CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3004	**Date: August 1, 2014**
	Change Request 8731

NOTE: This Transmittal is no longer sensitive and is being re-communicated April 7, 2015. The Transmittal Number, date of Transmittal and all other information remains the same. This instruction may now be posted to the Internet.

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

I. SUMMARY OF CHANGES: Through this change request, the Centers for Medicare & Medicaid Services (CMS) ensures that the shared systems maintainers will modify one element within the outbound 837 crossover claim format that takes into account the recent Benefits Coordination & Recovery Center (BCRC) contract award. Additionally, CMS will implement changes to the values reflected in the outbound 837 crossover claims format to mitigate current Health Insurance Portability and Accountability Act (HIPAA) compliance issues.

EFFECTIVE DATE: January 1, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 5, 2015

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	28/70.6.5/ Coordination of Benefits Agreement (COBA) ASC X12 837 Coordination of Benefits (COB) Mapping Requirements as of July 2012

III. FUNDING:
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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 3004	Date: August 1, 2014	Change Request: 8731

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

EFFECTIVE DATE: January 1, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 5, 2015

I. GENERAL INFORMATION

A. Background: As previously communicated, the Centers for Medicare & Medicaid Services (CMS) recently awarded its Benefits Coordination & Recovery Center (BCRC) contract to Group Health Incorporated. In addition to other activities, the BCRC has administrative responsibility for the national Coordination of Benefits Agreement (COBA) Medicare crossover process. Therefore, CMS will modify the "Submitter EDI Contact Information--Name" to ensure that "BCRC EDI Department" will now be reflected on all Health Insurance Portability and Accountability Act (HIPAA) 837 crossover claims transmitted to Coordination of Benefits Agreement (COBA) trading partners.

Like all HIPAA covered entities, CMS must produce electronic transactions that meet the compliance requirements found in the Technical Reports Version 3 (TR3) Implementation Guides. In accordance with those sources, CMS recognizes that the value "ZZ" (which means mutually defined) may be used in both the 2000B SBR09 and 2320 SBR09 segments of outbound HIPAA 837 crossover claims. However, the current practice of including the value ZZ where mentioned is contributing to problems involving the 835 Electronic Remittance Advices (ERAs) created by our COBA trading partners. Specifically, the current practice is enabling the applied use of "ZZ" in the 2100 CLP06 segment of the ERA by COBA trading partners. This, in turn, hinders billing vendors representing providers, physicians, and suppliers in their efforts to determine which contracted portion of an insurer entity (participating provider organization *versus* point of service *versus* indemnity plan option) is making payment to their clients. CMS develops a work-around to address this matter via this instruction.

Through Request for Information number 1786, the X12 Committee has indicated that, in its judgment, the 1-byte value reflected in 2300 CLM09 should not differ from the value reflected in 2320 OI06 on outbound 837 crossover claims. The maintainers of BCRC's edit validator, not unlike the maintainers of many other HIPAA validation products, also believe that the values in 2300 CLM09 and 2320 OI06 need to be the same. If the values are not the same, BCRC applies edit H46248 to the incoming 837 crossover claim; consequently, BCRC does not transmit the affected crossover claims to our COBA trading partners. CMS addresses the key problem contributing to edit H46248 through this instruction.

Currently in accordance with Common Working File (CWF) requirements, the BCRC sets the byte length for the "Beneficiary Supplemental ID Number" that it transmits to the CWF via the Health Utilization Beneficiary Other Insurance (HUBO) maintenance transaction to 10 bytes. Through this instruction, CMS will modify the HUBO and CWF BOI detail (BOID) screen so that up to 25 bytes can be transmitted to

CWF and displayed fully for external viewing.

B. Policy: The shared systems shall map "BCRC EDI Department" in the 1000A PER02 segment of all outbound HIPAA 837 crossover claims that they create and transmit to the BCRC.

The shared systems shall map the value "CI" (commercial insurance) in the 2000B SBR09 (Claim Filing Indicator Code) segment of their outbound 837 COB/crossover claims when they receive a 5-byte COBA identifier (ID) via the Beneficiary Other Insurance (BOI) reply trailer 29 that falls within the following COBA ID ranges: 00001--69999 and 80000-89999. Additionally, in creating the HIPAA 837 institutional and professional coordination of benefits (COB)/crossover claim, the shared systems shall ensure that any 2320 SBR09 (Claim Filing Indicator Code) segments created to qualify other supplemental payers included in 2330B will also contain "CI" in accordance with the COBA ID ranges 00001--69999 and 80000-89999. The shared systems shall continue to map "MC" in the 2000B SBR and 2320 SBR09 segments created within their outbound 837 COB/crossover claims when the destination payer or other supplemental payer is Medicaid (70000-78999) or the Medicaid Quality Project (79000-79999).

The shared systems shall ensure that the value received in 2300 CLM09 is the same value reflected in 2320 OI06 on all outbound 837 COB/crossover claims.

CWF shall modify the byte length of the Beneficiary Supplemental ID Number field within the HUBO maintenance transaction that the BCRC transmits to the CWF host sites from 10 to 25 bytes. The BCRC shall also modify its HUBO transaction accordingly. Additionally, CWF shall modify the Health Insurance Master Record (HIMR) BOID display screen to ensure that the "Identification Number" field will accommodate up to 25 bytes.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8731.1	The shared systems shall map "BCRC EDI Department" in the 1000A PER02 segment of all outbound HIPAA 837 crossover claims that they create and transmit to the BCRC.					X	X	X		
8731.2	The shared systems shall map the value "CI" (commercial insurance) in the 2000B SBR09 (Claim Filing Indicator Code) segment of their outbound 837 COB/crossover claims when they receive a 5-byte COBA identifier (ID) via the Beneficiary Other Insurance (BOI) reply trailer 29 that falls within the following COBA ID ranges: 00001--69999 and 80000-89999.					X	X	X		
8731.2.1	Additionally, in creating outbound HIPAA 837 institutional and professional COB/crossover claims, the shared systems shall ensure that any 2320 SBR09 segments created to qualify other supplemental payers					X	X	X		

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	reported in 2330B will also contain the value "CI" if the COBA ID ranges received via the CWF BOI reply trailer 29 equal 00001--69999 and 80000-89999.									
8731.2.2	The shared systems shall continue to map "MC" in the 2000B SBR and 2320 SBR09 segments created within their outbound 837 COB/crossover claims when the destination payer or other supplemental payer is Medicaid (70000-78999) or the Medicaid Quality Project (79000-79999).					X	X	X		
8731.3	The shared systems shall ensure that the value received in 2300 CLM09 is the same value reflected in 2320 OI06 on all outbound 837 COB/crossover claims.						X	X		
8731.4	CWF shall modify the byte length of the Beneficiary Supplemental ID Number field within the HUBO maintenance transaction that the BCRC transmits to each CWF host site from 10 to 25 bytes.								X	
8731.4.1	The BCRC, representing the COBA process, shall also modify its HUBO transaction to ensure that it will transmit values up to 25 bytes in the Beneficiary Supplemental ID Number field.									COBA
8731.4.2	CWF shall modify the HIMR BOID display screen to ensure that the "Identification Number" field will accommodate up to 25 bytes.								X	
8731.4.3	The Next Generation Desktop (NGD) application shall be modified, as necessary, to ensure that up to 25 bytes of the "Identification Number" field, as found on the HIMR BOID screen, will be displayed.									NGD

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes 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 Regional Coordinator.

VI. FUNDING

Section A: 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 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.

ATTACHMENTS: 0

70.6.5 - Coordination of Benefits Agreement (COBA) ASC X12 837 Coordination of Benefits (COB) Mapping Requirements as of July 2012

(Rev. 3004, Issued: 08-01-14, Effective: 01-01-15, Implementation: 01-05-15)

I. Health Insurance Portability and Accountability Act (HIPAA) 837 current, in use version to HIPAA future version COB Transitional Period Requirements

During the ASC X12 837 transitional period, the shared systems shall accommodate the multi-faceted scenarios that follow below each broad category with respect to creation of ASC X12 837 COB flat files.

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

Scenario 1: During the ASC X12 837 future version transitional period, if a provider, physician/practitioner, or supplier submits a HIPAA ASC X12 837 future version institutional or professional claim to an A/B MAC or DME MAC and if that entity receives a CWF BOI reply trailer (29) that contains a "P" current, in use version Test/Production indicator and a "T" future version indicator, the affected shared systems shall: 1) produce a "skinny" non- *store-and-forward (*SFR) "production" claim in the current, in use version ASC X12 837 COB flat file for transmission to the *Benefits Coordination and Recovery Center (BCRC)*; and 2) produce an ASC X12 837 future version "test" COB flat file that contains a claim with full SFR content for transmission to the *BCRC.*

Scenario 2: If a provider, physician/practitioner, or supplier submits a HIPAA ASC X12 837 future version institutional or professional claim to an A/B MAC or DME MAC and if that entity receives a CWF BOI reply trailer (29) that contains a "P" current, in use version Test/Production indicator and an "N" future version indicator, the affected shared systems shall: 1) produce a "skinny" non-SFR "production" claim in the ASC X12 current, in use version 837 COB flat file for transmission to the *BCRC* ; and 2) produce nothing in terms of an ASC X12 837 future version COB flat file.

Scenario 3: If a provider, physician/practitioner, or supplier submits a HIPAA ASC X12 837 future version institutional or professional claim to an A/B MAC or DME MAC and if that entity receives a CWF BOI reply trailer (29) that contains an "N" current, in use version Test/Production indicator and a "T" future version indicator, the affected shared system shall: 1) produce nothing in terms of a current version ASC X12 837 COB flat file; and 2) produce a future version "test" claim with full SFR content for COBA testing purposes.

Scenario 4: If a provider, physician/practitioner, or supplier submits a HIPAA ASC X12 837 future version institutional or professional claim to an A/B MAC or DME MAC and if that entity receives a CWF BOI reply trailer (29) that contains an "N" current, in use version Test/Production indicator and a "P" future version indicator, the affected shared system shall: 1) produce nothing in terms of a current, in use version ASC X12 837 COB flat file; and 2) produce a "production" future version claim with full SFR content for COBA "production" purposes.

(**NOTE:** Scenario 4 will be the profile of a COBA trading partner that has cut-over to the future version ASC X12 837 COB production.)

INCOMING HIPAA ASC X12 837 CURRENT, IN USE VERSION CLAIMS IN ASSOCIATION WITH COBA TRADING PARTNER COB FORMAT SPECIFICATIONS

Scenario 1: During the transitional period, if a provider, physician/practitioner, or supplier submits an ASC X12 837 current version institutional or professional claim to an A/B MAC (A, *HHH*) or DME MAC and if that entity receives a CWF (BOI reply trailer (29) that contains a "P" current version Test/Production indicator and a "T" future version indicator, the affected shared systems shall: 1) create an 837 COB flat file that contains full current version store-and-forward (SFR) content for the "production" claim for transmission to the *BCRC*; and 2) create a "skinny" non-SFR claim in the future version ASC X12 837 COB flat file format for the "test" future version claim and transmit the file to the *BCRC*.

Scenario 2: If a provider, physician/practitioner, or supplier submits an ASC X12 837 current version institutional or professional claim to an A/B MAC (A, *HHH*) or DME MAC, as appropriate, and if that entity receives a CWF BOI reply trailer (29) that contains a "P" current version Test/Production indicator and an "N" future version indicator, the affected shared systems shall: 1) create an 837 COB flat file that contains full SFR content for the "production" claim; and 2) create nothing in terms of a future version COB claim.

Scenario 3: If a provider, physician/practitioner, or supplier submits an ASC X12 837 current version institutional or professional claim to an A/B MAC (A, *HHH*) or DME MAC and if that entity receives a CWF BOI reply trailer (29) that contains an "N" current version Test/Production indicator and a "T" future version indicator, the affected shared systems shall: 1) create nothing in terms of a current use version COB claim; and 2) create a "test" future version non-SFR COB claim.

Scenario 4: If a provider, physician/practitioner, or supplier submits an ASC X12 837 current version institutional or professional claim to an A/B MAC (A, *HHH*) or DME MAC and if that entity receives a Common Working File (CWF) Beneficiary Other Insurance (BOI) reply trailer (29) that contains an "N" current version Test/Production indicator and a "P" future version indicator, the affected shared systems shall: 1) create nothing in terms of a current version COB claim; and 2) create a "production" future version 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 future version "skinny" claim, without SFR content, when a claim that an A/B MAC or DME MAC originally adjudicated in the current version format is later released from suspense status or is adjusted during a time frame when a COBA trading partner has moved to the ASC X12 837 future version production (that is, the BOI reply trailer 29 contains a "P" future version Test/Production indicator).

In addition, as of the mandatory cutover date to the future version claim transaction, all shared systems shall have the capability of repairing claims that previously errored out in the current version format prior to the cutover date, doing so in the future version 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, physician/practitioner, or supplier submits a hard-copy claim (paper Form CMS-1450 or Form CMS-1500) or, as applicable, enters a direct-data-entry (DDE) claim to an A/B MAC (A, *HHH*) or DME MAC and if that entity receives a 29 that contains a "P" current version Test/Production indicator and a "T" future version indicator, the affected shared system shall: 1) produce a "skinny" non-SFR current version "production" COB claim; and 2) produce a "skinny" non-SFR future version "test" COB claim.

Scenario 2: If a provider, physician/practitioner, or supplier submits a hard-copy claim (paper Form CMS-1450 or Form CMS-1500) or, as applicable, enters a DDE claim to an A/B MAC (A, *HHH*) or DME MAC and if that entity receives a CWF BOI reply trailer (29) that contains a "P" current version Test/Production indicator and an "N" future version indicator, the affected shared system shall: 1) produce a "skinny" non-SFR current version "production" COB claim; and 2) produce nothing in terms of a future version COB claim.

Scenario 3: If a provider, physician/practitioner, or supplier submits a hard-copy claim (paper Form CMS-1450 or Form CMS-1500) or, as applicable, enters a DDE claim to an A/B MAC (A, *HHH*) or DME MAC and if that entity receives a CWF BOI reply trailer (29) that contains an "N" current version Test/Production indicator and a "T" future version indicator, the affected shared system shall: 1) produce nothing in terms of a current version claim; and 2) produce a "skinny' non-SFR future version "test" COB claim.

Scenario 4: Finally, if a provider, physician/practitioner, or supplier submits a hard-copy claim (paper Form CMS-1450 or Form CMS-1500) or, as applicable, enters a DDE claim to an A/B MAC (A, *HHH*) or DME MAC and if that entity a CWF BOI reply trailer (29) that contains an "N" current version Test/Production indicator and a "P" future version indicator, the affected shared system shall: 1) produce nothing in terms of a current version COB claim; and 2) produce a "skinny" non-SFR future version "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 A/B MACs' or DME MACs' ASC X12 837 COB flat file transmissions to the *BCRC*.

II. General ASC X12 837 COB Flat File Mapping Requirements (Effective July 2012)

A. ASC X12 837 Institutional COB Claim Mapping Rules

Effective with the testing and implementation of the HIPAA ASC X12 837 institutional claim (new and now current version), the *Part A shared system* shall observe the following business rules for mapping of the ASC X12 837 COB (institutional) flat file:

1. The following segments shall **not** be passed to the *BCRC*:
   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 ASC X12 837 5010 COB flat file that corresponds to the ST03 segment.
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 *BCRC*—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—A/B MAC (A or HH) ID (9 bytes; A/B MAC (A or HH) ID, or, 5 bytes left justified, followed by 4 spaces);
   Bytes 10-14—Julian Date (5 bytes, expressed as "YYDDD");
   Bytes 15-19—Sequence Number (5 bytes, starting with "00001"; should increment for each ST-SE envelope);
   Bytes 20-21—Claim Version Indicator (2 bytes; value =50 for 5010 claims); and
   Byte 22—Test/Production Indicator (1 byte; valid values="T"—test; "P"—production).
   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;
   A—for routine adjustment claims, not previously classified;
   C— CMS directed mass adjustment action (use specified by CMS); and
   V—Void/cancel only claims.

   b. 23 bytes for COBA recovery claims as follows:
   Bytes 1-9—A/B MAC (A or HH) ID (9 bytes; A/B MAC (A or HH) ID, or, 5 bytes left justified, followed by 4 spaces);
   Bytes 10-14—Julian Date (5 bytes, expressed as "YYDDD");

Bytes 15-19—Sequence Number (5 bytes, starting with "00001"; should increment for each ST-SE envelope);
Bytes 20-21—Claim Version Indicator (2 bytes; values=50 for 5010 claims); and
Byte 22—COBA recovery indicator (1 byte; indicator =R).
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 "*BCRC* 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 (A, *HHH*) 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 shared systems, the shared systems shall format the following fields as indicated:
   a. NM101—populate "40";

   b. NM102—populate "2";

   c. NM103—populate spaces (*BCRC* 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), *the Part A shared system* 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 A/B MAC (A or HH)'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, *the Part A shared system* shall derive the required segments from the A/B MAC (A or HH)'s internal provider file.

7b. If the incoming claim is paper Form CMS-1450 or DDE, which is treated as paper, *the Part A shared system* shall complete the 2010AA NM1 (Billing Provider Name segments as follows:
   a. NM101—populate "85";

   b. NM102—populate "2";

   c. NM103—derive from the A/B MAC (A or HH)'s internal provider file;

   d. NM108—populate "XX"; and

   e. NM109—derive NPI from Form Locator (FL) 56 of the Form CMS-1450 claim or

applicable DDE field.

For 2010AA N3 and N4 segments, *the Part A shared system* shall derive the required segments from FLs 1 and 2 of the Form CMS-1450 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 A/B MAC (A or HH)'s internal provider file.

For 2010AB N3 and N4 segments, *the Part A shared system* shall derive the required segments from the A/B MAC (A or HH)'s internal provider file.

8b. If the incoming claim is paper Form CMS-1450 or DDE, which is treated as paper, *the Part A shared system* 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, *the Part A shared system* shall derive the required segments from the A/B MAC (A or *H*HH)'s internal provider file as necessary.

9. *The Part A shared system* 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 A/B MAC (A or *H*HH)'s internal provider file.

10a. For the 2000A and 2310-PRV in association with incoming electronic claims, *the Part A shared system* shall map the PRV01, PRV02, and PRV03 segments (which have already been validated for syntactical correctness at each affiliate A/B MAC (A or *H*HH)'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 Form CMS-1450 or DDE-entered, *the Part A shared system* 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 Form CMS-1450 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 Form CMS-1450 claim and DDE claim entry screens can only accommodate Bill-to Provider taxonomy code reporting.

11. *The Part A shared system* 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 A/B MAC (A or *H*HH)'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 new current version COB institutional flat file.

12a. For the 2320 SBR01, in situations where there is only one (1) payer that is primary to Medicare, *the Part A shared system* 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 Part A shared system* shall reflect the first payer as 2320 SBR01= "P"; the second as 2320 SBR01= "S"; and, the tertiary payer, Medicare, as 2320 SBR01="T." *The Part A shared system* shall reflect all additional supplemental payers as SBR01= "U."

Additionally, effective January 5, 2015, when creating COBA 837 crossover claims, the

Part A shared system shall populate the 2320 SBR09, as associated to the 2330B loop segments created for "other supplemental payers," with the value "CI" if the COBA IDs for these payers falls within the ranges of 00001—69999 and 80000—89999. The shared system shall continue to map "MC" in 2320 SBR09 when for Medicaid.

12b. For 2000B SBR01 (element 1138), *the Part A shared system* 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, *the Part A shared system* 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 (ranges 00001—69999 and 80000-89999)*, map "*CI*."

14. The 2010BA loop denotes beneficiary subscriber information. *The Part A shared system* 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 Part A 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 A* 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 ASC X12 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 A/B MAC (A, *H*HH) shared systems, *the Part A shared system* shall format the NM1, N3, and N4 segments as follows, with the *BCRC* 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. *The Part A shared system* shall not create the 2010AC loop within the 837 new version COB flat file.
18. If *the Part A 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 new version COB institutional flat file. (**NOTE:** The *Part A* 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 ASC X12 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 *the Part A shared system* 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 *BCRC* 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. *The Part A shared system* shall always send at least one (1) complete iteration of 2320, 2330A, and 330B on all ASC X12 837 COB flat files.

22a. *The Part A shared system* 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. *The Part A shared system* 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, *the Part A shared system* shall derive the attending, operating, and other operating physician name from the Form CMS-1450 claim or DDE entry, or as necessary from the A/B MAC (A or *H*HH)'s internal provider files. *The Part A shared system* shall always populate the NM108 segment with "XX" and shall derive the NPI from the Form CMS-1450 claim or DDE entry screen.

23. When the incoming claim is paper, Form CMS-1450 or DDE- entered, *the Part A shared system* shall continue with all other mapping practices not otherwise addressed above when creating the outbound "skinny" 837 COB flat file. [For example, *the Part A shared system* 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 Form CMS-1450 or from the DDE keyed information.]

24. *The Part A shared system* shall migrate the Line Item Control Number data from SFR to the area of the ASC X12 837 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, *the Part A shared system* 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 ASC X12 837 COB flat file if the incoming claim is received in a claim format other than the new, now current version, and the CWF BOI reply trailer 29 indicator for "the new, now current version" returned to the A/B MAC (A or *H*HH) for the claim= "T" or "P."

B. ASC X12 837 Professional COB Claim Mapping Rules

Effective with the testing and implementation of the HIPAA ASC X12 837 professional new and now current version, the *Part B shared system* and the DME MAC shared system shall observe the following common business rules for mapping of the new and now current version COB (professional) flat file:

1 The following segments shall **not** be passed to the*BCRC* :
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 (new and now current version) in the field of the ASC X12 837 new version COB flat file that corresponds to the ST03 segment.

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 *BCRC*—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—A/B MAC (B) or DME MAC ID (9 bytes; A/B MAC or DME MAC ID, or 5 bytes left justified, followed by 4 spaces);
Bytes 10-14—Julian Date (5 bytes, expressed as "YYDDD");
Bytes 15-19—Sequence Number (5 bytes, starting with "00001"; should increment for each ST-SE envelope);
Bytes 20-21—Claim Version Indicator (2 bytes; values=50 for 5010 claims); and
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 are:

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;

A—for routine adjustment claims, not previously classified;
C— CMS directed mass adjustment action (use specified by CMS); and
V—Void/cancel only claims.

b. 23 bytes for COBA recovery claims as follows:

Bytes 1-9—A/B MAC (B) or DME MAC ID (9 bytes; A/B MAC (B) or DME MAC ID, left justified, or 5 bytes 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=50 for 5010 claims); and
Byte 22—COBA recovery indicator (1 byte; indicator =R)
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 "*BCRC* 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 A/B MAC (B) or DME MAC receives multiple COBA IDs via the BOI reply trailer (29), the shared system shall submit a separate ASC X12 837 transaction for each COBA ID received. Since crossover trading partner information will be unknown to the shared 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 systems shall map the taxonomy code values reported in PRV01 through PRV03 on the incoming electronic claim to the corresponding fields within the ASC X12 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 shared system* and DME MAC shared systems shall derive information for 2010AA PER 03, PER04, PER05, and PER06 if such information is present and syntactically complete within the A/B MAC (B) or DME MAC's internal provider files. If such information is unavailable or incomplete, the affected shared systems shall not create the 2010AA PER loop on the ASC X12 837 new version professional COB flat file.

9. The *Part B* and DME MAC shared systems 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 A/B MAC (B) or DME MAC's internal provider files. In addition, where a provider's tax ID is required within a secondary REF segment, the shared systems shall also derive this information from each A/B MAC (B) or DME MAC's internal provider files.

10a. For 2320 SBR01, in situations where there is only one (1) payer that is primary to Medicare, *the DME MAC shared system* 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." *The Part B shared system* shall reflect all additional supplemental payers as 2320 SBR01 = "U."

Additionally, effective January 5, 2015, when creating COBA 837 crossover claims, the shared system shall populate the 2320 SBR09, as associated to the 2330B loop segments created for "other supplemental payers," with the value "CI" if the COBA IDs for these payers falls within the ranges of 00001—69999 and 80000—89999. The shared system shall continue to map "MC" in 2320 SBR09 when for Medicaid.

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 (range 00001—69999 and 80000—89999)*, map "*CI*."

12. The 2010BA loop denotes beneficiary subscriber information. There are two (2) crossover scenarios to 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. NM108—populate "MI"; and
g. NM109—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 ASC X12 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 shared systems, the shared system shall format the NM1, N3, and N4 segments as follows, with the *BCRC* 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 ASC X12 837 new version 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 MSP situations, the shared system shall **not** move those loops to the ASC X12 837 new version 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 A/B MAC (B) or DME 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 shared system shall format the NM1 segment as follows, with *BCRC* 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 ASC X12 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 new version "skinny" claim, as derived from paper/hard copy claim input, in the same manner that it now does in creating the current in-use (prior to new version) 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 ASC X12 837 new version COB professional flat file. 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 Form 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 ASC X12 837 New Version COB Files (Effective July 2012)

A. ASC X12 837 Institutional COB Claims

1. For all instances of the N403 segment, where created, *the Part A shared system* 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 systems-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 ASC X12 837 COB claim files.

5b. The shared system shall continue to send full ZIP code content (9-bytes) on outbound ASC X12 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 A/B MAC *(A, HHH)'s* internal beneficiary eligibility record contains blank or incomplete line-1 street address information, *the Part A shared system* shall apply "Xs" to satisfy the minimum length requirements of the N301 segments.
8. If the incoming claim is paper Form CMS-1450 or DDE-entered and the dosage information necessary to populate 2410 CTP05-1 is not available, *the Part A shared system* shall always default to the value of "F2."
9. If the incoming claim is paper or electronic, *the Part A shared system* shall map "non-specific procedure code" within the ASC X12 837 new version 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/Medicare/Billing/ElectronicBillingEDITrans/FFSEditing.html >
10. *The Part A shared system* shall not attempt to gap-fill or systems-fill the N4 segment (now situational) within the field corresponding to loop 2330B on the ASC X12 837 new version COB flat file. In addition, if information needed to create the N4 segment is available but is incomplete, *the Part A shared system* shall not create the loop 2330B N4 segment.
11. *The Part A shared system* shall not attempt to gap-fill or systems-fill any of the composite SVD03 elements within loop 2430.

B. ASC X12 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 ASC X12 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 ASC X12 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 new version COB flat file.
7. With respect to 2010BA N301 and 2330A N301, when the A/B MAC (B) or DME MAC'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:

N401 (City)—populate "Cityville";
N402 (State Code)—populate "MD"; and
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 ASC X12 837 new version 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 ASC X12 837 new version 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 A/B MAC (B) or DME MAC subsequently keys, the shared system shall not attempt to gap-fill the field that corresponds to 2410 LIN03 on the ASC X12 837 new version 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 A/B MAC *(B)* or DME MAC'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, the shared system shall map "non-specific procedure code" within the ASC X12 837 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/Medicare/Billing/ElectronicBillingEDITrans/FFSEditing.html

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 ASC X12 837 new version COB flat file.

17. For ambulance claims, the *Part B* shared system shall map LB in the ASC X12 837 new version 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* shared 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 ASC X12 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 ASC X12 837 New Version COB Requirements

A. Complementary Credits

Upon receipt of a BOI reply trailer (29) that contains a "P" ASC X12 837 indicator, the shared systems shall ensure that their affiliate A/B MACs and DME MACs are able to: 1) book complementary credits for the affected claim; and 2) transmit the "production" claim to the *BCRC* after it has finalized on the A/B MAC or DME MAC's payment floor.

Following receipt of a BOI reply trailer (29) that contains a "T" ASC X12 837 indicator, as applicable, the shared systems shall ensure that their affiliate MACs: 1) do **not** anticipate receipt of complementary credits for that version of the claim; and 2) transmit the "test" claim to the *BCRC* after it has finalized on the contractor's payment floor.

All shared systems shall, in addition, **not** expect complementary credits in association with their affiliated A/B MAC or DME MAC's receipt of a CWF BOI reply trailer (29) that contains an "N" new version indicator.

B. *BCRC* Business-Level Editing of Incoming New Version COB Flat Files

With the implementation of the new version claim standards, the *BCRC* will apply business level edits to ensure that incoming claims possess the structure necessary for successful translation into the HIPAA ASC X12 837 new version claim formats. See §70.6.1.1 of this chapter for charts that define the "111" level errors that *BCRC* will return to the A/B MACs or DME MACs when their incoming ASC X12 837 COB flat files cannot be utilized to build compliant outbound ASC X12 837 claim transactions.