment on the NCPDP D.0 COB flat file.

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

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

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

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

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

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