CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2569	**Date: October 26, 2012**
	Change Request 8071

NOTE: This Transmittal is no longer sensitive and is being re-communicated July 23, 2013. The Transmittal Number, date of Transmittal and all other information remain the same. This instruction may now be posted to the Internet.

SUBJECT: Modifications to the National Coordination of Benefits Agreement (COBA) Crossover Process

I. SUMMARY OF CHANGES: Through this instruction, the Centers for Medicare &Medicaid Services addresses a needed gap-fill measure for all version 5010 outbound 837 crossover claims. CMS also makes specific changes to add a new 23rd position file identifier value for use on outbound 837 professional claims when A/B Medicare Administrative Contractors or carriers reprocess claims in conjunction with a specific claims adjustment situation.

EFFECTIVE DATE: April 1, 2013
IMPLEMENTATION DATE: April 1, 2013

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	28/70.6.1/ Coordination of Benefits Agreement (COBA) Detailed Error Report Notification Process
R	28/70.6.5/ Coordination of Benefits Agreement (COBA) 5010 Coordination of Benefits (COB) Requirements

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

For Medicare Administrative Contractors (MACs):
The Medicare Administrative contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question

and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2569	Date: October 26, 2012	Change Request: 8071

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SUBJECT: Modifications to the National Coordination of Benefits Agreement (COBA) Crossover Process

EFFECTIVE DATE: April 1, 2013

IMPLEMENTATION DATE: April 1, 2013

I. GENERAL INFORMATION

A. Background: Currently, the Medicare shared systems maintainers apply various CMS-prescribed gap-fill or systems-fill measures in situations where data that are needed to meet Health Insurance Portability and Accountability Act (HIPAA) 837 claims compliance requirements cannot otherwise be derived. Through CMS Change Requests (CRs) 6308 and 6374, CMS supplied a listing of gap-fill or system-fill variables that shall be applied in the creation of various required segments for outbound coordination of benefits (COB)/claims crossover transactions. CMS already provided guidance for gap-filling of city, state, and zip code to meet HIPAA 5010 requirements for ambulance billing. Through this change request, CMS provides similar guidance for another situation where gap-filling of city, state, and zip as individual required data elements may be necessary.

CMS currently is enforcing a one (1) percent electronic prescribing (e-RX) negative adjustment on Part B claims paid under the Medicare Physician Fee Schedule (MPFS) for physicians and practitioners who do not comply with Medicare e-RX prescribing requirements. At regular intervals CMS apprises A/B Medicare Administrative Contractors (MACs) and carriers of specific situations where it 1) incorrectly assessed the negative adjustment against a given physician/practitioner or 2) waived the negative adjustment due to proven hardship. In such cases, each A/B MAC or carrier has 45 days to reprocess the affected claims. CMS proposes to make a change to the high-level file identifier associated with sets of reprocessed claims to allow Coordination of Benefits Agreement (COBA) trading partners the ability to more easily identify the affected claims among their larger stream of crossover claims received.

B. Policy: For situations where the data elements needed to populate 2010BA N401 (City), N402 (State), and N403 (Postal Code) cannot otherwise be derived, the shared systems shall gap-fill, or systems-fill, these elements individually as needed with “Cityville,” “MD,” and “96941."

The Part B shared system shall identify a method for grouping together all Part B physician/practitioner claims that its A/B MACs and carriers must reprocess to remove the previously imposed specified percentage e-RX negative adjustment. For COBA crossover claims purposes, the Part B shared system shall 1) input a new 1-byte "E" indicator (where "E" denotes an adjustment to claim formerly processed with e-RX negative adjustment) within the existing 23rd position of the Beginning of the Hierarchical Transaction Reference identification (BHT03) identifier associated with the reprocessed claims; and 2) transmit to the Coordination of Benefits Contractor (COBC) those reprocessed claims that formerly had included a 1 percent negative adjustment as a single grouping under a BHT03 whose 1-byte value in position 23 is "E."

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement.

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8071.1	For situations where the data needed to individually populate the 2010BA (Subscriber Name) N401 (City Name), N402 (State or Province Code), and N403 (Postal Code) cannot otherwise be derived, the indicated shared systems shall gap-fill, or systems-fill, the individual required elements on outbound 5010 837 institutional and professional crossover claims as follows: N401= Cityville; N402= MD; N403= 96941								X	X		
8071.1.1	Until further notice, the indicated shared systems shall **not**attempt to replace**valid** data already present within the 2010BA N401, N402, and N403 with the gap-fill, or systems-fill, data specified in 8071.1.								X	X		
8071.1.2	For all provider-related loops, where a 9-byte zip code is required for the N403 segment, the shared systems shall continue to gap-fill, or systems-fill, the last 4 positions of the 9-byte zip code with “9998” when necessary.								X	X		
8071.2	The Part B shared system shall identify a method for grouping together all Part B physician/practitioner claims that its A/B MACs and carriers must reprocess to remove the previously imposed CMS-specified percentage (.e.g. 1 percent) e-RX negative adjustment and make the affected physicians/practitioners whole.								X			
8071.2.1	For COBA crossover claims purposes, the Part B shared system shall input a new 1-byte "E" indicator (where "E" denotes an adjustment to claim formerly processed with e-RX negative adjustment) within the 23rd position of the BHT03 identifier associated with the reprocessed claims.								X			
8071.2.1.1	In addition, the Part B shared system shall transmit to the COBC those reprocessed claims that formerly included a CMS-specified percentage								X			COBC

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	negative adjustment as a single grouping under a BHT03 whose 1-byte value in position 23 is "E."											
8071.2.2	The indicated Medicare contractors shall ensure that they always follow the multi-carrier system (MCS) developed specifications when reprocessing e-RX negative adjustment claims to ensure that the value "E" will be included in position 23 of the BHT03 file identifier created for COBA crossover claims.		X			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					
	None							

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Brian Pabst, 410-786-2487 or brian.pabst@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

Section B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS do not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

70.6.1 - Coordination of Benefits Agreement (COBA) Detailed Error Report Notification Process

(Rev.2569, Issued: 10- 26-12, Effective: 04-01-13, Implementation, 04-01-13)

Effective with the July 2005 release, CMS will implement an automated process to notify physicians, suppliers, and providers that specific claims that were previously tagged by the Common Working File (CWF) for crossover will not be crossed over due to claim data errors. Claims transmitted via 837 flat file by the Medicare contractor systems to the COBC may be rejected at the flat file level, at an HIPAA ANSI pre-edit validation level, or by trading partners as part of a financial dispute arising from an invoice received. By contrast, claims transmitted via NCPDP file will be rejected only at the flat file and trading partner dispute levels. Effective with the April 2005 release, the contractor systems will have begun to populate the BHT 03 (Beginning of Hierarchical Reference Identification) portion of their 837 COB flat file submissions to the COBC with a unique 22-digit identifier. This unique identifier will enable the COBC to successfully tie a claim that is rejected by the COBC at the flat file or HIPAA ANSI pre-edit validation levels as well as claims disputed by trading partners back to the original 837 flat file submissions.

Effective with October 4, 2005, contractors or their shared systems will receive notification via the COBC Detailed Error Reports, whose file layout structures appear below, that a COBA trading partner is in test or production mode via the BHT 03 identifier that is returned from the COBC.

Effective with April 3, 2011, all Medicare contractors shall begin an extra 1-byte "Original versus Adjustment Claim Indicator" value within the BHT03 identifier on all 837 institutional and professional claims they transmit to the COBC for crossover purposes. The COBC shall, in turn, return this value to the appropriate Medicare contractor via the COBC Detailed Error Report process. In addition, the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) shared system shall send an additional 1-byte value (defined as "reserved for future use") as spaces in field 504-F4 (Message) of the NCPDP flat file sent to the COBC. The COBC shall, in turn, also return this value to the appropriate Medicare contractor via the COBC Detailed Error Report process.

Effective with April 1,2013, CMS has added a new 1-byte Original versus Adjustment indicator to the suite of possible 1-byte options for position 23 of the BHT03 identifier, as reflected below.

A. Inclusion of the Unique 23-Digit Identifier on the 837 Flat File and NCPDP File

1. Populating the BHT 03 Portion of the 837 Flat File

The contractor shared systems shall populate the BHT 03 (Beginning of Hierarchical Transaction Reference Identification; **field length=30 bytes**) portion of their 837 flat files that are sent to the COBC for crossover with a 23-digit Contractor Reference Identifier (CRI). The identifier shall be formatted as follows:

a. Contractor number (9-bytes; until the 9-digit contractor number is used, report the 5-digit contractor number, left-justified, with spaces for the remaining 4 positions);

b. Julian date as YYDDD (5 bytes);

c. Sequence number (5 bytes; this number begins with "00001," so the sequence number should increment for each ST-SE envelope, which is specific to a trading partner, on a given Julian date);

d. Claim version indicator (2 bytes, numeric, to denote claim version)

**Acceptable values=40 (for 4010A1 version claims), 50 (for 5010 claims), 11 (for NCPDP 5.1 claims), and 20 (for NCPDP D.0 claims);

e. COBA Test/Production Indicator (1-byte alpha indicator; acceptable values = "T" [test] and "P" [production]) or "R" if the claims were recovered for a "production" COBA trading partner (see §70.6.3 of this chapter for more details;

f. Original versus Adjustment Claim Indicator (1-byte alpha indicator; acceptable values are defined as the following:

E—for reprocessed claims that formerly included an electronic prescribing (e-RX) negative adjustment amount;

O—for original claims;

P— for Affordable Care Act or other congressional imperative mass adjustments;

M—for non-Affordable Care Act mass adjustments tied to Medicare Physician Fee Schedule (MPFS);

S—for mass adjustment claims—all others;

R—for RAC adjustment claims, and

A—for routine adjustment claims, not previously classified.

The 23-digit CRI shall be left-justified in the BHT 03 segment of the 837 flat file, with spaces used for the remaining 8 positions. (**NOTE:** The CRI is unique inasmuch as no two files should ever contain the same combination of numbers.)

2. NCPDP 23-Digit Unique Identifier

Effective with April 3, 2011, the DMERC/DME Medicare Administrative Contractor (DME MAC) contractor system shall also adopt a unique 23-digit format, referenced directly above under "Populating the BHT 03 Portion of the 837 Flat File." However, the system shall populate the unique 23-digit identifier (defined as "future use") with spaces in field 504-F4 (Message) within the NCPDP file (field length=35 bytes). The DMERC/DME MAC contractor system shall populate the unique identifier, left justified, in the field. Spaces shall be used for the remaining bytes in the field.

B. COBC Institutional, Professional, and NCPDP Detailed Error Reports

The contractor systems shall accept the COBC Institutional, Professional, and NCPDP Detailed Error Reports received from the COBC. The formats for each of the Detailed Error Reports appear below.

Beginning with July 2007, all contractor systems shall no longer interpret the percentage values received for 837 institutional and professional claim "222" and "333" errors via the COBC Detailed Error Reports as if the values contained a 1-position implied decimal (e.g., "038"=3.8 percent). DMERCs/DME MACs shall also no longer interpret the percentage values received for NCPDP claims for "333" errors via the COBC Detailed Error Report for such claims as if the values should contain a 1-position implied decimal.

In addition, contractors and their systems shall now base their decision making calculus for initiation of a claims repair of "111" (flat file) errors upon the number of errors received rather than upon an established percent parameter, as otherwise described within this section.

Effective with July 2009, the shared systems shall accept the modified versions of the COBC Detailed Error Reports for institutional and professional claims as reflected below. As part of the July 2009 changes, the COBC will, at CMS's direction, expand the length of the "error description" field. (**NOTE:** This means that the shared systems shall therefore include the expanded error description code as part of their special provider notification letters.)

The Institutional Error File Layout, including summary portion, will be used for Part A claim files.

COBC Detailed Error Report

Institutional Error File Layout
(Detail Record)

1. Date	**8**	**1-8**
2. Control Number	**9**	**9-17**
3. COBA-ID	**10**	**18-27**
4. Subscriber ID/HICN	**12**	**28-39**
5. Claim DCN/ICN	**14**	**40-53**
6. Record Number	**9**	**54-62**
7. Record/Loop Identifier	**6**	**63-68**
8. Segment	**3**	**69-71**
9. Element	**2**	**72-73**
10. Error Source Code	**3**	**74-76 (‘111,’ ‘222,’ or ‘333’)**
11. Error/Trading Partner		
Dispute Code	**6**	**77-82**
12. Filler	**100**	**83-182**
13. Field Contents	**50**	**183-232**
14. BHT 03 Identifier	**30**	**233-262** *(23 bytes used)*
15. Claim DCN/ICN	**23**	**263-285**
16. Error Description	**300**	**286-585**
17. Filler	**15**	**586-600**

Institutional Error File Layout – (Summary Record)

1. Date	**8**	**1-8**
2. Total Number of Claims		
For Processing Date	**10**	**9-18**
3. Number of ‘111’ Errors	**10**	**19-28**
4. Number of ‘222’ Errors	**10**	**29-38**
5. Percentage of ‘222’ Errors	**3**	**39-41**
6. Number of ‘333’ Errors	**10**	**42-51**
7. Percentage of ‘333’ Errors	**3**	**52-54**
8. Filler	**19**	**55-73**
9. Summary Record Id		
(Error Source Code)	**3**	**74-76 (‘999’)**
10. Filler	**524**	**77-600**

The Professional Error File Layout, including summary portion, will be used for Part B and DME MAC claim files.

COBC Detailed Error Report

Professional Error File Layout

(Detail Record)

1. Date	**8**	**1-8**
2. Control Number	**9**	**9-17**
3. COBA-ID	**10**	**18-27**
4. Subscriber ID/HICN	**12**	**28-39**
5. Claim DCN/ICN	**14**	**40-53**
6. Record Number	**9**	**54-62**
7. Record/Loop Identifier	**6**	**63-68**
8. Segment	**3**	**69-71**
9. Element	**2**	**72-73**
10. Error Source Code	**3**	**74-76 (‘111,’’ 222,’ or’ 333’)**
11. Error/Trading Partner Dispute Code	**6**	**77-82**
12. Filler	**100**	**83-182**
13 Field Contents	**50**	**183-232**
14 BHT 03 Identifier	**30**	**233-262** *(23 bytes used)*
15 Claim DCN/ICN	**23**	**263-285**
16. Error Description	**300**	**286-585**
17. Filler	**15**	**586-600**

Professional Error File Layout – (Summary Record)

1. Date	**8**	**1-8**
2. Total Number of Claims For Processing Date	**10**	**9-18**
3. Number of ‘111’ Errors	**10**	**19-28**
4. Number of ‘222’ Errors	**10**	**29-38**
5. Percentage of ‘222’ Errors	**3**	**39-41**
6. Number of ‘333’ Errors	**10**	**42-51**
7. Percentage of ‘333’ Errors	**3**	**52-54**
8. Filler	**19**	**55-73**
9. Summary Record Id (Error Source Code)	**3**	**74-76 (‘999’)**
10. Filler	**524**	**77-600**

The NCPDP Error File Layout, including summary portion, will be used by DME MACs for Prescription Drug Claims

COBC Detailed Error Report

NCPDP Error File Layout
(Detail Record)

1. Date	**8**	**1-8**
2. Batch Number	**7**	**9-15**
3. COBA-ID	**5**	**16-20**
4. HICN	**12**	**21-32**
5. CCN	**14**	**33-46**
6. Record Number	**9**	**47-55**
7. Batch Record Type	**2**	**56-57**
8. Segment ID	**2**	**58-59**
9. Error Source Code	**3**	**60-62 ('111' or '333')**
10. Error/Trading Partner Dispute Code	**6**	**63-68**
11. Error Description	**100**	**69-168**
12. Field Contents	**50**	**169-218**
13. Unique File Identifier	**30**	**219-248** *(23 bytes used)*
14. CCN	**23**	**249-271**
15. Filler	**18**	**272-289**

NCPDP Error File Layout – (Summary Record)

1. Date	**8**	**1-8**
2. Total Number of Claims For Processing Date	**10**	**9-18**
3. Number of '111' Errors	**10**	**19-28**
4. Number of '333' Errors	**10**	**29-38**
5. Percentage of '333' Errors	**3**	**39-41**
6. Filler	**18**	**42-59**
7. Summary Record Id (Error Source Code)	**3**	**60-62 ('999')**
8. Filler	**227**	**63-289**

If the COB Contractor has rejected back to the contractor system for 2 or more COBA Identification Numbers (IDs), the contractor system shall receive a separate error record for each COBA ID. Also, if a file submission from a contractor system to the COBC contains multiple provider, subscriber, or patient level errors for one COBA ID, the system will receive a separate error record for each provider, subscriber, or patient portion of the file on which errors were found.

C. Further Requirements of the COBA Detailed Error Report Notification Process

1. Error Source Code

Contractors, or their shared systems, shall use all information supplied in the COBC Detailed Error Report (particularly error source codes provided in Field 10 of Attachment B) to (1) identify shared system changes necessary to prevent future errors in test mode or production mode (Test/Production Indicator= T or P) and (2) to notify physicians, suppliers, and providers that claims with the error source codes "111," "222," and "333" will not be crossed over to the COBA trading partner.

The DME MACs, or their shared system, will only receive error source codes for a flat file error ("111") and for a trading partner dispute ("333"). Both error types shall be used to identify shared system changes necessary to prevent future errors and notify physicians, suppliers, and providers that claims with error source codes of "111" and "333" will not be crossed over to the COBA trading partner.

2. Time frames for Notification of Contractor Financial Management Staff and Providers
Contractors, or their shared systems, shall provide notification to contractor financial management staff for purposes of maintaining an effective reconciliation of crossover fee/ complementary credit accruals within five (5) business days of receipt of the COBC Detailed Error Report.

Effective with the October 2005 release, contractors and their shared systems shall receive COBC Detailed Error Reports that contain BHT03 identifiers that indicate "T" (test) or "P" (production) status for purposes of fulfilling the provider notification requirements. (Note: The "T" or the P" portion of the BHT03 indicator will be identical to the Test/Production indicator originally returned from CWF on the processed claim.)

a) **Special Automated Provider Correspondence**

Contractors, or their shared systems, shall also take the following actions indicated below only when they determine via the Beneficiary Other Insurance (BOI) reply trailer (29) that a COBA trading partner is in crossover production mode with the COBC (Test/Production Indicator=P). After a contractor, or its shared system, has received a COBC Detailed Error Report that contains claims with error source codes of "111" (flat file error) "222" (HIPAA ANSI error), or "333" (trading partner dispute), it shall take the following two specified actions within five (5) business days:

1. Notify the physician, supplier, or provider via automated letter from your internal correspondence system that the claim did not cross over. The letter shall include specific claim information, not limited to, Internal Control Number (ICN)/Document Control Number (DCN), Health Insurance Claim (HIC) number, Medical Record Number (for Part A only), Patient Control Number (only if it is contained in the claim), beneficiary name, date of service, and the date claim was processed.

Effective with July 2007, contractors and their systems shall ensure that, in addition to the standard letter language (the claim(s) was/were not crossed over due to claim data errors and was/were rejected by the supplemental insurer), their contractors' special provider letters/reports, which are generated for '222' and '333' error rejections in accordance with CR 4277, now include the following additional elements, as derived from the COBC Detailed Error Report: 1) Claredi HIPAA rejection code or other rejection code, and 2) the rejection code's accompanying description.

NOTE: Contractors, or their shared systems, are not required to reference the COBA trading partner's name on the above described automated letter, since the original remittance advice (RA)/electronic remittance advice (ERA) would have listed that information, if appropriate.

2. Update its claims history to reflect that the claim(s) did not cross over as a result of the generation of the automated letter.

Effective with October 1, 2007, all contractors shall modify their special provider notification letters that are generated for "111," "222," and "333" error situations to include the following standard language within the

opening paragraph of their letters: "This claim(s) was/were not crossed over due to claim data errors or was/were rejected by the supplemental insurer."

Contractors shall reformat their provider notification letters to ensure that, in addition to the new standard letter language, they continue to include the rejection code and accompanying description, as derived from the COBC Detailed Error Report, for "222" or "'333" errors in association with each errored claim.

Effective with the July 7, 2009, release, upon receipt of the COBC Detailed Error Report (DER), the Part A shared system shall configure the existing 114 report, as derived from the COBC DER, so that it 1) continues to display in landscape format; and 2) includes a cover page that contains the provider's correspondence mailing address.

b) Special Exemption from Generating Provider Notification Letters

Effective July 7, 2008, upon their receipt of COBC Detailed Error Reports that contain "222" error codes 000100 ("Claim is contained within a BHT envelope previously crossed; claim rejected") and 00010 ("Duplicate claim; duplicate ST-SE detected"), all contractor systems shall automatically suppress generation of the special provider notification letters that they would normally generate for their associated contractors in accordance with the requirements of this section as well as §70.6.3 of this chapter. In addition, upon receipt of COBC Detailed Error Reports that contain "333" (trading partner dispute) error code 000100 (duplicate claim) or 000110 (duplicate ISA-IEA) or 000120 (duplicate ST-SE), all contractor systems shall automatically suppress generation of the special provider notification letters, as would normally be required in accordance with this section as well as §70.6.3 of this chapter.

NOTE: When suppressing their provider notification letters for the foregoing qualified situations, the contractors shall also not update their claims histories to reflect the non-crossing over of the associated claims. Contractors should, however, continue to take into account the volume of claims that they are suppressing for financial reconciliation purposes.

Effective with October 6, 2008, when the COBC returns the "222" error code "N22225" to Medicare contractors via the COBC Detailed Error Report, the contractors' shared systems shall suppress generation of the special provider notification letters that they would normally issue in accordance with CRs 3709 and 5472.

When suppressing their provider notification letters following their receipt of a "N22225" error code, the contractors' shared systems shall also not update their claims histories to reflect the non-crossing over of the associated claims. Contractors should, however, continue to take into account the volume of claims that they are suppressing for financial reconciliation purposes.

Effective with January 5, 2009, when the COBC returns claims on the COBC Detailed Error Report whose COBA ID falls in the range 89000 through 89999 (range designates "Other-Health Care Pre-payment Plan [HCPP]"), the contractors' systems shall take the following actions:

1) Suppress generation of the special provider letters; and

2) Not update their affiliated contractors' claims histories to indicate that the COBC will **not** be crossing the affected claims over.

70.6.5 - Coordination of Benefits Agreement (COBA) 5010 Coordination of Benefits (COB) Requirements

(Rev.2569, Issued: 10- 26-12, Effective: 04-01-13, Implementation, 04-01-13)

I. Health Insurance Portability and Accountability Act (HIPAA) 837 4010-A1 to HIPAA 5010 COB Transitional Period Requirements

During the 837 5010 transitional period, the Medicare shared systems shall accommodate the multi-faceted scenarios that follow below each broad category with respect to creation of 837 COB flat files.

INCOMING HIPAA 5010 CLAIMS IN ASSOCIATION WITH COBA TRADING PARTNER COB FORMAT SPECIFICATIONS

Scenario 1: During the 837 5010 transitional period, if a provider or supplier submits a HIPAA 837 5010 institutional or professional claim to a Medicare contractor and if the Medicare contractor receives a CWF BOI reply trailer (29) that contains a "P" 4010-A1 Test/Production indicator and a "T" 5010 indicator, the affected shared systems shall: 1) produce a "skinny" non-SFR "production" claim in the 4010-A1 837 COB flat file for transmission to the COBC; and 2) produce an 837 5010 "test" COB flat file that contains a claim with full SFR content for transmission to the COBC.

Scenario 2: If a provider or supplier submits a HIPAA 837 5010 institutional or professional claim to a Medicare contractor and if the Medicare contractor receives a CWF BOI reply trailer (29) that contains a "P" 4010-A1 Test/Production indicator and a "N" 5010 indicator, the affected shared systems shall: 1) produce a "skinny" non-SFR "production" claim in the 4010-A1 837 COB flat file for transmission to the COBC; and 2) produce nothing in terms of an 837 5010 COB flat file.

Scenario 3: If a provider of supplier submits a HIPAA 837 5010 institutional or professional claim to a Medicare contractor and if the Medicare contractor receives a CWF BOI reply trailer (29) that contains an "N" 4010-A1 Test/Production indicator and a "T" 5010 indicator, the affected shared system shall: 1) produce nothing in terms of a 4010-A1 837 COB flat file; and 2) produce a 5010 "test" claim with full SFR content for COBA testing purposes.

Scenario 4: If a provider of supplier submits a HIPAA 837 5010 institutional or professional claim to a Medicare contractor and if the Medicare contractor receives a CWF BOI reply trailer (29) that contains an "N" 4010-A1 Test/Production indicator and a "P" 5010 indicator, the affected shared system shall: 1) produce nothing in terms of a 4010-A1 837 COB flat file; and 2) produce a "production" 5010 claim with full SFR content for COBA "production" purposes.

(**NOTE:** This will be the profile of a COBA trading partner that has cut-over to 5010 COB production.)

INCOMING HIPAA 4010-A1 CLAIMS IN ASSOCIATION WITH COBA TRADING PARTNER COB FORMAT SPECIFICATIONS

Scenario 1: During the transitional period, if a provider or supplier submits an 837 4010-A1 institutional or professional claim to a Medicare Part A contractor or DME MAC and if the Medicare contractor receives a Common Working File (CWF) Beneficiary Other Insurance (BOI) reply trailer (29) that contains a "P" 4010-A1 Test/Production (4010-A1) indicator and a "T" 5010 indicator, the affected shared systems shall: 1) create an 837 COB flat file that contains full 4010-A1 store-and-forward (SFR) content for the "production" claim for transmission to the COBC; and 2) create a "skinny" non-SFR claim in the 5010 837 COB flat file format for the "test" 5010 claim and transmit the file to the COBC.

Scenario 2: If a provider or supplier submits an 837 4010-A1 institutional or professional claim to a Medicare Part A contractor or DME MAC, as appropriate, and if the Medicare contractor receives a Common Working File (CWF) Beneficiary Other Insurance (BOI) reply trailer (29) that contains a "P" 4010-A1 Test/Production (4010-A1) indicator and a "N" 5010 indicator, the affected shared systems shall: 1) create an 837 COB flat file that contains full 4010-A1 store-and-forward (SFR) content for the "production" claim; and 2) create nothing in terms of a 5010 COB claim.

Scenario 3: If a provider or supplier submits an 837 4010-A1 institutional or professional claim to a Medicare Part A contractor or DME MAC and if the Medicare contractor receives a Common Working File (CWF) Beneficiary Other Insurance (BOI) reply trailer (29) that contains a "N" 4010-A1 Test/Production (4010-A1) indicator and a "T" 5010 indicator, the affected shared systems shall: 1) create nothing in terms of a 4010-A1 COB claim; and 2) create a "test" 5010 non-SFR COB claim.

Scenario 4: If a provider or supplier submits an 837 4010-A1 institutional or professional claim to a Medicare Part A contractor or DME MAC and if the Medicare contractor receives a Common Working File (CWF) Beneficiary Other Insurance (BOI) reply trailer (29) that contains a "N" 4010-A1 Test/Production (4010-A1) indicator and a "P" 5010 indicator, the affected shared systems shall: 1) create nothing in terms of a 4010-A1 COB claim; and 2) create a "production" 5010 non-SFR COB claim.

SPECIAL ONGOING RULE FOR ADJUSTMENT CLAIMS, CLAIMS HELD IN SUSPENSE, AND CLAIMS TO BE REPAIRED

The shared system shall produce a 5010 "skinny" claim in the event that a claim that a Medicare contractor originally adjudicated in the 4010-A1 format is later released from suspense status or is adjusted during a time frame when a COBA trading partner has moved to 837 5010 production (that is, the BOI reply trailer 29 contains a "P" 5010 Test/Production indicator).

In addition, as of the mandatory cutover date to the 5010 claim transaction, all shared systems shall have the capability of repairing claims that previously errored out in the 4010-A1 format prior to the cutover date in the 5010 COB claim format on and after January 1, 2012.

ADDRESSING INCOMING PAPER CLAIMS FOR OUTBOUND COB PURPOSES

Scenario 1: During the transitional period, if a provider or supplier submits a hard-copy claim (paper UB-04 or CMS-1500) or, as applicable, enters a direct-data-entry (DDE) claim to a Medicare Part A contractor or DME MAC and if the Medicare contractor receives a CWF BOI reply trailer (29) that contains a "P" 4010-A1 Test/Production indicator and a "T" 5010 indicator, the affected shared system shall: 1) produce a "skinny" non-SFR 4010-A1 "production" COB claim; and 2) produce a "skinny" non-SFR 5010 "test" COB claim.

Scenario 2: If a provider or supplier submits a hard-copy claim (paper UB-04 or CMS-1500) or, as applicable, enters a DDE claim to a Medicare Part A contractor or DME MAC and if the Medicare contractor receives a CWF BOI reply trailer (29) that contains a "P" 4010-A1 Test/Production indicator and a "N" 5010 indicator, the affected shared system shall: 1) produce a "skinny" non-SFR 4010-A1 "production" COB claim; and 2) produce nothing in terms of a 5010 COB claim.

Scenario 3: If a provider or supplier submits a hard-copy claim (paper UB-04 or CMS-1500) or, as applicable, enters a DDE claim to a Medicare Part A contractor or DME MAC and if the Medicare contractor receives a CWF BOI reply trailer (29) that contains a "N" 4010-A1 Test/Production indicator and a "T" 5010 indicator, the affected shared system shall: 1) produce nothing in terms of a 4010-A1 claim; and 2) produce a "skinny' non-SFR 5010 "test" COB claim.

Scenario 4: Finally, if a provider or supplier submits a hard-copy claim (paper UB-04 or CMS-1500) or, as applicable, enters a DDE claim to a Medicare Part A contractor or DME MAC and if the Medicare contractor receives a CWF BOI reply trailer (29) that contains a "N" 4010-A1 Test/Production indicator and

a “P” 5010 indicator, the affected shared system shall: 1) produce nothing in terms of a 4010-A1 COB claim; and 2) produce a “skinny” non-SFR 5010 “production” COB claim.

IMPORTANT: For all scenarios, if the inbound claim’s format is the same as the outbound claim, the shared system shall produce crossover claims with full SFR claim content as part of their contractors’ 837 COB flat file transmissions to the COBC.

II. General 5010 COB Flat File Mapping Requirements

A. 837 Institutional COB Claim Mapping Rules

Effective with the testing and implementation of the Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X12-N 837 institutional claim (version 5010), the Fiscal Intermediary Shared System (FISS) shall observe the following business rules for mapping of the 5010 COB (institutional) flat file:

1. The following segments shall **not** be passed to the COBC:

   a. ISA (Interchange Control Header Segment);
   b. IEA (Interchange Control Trailer Segment);
   c. GS (Functional Group Header Segment); and
   d. GE (Functional Group Trailer Segment).

2. The shared system shall map the claim version (version 005010X223A2 upon adoption of the 5010 Errata changes) in the field of the 837 5010 COB flat file that corresponds to the ST03 segment. (**NOTE:** The shared system shall **not** take this approach with respect to 4010-A1 claims that it will be transmitting to the COBC during the transitional period.)

3. The BHT02 (Beginning of the Hierarchical Transaction—Transaction Set Purpose Code) shall be passed either with value 00 or 18 under the following circumstances:

   a. Normal claims submission to the COBC—use “00”; and
   b. COBA claims repair process—use “18.”

4. The BHT03 (Beginning of the Hierarchical Transaction—Reference Identification or Originator Application Transaction ID) shall contain identifiers populated as follows:

a. *23* bytes for non-COBA recovery claims 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—Claim Version Indicator (2 bytes; values=40 for 4010A1 and 50 for 5010 claims);
Byte 22—Test/Production Indicator (1 byte; valid values=”T”—test; “P”—production)*; and*
Byte 23—Original versus Adjustment Claim Indicator (1 byte)
Valid values:

E—for reprocessed claims that formerly included an electronic prescribing (e-RX) negative adjustment amount;

O—for original claims;

P— for Affordable Care Act or other congressional imperative mass adjustments;

M—for non-Affordable Care Act mass adjustments tied to Medicare Physician Fee Schedule (MPFS);

S—for mass adjustment claims—all others;

R—for RAC adjustment claims, and

A—for routine adjustment claims, not previously classified.

b. 2*3* bytes for COBA recovery claims 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—Claim Version Indicator (2 bytes; values=40 for 4010A1 and 50 for 5010 claims);
Byte 22—COBA recovery indicator (1 byte; indicator =R)*; and*
*Byte 23—Original versus Adjustment Claim Indicator (1 byte) (**NOTE**: For valid values see II.A.4.a directly above.)*

5. The 1000-A PER (Submitter EDI Contact Information) shall be populated as follows:

a. PER01—populate "1C";
b. PER02—populate "COBC EDI Department";
c. PER03—populate "TE"; and
d. PER04—populate "6464586740."

6. The 1000-B loop NM1 (Receiver Name) denotes the crossover trading partner. If an A/B MAC on FISS receives multiple COBA IDs via the BOI reply trailer (29), the shared system shall submit a separate 837 transaction for each COBA ID received. Since crossover trading partner information will be unknown to the standard systems, the shared systems shall format the following fields as indicated:

a. NM101—populate "40";
b. NM102—populate "2";
c. NM103—populate spaces (COBC will complete);
d. NM108—populate "46"; and
e. NM109—include COBA ID (5-digit COBA ID obtained from the BOI reply trailer 29).

7a. To populate the 2010AA NM1 (Billing Provider Name), FISS shall complete the segments as indicated below if the incoming claim is electronic.

a. NM101—populate "85";
b. NM102—populate "2";
c. NM103—derived from contractor's internal provider file;
d. NM108—populate "XX"; and
e. NM109—populate NPI value, as derived from the incoming claim.

For 2010AA N3 and N4 segments, FISS shall derive the required segments from the contractor's internal provider file.

7b. If the incoming claim is paper UB04 or direct data entry (DDE), which is treated as paper, FISS shall complete the 2010AA NM1 (Billing Provider Name segments as follows:

a. NM101—populate “85”;
b. NM102—populate “2”;
c. NM103—derive from the contractor’s internal provider file;
d. NM108—populate “XX”; and
e. NM109—derive NPI from Form Locator (FL) 56 of the UB04 claim or applicable DDE field.

For 2010AA N3 and N4 segments, FISS shall derive the required segments from FLs 1 and 2 of the UB04 claim or internal provider file as necessary.

8a. To populate the 2010AB NM1 (Pay-to Address Name), the Part A shared system shall complete the segments as indicated below if the incoming claim is electronic.

a. NM101—populate “87”;
b. NM102—populate “2”; and
c. NM103—derived from contractor’s internal provider file.

For 2010AB N3 and N4 segments, FISS shall derive the required segments from the contractor’s internal provider file.

8b. If the incoming claim is paper UB04 or direct data entry (DDE), which is treated as paper, FISS shall complete the 2010AB NM1 (Pay-to Address Name) segments as follows:

a. NM101—populate “87”;
b. NM102—populate “2”; and
c. NM103—derived from incoming claim.

For 2010AB N3 and N4 segments, FISS shall derive the required segments from the contractor’s internal provider file as necessary.

9. FISS shall derive the 2010AA REF (Billing Provider-TAX ID) segments as follows, regardless of incoming claim’s format:

a. For REF01—populate “EI”; and
b. For REF02—derive from contractor’s internal provider file.

10a. For the 2000A and 2310-PRV in association with incoming electronic claims, FISS shall map the PRV01, PRV02, and PRV03 segments (which have already been validated for syntactical correctness at each affiliate contractor’s front-end) to the equivalent 837 COB flat as follows:
a. For PRV01—populate “BI”;
b. For PRV01—populate “PXC”; and
c. For PRV03—populate taxonomy code value from incoming claim.

10b. If the incoming claim is paper UB04 or DDE entered, FISS shall only populate the 2000A-PRV (Bill-to Taxonomy) segments within the equivalent 837 COB flat fields as follows if the reported taxonomy code is syntactically correct:

a. For PRV01—populate “BI”;

b. For PRV01—populate “PXC”; and

c. For PRV03—populate taxonomy code as derived from the keying of FL 81cc(a) of the UB04 claim form or as derived from the appropriate field from the online DDE screen.

NOTE: The only reason why the 2310A PRV cannot be included on the 837 COB flat file is that the UB04 claim and DDE claim entry screens can only accommodate Bill-to Provider taxonomy code reporting.

11. FISS shall derive information for 2010AA PER 03, PER04, PER05, and PER06 if such information is present on the incoming electronic or paper claim or is available within the contractor’s internal provider files. If the information is **not** available, or is available in incomplete form (i.e., fewer digits than required), the shared system shall **not** create the 2010AA PER loop within the 837 5010 COB institutional flat file.

12a. For the 2320B SBR01, in situations where there is only one (1) payer that is primary to Medicare, FISS shall apply “P” to any payer that is primary before Medicare; “S” for Medicare as the secondary payer; and “U” for all supplemental payers after Medicare.

SPECIAL NOTE: If, for example, a claim contains at least two (2) primary payers before Medicare, FISS shall reflect the first payer as 2320 SBR01= “P”; the second as 2320 SBR01= “S”; and, the tertiary payer, Medicare, as 2320 SBR01=”T.” FISS shall reflect all additional supplemental payers as SBR01= “U.”

12b. For 2000B SBR01 (element 1138), FISS shall apply “P” when Medicare is the primary payer and shall apply “U” for all other supplemental payers after Medicare.

13. For additional 2000B requirements, FISS shall take the following actions:

a. SBR03—map spaces; and

b. SBR09—map “MC” if the COBA ID returned via the BOI reply trailer (29)=70000-79999; for all other COBA IDs, map “ZZ.”

14. The 2010BA loop denotes beneficiary subscriber information. FISS shall populate this loop and accompanying segments within the equivalent 837 COB flat file fields as indicated below.

2010BA NM1—Subscriber Name:

a. NM101—populate “IL”;
b. NM102—populate “1”;
c. NM103—derive from internal beneficiary eligibility file;
d. NM104—derive from internal beneficiary eligibility file;
e. NM105—derive from internal beneficiary eligibility file if available; otherwise populate spaces;
f. NM108—populate “MI”; and
g. NM109—populate HICN.

2010BA N3—Subscriber Address:

a. N301—derive from internal beneficiary eligibility file; and
b. N302—derive, as necessary, from internal beneficiary eligibility file; otherwise populate spaces.

2010BA N4—Subscriber City/State/ZIP Code:

a. N401—derive from internal beneficiary eligibility file;
b. N402—derive from internal beneficiary eligibility file;
c. N403—derive from internal beneficiary eligibility file; and

d. N407—derive if available and applicable from internal beneficiary eligibility file; otherwise populate spaces.

NOTE: *See "Gap-Fill" section for the values to be populated on outbound COBA crossover claims when the individual data content for N401(City) or N402 (State) or N403(Zip/Postal Code) cannot otherwise be derived.*

15. The shared systems shall populate the 2330A (Other Subscriber) NM1, N3, and N4 segments as follows:

2330A—NM1:

a NM101—populate "IL";
b. NM102—populate "1";
c. NM103—derive from internal beneficiary eligibility file;
d. NM104—derive from internal beneficiary eligibility file;
e. NM105—derive from internal beneficiary eligibility file if available; otherwise populate spaces;
f. NM108—populate "MI"; and
g. NM109—populate HICN.

2330A-N3:

a. N301—derive from internal beneficiary eligibility file; and
b. N302—derive, as necessary, from internal beneficiary eligibility file as necessary; otherwise populate spaces.

2330A-N4:

Upon implementation of the 5010 Errata, the shared system shall not attempt to gap-fill or systems-fill any elements (N401—N407) within this segment. Also, if these elements are available but are incomplete, the shared system shall not create the N4 segment tied to loop 2330A within the 837 COB flat file.

a. N401—derive from internal beneficiary eligibility file; and
b. N402, N403, N404, N407—derive from internal beneficiary eligibility file if available and applicable; otherwise populate spaces.

16. The 2010BB loop denotes the payer name. Per the HIPAA Implementation Guide, this loop should define the secondary payer when sending the claim to the second destination payer. Thus, since the payer related to the COBA ID will be unknown by the contractor shared systems, FISS shall format the NM1, N3, and N4 segments as follows, with the COBC completing any missing information:

2010BB—NM1:

a. NM101—populate "PR";
b. NM102—populate "2";
c. NM103---populate spaces;
d. NM108—populate "PI"; and
e. NM109—populate the COBA ID (5 digit COBA ID as obtained from the BOI reply trailer 29).

2010BB-N3 & 2010BB-N4:

a. N301 & N302—populate spaces; and
b. For N401, N402, N403, N404, N407, populate spaces.

17. FISS shall **not** create the 2010AC loop within the 837 5010 COB flat file.

18. If FISS notes the presence of other payers within 2320 SBR and 2330B loops that had made no financial determination on a claim prior to Medicare, as in the case of Medicare secondary payer (MSP) situations, the shared system shall **not** move those loops to the 837 5010 COB institutional flat file. (**NOTE:** The shared system shall continue to populate information as received from the CWF BOI reply trailer (29) within the 2320 SBR and 2330 loops of the associated 837 COB flat file fields.)

19. The 2330B loop denotes other payers for the claim following Medicare. All should note that there will always be one (1) 2330B that denotes Medicare as a payer, with FISS completing all required information for NM101, NM102, NM103, NM108, NM109, as well as the N3 and N4 segments.

20. For additional 2330B loop iterations relating to COB, if the A/B MAC receives multiple COBA IDs via the BOI reply trailer (29), payer information for additional COBA IDs will be unknown. As with the 2010BB loop, the NM1 segment should be formatted as follows, with COBC completing missing information:

2nd and additional iterations of 2330B—NM1:

a. NM101—populate "PR":
b. NM102—populate "2";
c. NM103—populate spaces;
d. NM108—populate "PI"; and
e. NM109—populate the COBA ID (5 digit COBA ID as obtained from the BOI reply trailer 29).

2nd and additional iterations of 2330B-N3 & 2330B-N4:

a. N301 & N302—populate spaces; and
b. For N401, N402, N403, N404, N407, populate spaces.

21. FISS shall always send at least one (1) complete iteration of 2320, 2330A, and 330B on all 837 COB flat files.

22a. FISS shall populate the required 2310-A (Attending Provider Name), 2310B (Operating Physician Name), and 2310C (Other Operating Physician Name) NM1 segments, with information derived from the incoming electronic claim. FISS shall **always** populate the NM108 segment always indicating "XX" and shall derive the NPI from the incoming claim.

22b. If the incoming claim is paper or DDE entered, FISS shall derive the attending, operating, and other operating physician name from the UB04 claim or DDE entry, or as necessary from the contractor's internal provider files. FISS shall always populate the NM108 segment with "XX" and shall derive the NPI from the UB04 claim or DDE entry screen.

23. When the incoming claim is paper UB04 or DDE entered, FISS shall continue with all other mapping practices not otherwise addressed above and now pursued for creation of the outbound "skinny" 837 COB flat file (version 4010-A1) when creating the outbound "skinny" 837 COB flat file (version 5010). [For example, FISS shall continue to derive the discharge hour, admission date/hour, admission source code, medical record number, principal diagnosis, admitting diagnosis code, principal procedure information, occurrence codes, occurrence span codes, value codes, and condition codes from the associated FL fields of the UB04 or from the DDE keyed information.]

24. FISS shall migrate the Line Item Control Number data from the Store and Forward Repository (SFR) to the area of the 837 5010 COB flat file that corresponds to loop 2400, REF02, where REF01=6R, as per the Implementation Guide.

25. Upon implementation of the 5010 Errata changes, FISS shall take the following action with respect to the creation of the field corresponding to 2300 CL101 on the 837 COB flat file as a gap-fill or systems-fill value when necessary:

Map the value "9" (Information Not Available) to the field corresponding to 2300 CL101 on the 837 COB flat file if the incoming claim is received in a claim format other than version 5010, and the CWF BOI reply trailer 29 indicator for "5010" returned to the Medicare contractor for the claim= "T" or "P."

B. 837 Professional COB Claim Mapping Rules

Effective with the testing and implementation of the Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X12-N 837 institutional claim (version 5010), the Multi-Carrier System (MCS, the Part B shared system) and the ViPS Medicare System (VMS, the DME MAC shared system) shall observe the following common business rules for mapping of the 5010 COB (professional) flat file:

1 The following segments shall **not** be passed to the COBC:

a. ISA (Interchange Control Header Segment);
b. IEA (Interchange Control Trailer Segment);
c. GS (Functional Group Header Segment); and
d. GE (Functional Group Trailer Segment).

2. The shared system shall map the claim version *(version 005010X222A1)* in the field of the 837 5010 COB flat file that corresponds to the ST03 segment. (**NOTE:** The shared system shall not take this approach with respect to 4010-A1 claims that it will be transmitting to the COBC during the transitional period.)

3. The BHT02 (Beginning of the Hierarchical Transaction—Transaction Set Purpose Code) shall be passed either with value 00 or 18 under the following circumstances:

a. Normal claims submission to the COBC—use "00"**;** and

b. COBA claims repair process—use "18."

4. The BHT03 (Beginning of the Hierarchical Transaction—Reference Identification or Originator Application Transaction ID) shall contain identifiers populated as follows:

a. 2*3* bytes for non-COBA recovery claims 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—Claim Version Indicator (2 bytes; values=40 for 4010A1 and 50 for 5010 claims);
Byte 22—Test/Production Indicator (1 byte; valid values="T"—test; "P"—production); *and*
Byte 23—Original versus Adjustment Claim Indicator (1 byte)
Valid values:

E—for reprocessed claims that formerly included an electronic prescribing (e-RX) negative adjustment amount;

O—for original claims;

P— for Affordable Care Act or other congressional imperative mass adjustments;

M—for non-Affordable Care Act mass adjustments tied to Medicare Physician Fee Schedule (MPFS);

S—for mass adjustment claims—all others;

R—for RAC adjustment claims, and

A—for routine adjustment claims, not previously classified.

b. 2*3* bytes for COBA recovery claims 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—Claim Version Indicator (2 bytes; values=40 for 4010A1 and 50 for 5010 claims*)*;
Byte 22—COBA recovery indicator (1 byte; indicator =R)*; and*
*Byte 23—Original versus Adjustment Claim Indicator (1 byte) (**NOTE:** See II.B.4.a directly above for valid values.)*

5. The 1000-A PER (Submitter EDI Contact Information) shall be populated as follows:

a. PER01—populate "1C";
b. PER02—populate "COBC EDI Department";
c. PER03—populate "TE"; and
d. PER04—populate "6464586740."

6. The 1000-B loop NM1 (Receiver Name) denotes the crossover trading partner. If the Medicare contractor receives multiple COBA IDs via the BOI reply trailer (29), the shared system shall submit a separate 837 transaction for each COBA ID received. Since crossover trading partner information will be unknown to the standard systems, the shared system shall format the following fields as indicated:

a. NM101—populate "40";
b. NM102—populate "2";
c. NM103—populate spaces;
d. NM108—populate "46"; and
e. NM109—include COBA ID (5-digit COBA ID obtained from the BOI reply trailer 29).

7a. For all 2000A, 2310B, and 2420A PRV (Billing Provider Specialty Information) segments, the Part B and DME MAC shared system shall map the taxonomy code values reported in PRV01 through PRV03 on the incoming electronic claim to the corresponding fields within the 837 COB flat file. If the values reported for these loops on the incoming claim are incomplete or syntactically incorrect, the shared system shall **not** create the loop and associated segments.

7b. The Part B shared system shall continue the practice of only mapping 2420A-level PRV segments if the incoming electronic claim is multi-line, with differing rendering physicians associated to each line. The Part B shared system shall **not** map a 2420A-level reported PRV segment if the incoming electronic claim contains a single detail line.

8. The Part B and DME MAC shared system shall derive information for 2010AA PER 03, PER04, PER05, and PER06 if such information is present and syntactically complete within the contractor's internal provider files. If such information is unavailable or incomplete, the affected shared systems shall **not** create the 2010AA PER loop on the 837 5010 professional COB flat file.

9. The Part B and DME MAC shared system shall derive all provider specific information necessary to populate the NM1 and N3 and N4 segments of such loops as 2010AA, 2010AB, and 2310B from each contractor's internal provider files. In addition, where a provider's tax ID is required within a secondary REF segment, the shared system shall also derive this information from each contractor's internal provider files.

10a. For 2320 SBR01, in situations where there is only one (1) payer that is primary to Medicare, VMS shall apply "P" to any payer that is primary before Medicare; "S" for Medicare as the secondary payer; and "U" for all supplemental payers after Medicare.

SPECIAL NOTE: If, for example, a claim contains at least two (2) primary payers before Medicare, the DME MAC shared system shall reflect the primary payer as 2320 SBR01as "P"; the secondary payer as 2320 SBR01 = "S"; and, the tertiary payer, Medicare, as 2320 SBR01 = "T." MCS shall reflect all additional supplemental payers as 2320 SBR01 = "U."

10b. For 2000B SBR01 (element 1138), the shared system shall apply "P" when Medicare is the primary payer and shall apply "U" for all other supplemental payers after Medicare.

11. For additional 2000B requirements, the shared system shall take the following actions:

a. SBR03—map spaces; and
b. SBR09—If the COBA ID returned via the BOI reply trailer (29)=70000-79999, map "MC"; for all other COBA IDs, map "ZZ."

12. The 2010BA loop denotes beneficiary subscriber information. There are two (2) crossover scenarios o address: Regular, eligibility file-based crossover, and Medigap claim-based crossover.

(1) For regular eligibility file-based crossover (COBA ID=anything except 55000 through 59999), the shared system shall populate the NM1, N3, and N4 segments as follows:

2010BA NM1—Subscriber Name:

a. NM101—populate "IL";
b. NM102—populate "1";
c. NM103—derive from internal beneficiary eligibility file;
d. NM104—derive from internal beneficiary eligibility file;
e. NM105—derive from internal beneficiary eligibility file if available;
otherwise populate spaces;
f. NM108—populate "MI"; and
g. NM109—populate HICN.

2010BA N3—Subscriber Address:

a. N301—derive from internal beneficiary eligibility file; and
b. N302—derive, as necessary, from internal beneficiary eligibility file; otherwise populate spaces.

2010BA N4—Subscriber City/State/ZIP Code:

a. N401—derive from internal beneficiary eligibility file;
b. N402—derive from internal beneficiary eligibility file;

c. N403—derive from internal beneficiary eligibility file; and
d. N407—derive if available and applicable from internal beneficiary eligibility file; otherwise populate spaces.

NOTE: *See "Gap-Fill" section for the values to be populated on outbound COBA crossover claims when the individual data content for N401(City) or N402 (State) or N403(Zip/Postal Code) cannot otherwise be derived.*

(2) *For* Medigap claim-based crossover (COBA ID=55000 through 59999 only), the shared system shall populate the NM1, N3, and N4 segments as follows:

2010BA NM1—Subscriber Name:

a. NM101—populate "IL";
b. NM102—populate "1";
c. NM103—derive from internal beneficiary eligibility file;
d. NM104—derive from internal beneficiary eligibility file;
e. NM105—derive from internal beneficiary eligibility file if available; otherwise populate spaces;
f. M108—populate "MI"; and
g. M109—populate beneficiary policy number as derived from Item 9-D of Form CMS-1500 claim or 2330B NM109 of the incoming 837 professional claim. The shared system shall only populate HICN here if the policy number is unavailable on the incoming claim.

2010BA N3—Subscriber Address:

a. N301—derive from internal beneficiary eligibility file;
b. N302—derive, as necessary, from internal beneficiary eligibility file; otherwise populate spaces.

2010BA N4—Subscriber City/State/ZIP Code:

a. N401—derive from internal beneficiary eligibility file;
b N402—derive from internal beneficiary eligibility file;
c. N403—derive from internal beneficiary eligibility file; and
d. N407—derive, if available, from internal beneficiary eligibility file; otherwise populate spaces.

NOTE: *See "Gap-Fill" section for the values to be populated on outbound COBA crossover claims when the individual data content for N401(City) or N402 (State) or N403(Zip/Postal Code) cannot otherwise be derived.*

13. The shared system shall populate the 2330A (Other Subscriber) NM1, N3, and N4 segments as follows:

2330A—NM1:

a. NM101—populate "IL";
b. NM102—populate "1";
c. NM103—derive from internal beneficiary eligibility file;
d. NM104—derive from internal beneficiary eligibility file;
e. NM105—derive from internal beneficiary eligibility file if available; otherwise populate spaces;
f. NM108—populate "MI"; and
g. NM109—populate HICN.

2330A-N3:

a. N301—derive from internal beneficiary eligibility file; and
b. N302—derive, as necessary, from internal beneficiary eligibility file as necessary; otherwise populate spaces.

2330A-N4:

Upon implementation of the 5010 Errata, the Part B and DME MAC shared systems shall not attempt to gap-fill or systems-fill any elements (N401—N407) within this segment. Also, if these elements are available but are incomplete, the shared systems shall not create the N4 segment tied to loop 2330A within the 837 COB flat file.

a. N401—derive from internal beneficiary eligibility file; and
b. N402, N403, N404, N407—derive from internal beneficiary eligibility file if available and applicable; otherwise populate spaces.

14. The 2010BB loop denotes the payer name. Per the HIPAA Implementation Guide, this loop should define the secondary payer when sending the claim to the second destination payer. Thus, since the payer related to the COBA ID will be unknown by the contractor shared systems, the shared system shall format the NM1, N3, and N4 segments as follows, with the COBC completing any missing information:

2010BB—NM1:

a. NM101—populate "PR";
b. NM102—populate "2";
c. NM103—populate spaces;
d. NM108—populate "PI"; and
e. NM109—populate the COBA ID (5 digit COBA ID as obtained from the BOI reply trailer 29).

2010BB-N3 & 2010BB-N4:

a. N301 & N302—populate spaces; and
b. For N401, N402, N403, N404, N407, populate spaces.

15. The shared system shall **not** create the 2000C or the 2010CA loops within the 837 5010 professional COB flat file.

16. If the shared system notes the presence of other payers within 2320 SBR and 2330B loops that had made no financial determination on a claim prior to Medicare, as in the case of Medicare secondary payer (MSP) situations, the shared system shall **not** move those loops to the 837 5010 COB professional flat file.

17. The 2330B loop denotes other payers for the claim following Medicare. There will always be one (1) 2330B that denotes Medicare as a payer, with the shared system completing all required information for NM101, NM102, NM103, NM108, NM109, as well as the N3 and N4 segments.

18. For additional 2330B loop iterations relating to COB, if the Medicare contractor receives multiple COBA IDs via the BOI reply trailer (29), payer information for additional COBA IDs will be unknown. As with the 2010BB loop, the shared system shall format the NM1 segment as follows, with COBC completing missing information:

2nd and additional iterations of 2330B—NM1:

a. NM101—populate "PR";
b. NM102—populate "2";

c. NM103—populate spaces;

d. NM108—populate "PI"; and

e. NM109—populate the COBA ID (5 digit COBA ID as obtained from the BOI reply trailer 29).

2nd and additional iterations of 2330B-N3 & 2330B-N4:

a. N301 & N302—populate spaces; and
b. For N401, N402, N403, N404, N407, populate spaces.

19. The shared system shall always send at least one (1) complete iteration of 2320, 2330A, and 2330B on all 837 COB flat files.

20. For 2300 REF (4081-Mandatory Crossover Indicator), the shared system shall take the action indicated below in accordance with the applicable scenario:

a. REF01, always map "F5";

b. REF02, map "Y" if the COBA ID returned via the BOI reply trailer (29)=55000 through 55999 (Medigap claim-based crossover); and

c. REF02, map "N" if the COBA ID returned via the BOI reply trailer (29) =anything except for 55000 through 55999 (regular crossover).

Additional Mapping Requirements When Incoming Claim is Paper/Hard-Copy

****IMPORTANT: The shared system shall create an outbound 5010 "skinny" claim, as derived from paper/hard copy claim input, in the same manner that it now does when creating an outbound 4010-A1 "skinny" claim unless otherwise specified above or below.**

1. The shared system shall **always** map NDC codes keyed from hard-copy claims to the field that corresponds to 2410 LIN03 on the 837 5010 COB professional flat file and shall discontinue the practice of mapping the NDC code to the equivalent flat file field that corresponds to 2300 NTE-02. In addition, the shared system shall auto-plug the appropriate qualifier that designated NDC within the field that corresponds to 2410 LIN02.

2. If the incoming paper claim contains an NPI in block 32 of the CMS-1500, the shared system shall continue to utilize this keyed value for purposes of deriving the information necessary to populate all required segments associated with 2310C (Service Facility Name). The shared system shall continue to not create the 2310C loop if block 32 on the incoming paper claim is blank.

3. If the incoming claim is paper and does **not** contain information necessary to derive 2410 CTP5-1 (in association with Part B drugs), the shared system shall auto-plug the value "F2."

III. Gap-Filling Requirements for 837 5010 COB Files

A. 837 Institutional COB Claims

1. For all instances of the N403 segment, where created, the Part A shared system (FISS) shall ensure that it creates a 5-byte base ZIP code and additional 4-byte component for the COB flat file when required.

2. The Part A shared system shall universally gap-fill or system*s*-fill required *individual* address *elements*, when not otherwise obtainable, for *Subscriber-related* loops as follows:

N401 (City Name) = Cityville;
N402 (State or Province Code) = MD; and
N403 (Postal Zone/ZIP Code) = 96941.

NOTE: *The above is particularly applicable in the creation of the indicated segments within the 2010BA loop when the needed data are individually not otherwise unavailable.*

3. The Part A shared system shall gap-fill the +4 ZIP code component with 9998 when the actual +4 ZIP code component is unavailable when creating the N403 in association with loops 2010AA (Billing Provider) and 2310E (Service Facility). (**NOTE:** The full 9-byte ZIP code is required **only** for the N403 segment of the indicated loops.)

4. The Part A shared system shall *never* input "0000" as a gap-fill or system-fill +4 ZIP code in association with any of the N403 segments.

5a. If the shared system has valid city, state, and 5-byte ZIP code information available, it shall only gap-fill or system-fill the +4 ZIP code component, where required, with "9998" when creating outbound 837 COB claim files.

5b. The shared system shall continue to send full ZIP code content (9-bytes) on outbound 837 COB claim files, if available, for creation of situational N403 segments.

6. When the shared system determines that it has data within its internal provider file to populate 2010AA PER 04, it shall **only** move that information to the corresponding flat file field if the available data are complete. If the available data are incomplete (i.e., fewer than 10 digits for telephone number), the shared system shall **not** attempt to gap-fill the missing digits. The shared system shall also not create that PER segment.

7. With respect to 2010BA N301 and 2330A N301, when the contractor's internal beneficiary eligibility record contains blank or incomplete line-1 street address information, FISS shall apply "Xs" to satisfy the minimum length requirements of the N301 segments.

8. If the incoming claim is paper UB04 or DDE-entered and the dosage information necessary to populate 2410 CTP05-1 is not available, FISS shall always default to the value of "F2."

9. If the incoming claim is paper or electronic, FISS shall map "non-specific procedure code" within the 837 5010 COB flat file field that corresponds to loop 2400 SV202-7 (non-specific composite medical procedure description) if a non-specific procedure code description is required, as per the Implementation Guide, and the associated procedure code is defined as "not otherwise classified." (See the following link for the latest listing of not otherwise classified procedure codes: <http://www.cms.hhs.gov/apps/ama/license.asp?file=/HospitalOutpatientPPS/Downloads/CY2009_Unlisted_Codes.zip>.)

*10. FISS shall **not** attempt to gap-fill or systems-fill the N4 segment (now situational) within the field corresponding to loop 2330B on the 837 COB flat file. In addition, if information needed to create the N4 segment is available but is incomplete, FISS shall not create the loop 2330B N4 segment.*

*11. FISS shall **not** attempt to gap-fill or systems-fill any of the composite SVD03 elements within loop 2430.*

B. 837 Professional COB Claims

1. For all instances of the N403 segment, where created, the Part B and DME MAC shared systems shall ensure that it creates a 5-byte base ZIP code and additional 4-byte component for the COB flat file when required.

2. The Part B and DME MAC shared systems shall universally gap-fill or system-fill required *individual* address *elements*, when not otherwise obtainable, for all *Subscriber-related* loops as follows:

N401 (City Name) = Cityville;
N402 (State or Province Code) = MD; and
N403 (Postal Zone/ZIP Code) = 96941.

NOTE: *The above is particularly applicable in the creation of the indicated segments within the 2010BA loop when the needed data are individually otherwise not unavailable.*

3. The Part B and DME MAC shared systems shall gap-fill the +4 ZIP code component with 9998 when the actual +4 ZIP code component is unavailable when creating the N403 in association with loops 2010AA (Billing Provider), 2310C (Service Facility—claim level), and 2420C (Service Facility—service line level). (**NOTE:** The full 9-byte ZIP code is required **only** for the N403 segment of the indicated loops.)

4. The Part B and DME MAC shared systems shall *never* input "0000" as a gap-fill or system-fill +4 ZIP code in association with any of the N403 segments.

5a. If the Part B and DME MAC shared systems have valid city, state, and 5-byte ZIP code information available, they shall only gap-fill or system-fill the +4 ZIP code component, where required, with "9998" when creating outbound 837 COB claim files.

5b. The Part B and DME MAC shared system shall continue to send full ZIP code content (9-bytes) on outbound 837 COB claim files, if available, for creation of situational N403segments

6. When the shared system determines that it has data within its internal provider file to populate 2010AA PER 04, it shall **only** move that information to the corresponding flat file field if the available data are complete. If the available data are incomplete (i.e., fewer than 10 digits for telephone number), the shared system shall not attempt to gap-fill the equivalent field on the 5010 COB flat file.

7. With respect to 2010BA N301 and 2330A N301, when the contractor's internal beneficiary eligibility record contains blank or incomplete line-1 street address information, the shared system shall apply "Xs" to satisfy the minimum length requirements of the N301 segments.

8a. In association with paper-submitted Part B ambulance claims, the Part B shared system shall apply gap-filling to the N3 and N4 portions of loop 2310E and 2310F as follows for the segments indicated:

For N301: The Part B shared system shall map "Xs" to the **minimum** standard required for the field.

For N401—N403: The Part B shared system shall undertake the following actions:

a. N401 (City)—populate "Cityville";
b. N402 (State Code)—populate "MD"; and
c. N403 (Postal Zone/ZIP Code)—populate "96941."

8b. In addition, the Part B shared system shall gap-fill the required +4 component of ZIP code (N403 segment) with 9998 **only** in association with loops 2010AA, 2310C, and 2420C.

9. The shared system shall map "UN" in the 837 5010 COB flat file field that corresponds to loop 2410 (CTP) and segment CPT04 only when the 2410 (CTP) CTP04 segment is either blank or contains a non-valid value.

10. The shared system shall apply the gap-fill value "X" to the field corresponding to loop 2430 (SVD) and segment SVD03-2 in situations where the value on the incoming claim is either missing or non-valid.

11. The Part B shared system shall discontinue the process of gap-filling diagnosis code information within loop 2300 HI in association with ambulance claims that ambulance suppliers file to Medicare on paper.

12a. Following adjudication of both electronic and paper billed claims, the shared system shall discontinue the practice of applying gap-fill values of all "9s" within the 837 5010 COB flat file field that corresponds to 2410 LIN03 if the incoming claim contains an incomplete or non-valid national drug code (NDC). If an incoming paper claim contains a syntactically non-valid NDC code that the Medicare contractor subsequently keys, the shared system shall not attempt to gap-fill the field that corresponds to 2410 LIN03 on the 837 5010 COB flat file.

12b. The DME MAC shared system shall gap-fill the loop 2430 (SVD) SVD03-2 segment with "S5000" or "S5001," as appropriate, in situations where the incoming claim contains an NDC within the 2410 LIN02 that does not correspond to a HCPCS on the NDC/HCPCS crosswalk.

13. If the incoming claim is paper and contractor's internal provider file contains incomplete information necessary to populate the 2310C loop (in cases where required), the shared system shall gap-fill all required segments with "Xs." NOTE: The shared system shall discontinue the practice of mapping "submitted but not forwarded" as a gap-fill convention in this situation for segments where information is required.

14. If the incoming claim is paper or electronic, FISS shall map "non-specific procedure code" within the 837 5010 COB flat file field that corresponds to loop 2400 SV202-7 (non-specific composite medical procedure description) if a non-specific procedure code description is required, as per the Implementation Guide, and the associated procedure code is defined as "not otherwise classified." (See the following link for the latest listing of not otherwise classified procedure codes: <http://www.cms.hhs.gov/apps/ama/license.asp?file=/HospitalOutpatientPPS/Downloads/CY2009_Unlisted_Codes.zip>.)

15. The Part B shared system shall utilize the claim's earliest service date to satisfy the requirement for 2300 DTP03 (date of admission), where required, in association with claims whose place of service code is 21, 51, or 61.

16. The Part B shared system shall populate 99 as a gap-fill/default value for loop 2300 (CLM) segment CLM05-1 (Facility Type Code) within the corresponding field of the 837 5010 COB flat file.

17. For ambulance claims, the Part B shared system shall map LB in the 837 5010 COB flat file field the corresponds to 2400 CR101 if that field would otherwise contain spaces where there is a value (weight) present in 2400 CR102.

18. Also, for ambulance claims, the Part B system shall produce spaces in the field that corresponds to loop 2400 CR101 when loop 2400 CR102 on the incoming claim is blank.\

*19. All shared systems shall **not** attempt to gap-fill or systems-fill the N4 segment (now situational) within the field corresponding to loop 2330B on the 837 COB flat file. In addition, if information needed to create the N4 segment is available but is incomplete, the shared systems shall **not** create the loop 2330B N4 segment.*

IV. Other 837 5010 COB Requirements

A. Complementary Credits

Upon receipt of a Beneficiary Other Insurance (BOI) reply trailer (29) that contains a "P" 837 5010 indicator, the shared systems shall ensure that their affiliate contractors are able to: 1) book complementary credits for the affected claim; and 2) transmit the "production" claim to the COB Contractor (COBC) after it has finalized on the contractor's payment floor.

Following receipt of a BOI reply trailer (29) that contains a "T" 837 5010 indicator, the shared systems shall ensure that their affiliate contractors: 1) do **not** book complementary credits for that version of the claim; and 2) transmit the "test" claim to the COBC after it has finalized on the contractor's payment floor.

All shared systems shall, in addition, **not** book complementary credits in association with their affiliated contractors' receipt of a CWF BOI reply trailer (29) that contains either an "N" 4010-A1 Test/Production indicator or an "N" 5010 indicator.

B. Coordination of Benefits Contractor (COBC) Business-Level Editing of Incoming 5010 COB Flat Files

With the implementation of the 5010 claim standards, the COBC will apply business level edits to ensure that incoming claims possess the structure necessary for successful translation into the HIPAA ANSI X12-N 837 version 5010 claim formats. See §70.6.1.1 of this chapter for charts that define the "111" level errors that COBC will return to the Medicare contractors when their incoming 837 COB flat files cannot be utilized to build compliant outbound 837 claim transactions.