CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1720	**Date: April 24, 2009**
	Change Request 6374

Subject: Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) 837 5010 Coordination of Benefits (COB) Requirements--Part II

I. SUMMARY OF CHANGES: Through this instruction, CMS is implementing its HIPAA 837 5010 COB requirements for the Part A and Durable Medical Equipment Medicare Administrative Contractor (DME MAC) shared systems. These requirements will be implemented across two releases--July 2009 for analysis and design; and October 2009 for full implementation. Accordingly, CMS is updating the various sections of the Internet Only Manual (IOM) to reflect the changes associated with this instruction.

New / Revised Material
Effective Date: July 1, 2009 (for analysis and design); October 1, 2009 (for full implementation)
Implementation Date: July 6, 2009 (for analysis and design); October 5, 2009 (for full implementation)

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	24/40/40.4/COB Trading Partner and Contractor Crossover Claim Requirements
N	28/70/70.6.5/Coordination of Benefits Agreement (COBA) 5010 Coordination of Benefits (COB) Requirements

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs): N/A

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1720	Date: April 24, 2009	Change Request: 6374

SUBJECT: Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) 837 5010 Coordination of Benefits (COB) Requirements--Part II

Effective Date: July 1, 2009 (for analysis and design); October 1, 2009 (for full implementation)

Implementation Date: July 6, 2009 (for analysis and design); October 5, 2009 (for full implementation)

I. GENERAL INFORMATION

A. Background: Following receipt of a Common Working File (CWF) Beneficiary Other Insurance (BOI) reply trailer (29), Medicare contractors' shared systems transmit to the Coordination of Benefits Contractor (COBC) Medicare paid claims data in an 837 flat file that contains Health Insurance Portability and Accountability Act (HIPAA) 837 4010-A1 required content. At present, Medicare Part A contractors and Durable Medical Equipment Medicare Administrative Contractor (DME MACs) accept incoming hard copy claims (UB-04 or CMS-1500, as applicable), under defined circumstances, for claims adjudication purposes. Upon adjudication of these claims, these contractors' shared systems create an 837 COB flat file that contains a "skinny" version of the 4010-A1 claim format and transmit that file to the COBC.

Through this instruction, CMS outlines the requirements necessary for the Part A and DME MAC shared systems to implement the HIPAA 837 5010 COB claims transactions that they, in turn, will generate to the COBC for claims crossover purposes. This instruction will be implemented across two releases—July 2009 for analysis and design; and October 2009 for full implementation. Requirements relating to the processing of two versions of the COBC Detailed Error Report—one based on the contractor's generation of 4010-A1 COB claims; and another based on the contractors' generation of 5010 COB claims—as well as "111" error processes, claims repair, and recovery processes under HIPAA 5010 will be issued shortly as part of another instruction. Cut-over requirements for contractors to ensure a smooth transition from 4010-A1 COB to 5010 COB formats will also be include within that instruction.

B. Policy: During the 837 5010 transitional period, the Part A and DME MAC shared systems shall accommodate the following multi-faceted scenarios with respect to creation of 837 COB flat files:

Scenario 1: 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 "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.

Scenario 5: 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 COB flat file that contains a "test" claim with full SFR content for transmission to the COBC.

Scenario 6: 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 7: 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 "test" 5010 claim with full SFR content for COBA testing purposes.

Scenario 8: 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 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.)

Scenario 9: If a provider or supplier submits a hard-copy (paper UB-04 or CMS-1500) 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 10: 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 "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 11: 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 12: 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.

(**NOTE:** The Part B shared system accommodated all of these scenarios as part of its 5010 COB requirements as specified in CR 6308.)

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

Upon receipt of a BOI reply trailer (29) that contains a "P" 837 5010 indicator, the Part A and DME MAC 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 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 Part A and DME MAC 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. The affected 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.

The Part A and DME MAC shared systems shall implement all 837 5010 flat file mapping as well as gap-filling requirements in accordance with the specifications provided in Attachments A through D. To the extent that certain gap-filling scenarios are **not** otherwise specified within Attachments C and D, the Part A and DME MAC shared systems shall implement the same gap-fill conventions that it follows for the situation currently when creating 837 4010-A1 COB flat files for transmission to the COBC.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6374.1	The Part A and DME MAC shared systems shall create versions of the outbound 837 COB flat files in accordance with the requirements outlined within the first paragraph of the above "Policy" section.						X		X		

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6374.2	The Part A and DME MAC shared systems shall develop a 5010 "skinny" non-SFR format that addresses the scenario of claims originally adjudicated in the 4010-A1 format and later adjusted after the HIPAA 837 5010 format is required for all electronic claims transactions.						X		X		
6374.2.1	The Part A and DME MAC shared systems shall also develop a 5010 "skinny" non-SFR format that addresses the scenario of claims that a contractor originally adjudicated in the 4010-A1 format but suspended for a period of time that meets or transcends the date by which the HIPAA 837 5010 format is required for all electronic claims transactions.						X		X		
6374.3	The Part A and DME MAC shared systems shall develop a 4010-A1 "skinny" non-SFR claim format to accommodate those situations where COBA trading partners are unable to accept provider-submitted claims in the 837 5010 format.						X		X		
6374.4	Upon receipt of a BOI reply trailer (29) that contains a "P" 837 5010 indicator, the indicated shared systems shall: 1) book complementary credits for the affected claim; and 2) transmit the "production" claim to the COBC after it has finalized on the contractor's payment floor.						X		X		
6374.4.1	Upon receipt of a BOI reply trailer (29) that contains a "T" 837 5010 indicator, the shared systems shall: 1) **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.						X		X		
6374.4.2	The affected 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.						X		X		
6374.5	The Part A and DME MAC shared systems shall implement all mapping requirements as found in Attachments A and B.						X		X		
6374.5.1	The Part A and DME MAC shared systems shall implement the electronic and "paper input to 837 5010" gap-fill requirements as outlined in Attachments C and D.						X		X		

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6374.5.2	Unless specified otherwise, the Part A and DME MAC shared systems shall utilize the same gap-filling requirements for creation of the 5010 "skinny" non-SFR format as it now employs in the creation of the 4010-A1 "skinny" non-SFR format, where the incoming claim is hard copy/paper. (**NOTE:** The FISS and VMS maintainers are advised to consult Attachments A and B, to ensure that previous gap-fill scenarios are not now folded into overall flat-file mapping requirements, wherein actual values are expected.)						X		X		
6374.6	The DME MAC shared system shall assume that all Medigap claim-based crossover requirements, as stipulated in Change Requests 5601 and 6037, will be unchanged as the result of the 837 5010 COB implementation.								X		
6374.7	The COBC will effectuate cut-over of COBA trading partners to the HIPAA 5010 format through actions taken on the COIF.										X COBC
6374.7.1	Upon receipt of a CWF BOI reply trailer (29) that contains a "P" 5010 indicator **and** an "N" 4010-A1 indicator, FISS and VMS shall cease creation of 4010-A1 full COB or 4010-A1 non-SFR skinny COB claims as well as transmission of these files to the COBC.						X		X		

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	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: Recommendations and supporting information: N/A

V. CONTACTS

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

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VI. FUNDING

Section A: ***For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),*** **and/or** ***Carriers:***

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: ***Medicare Administrative Contractors (MACs)*** **shall include the following statement: N/A**

ATTACHMENTS:

Attachment A - Business Rules for A/B Medicare Administrative Contractors (MACs) for 837 5010 Institutional COB Flat Files

Attachment B - Business Rules for A/B Medicare Administrative Contractors (MACs) for 837 5010 Professional COB Flat Files

Attachment C - Gap-Fill Requirements for 837 5010 COB Institutional Claims

Attachment D - Gap-Fill Requirements for 837 5010 COB Professional Claims as Created by DME MACs

837 5010 Coordination of Benefits (COB) Flat File Mapping Business Rules
ATTACHMENT A

Business Rules for A/B Medicare Administrative Contractors (MACs)
for 837 5010 Institutional COB Flat Files

(NOTE: The mapping rules below are applicable whether the incoming claim to Medicare Part A is electronic or paper/hard-copy UB04 claims)

With respect to the 837 5010 Institutional COB flat file submissions to the COB Contractor (COBC), the Fiscal Intermediary Shared System (FISS) shall observe the following business rules for mapping:

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 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) 22 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—Data Center ID (2 bytes); and
      Byte 22—Test/Production Indicator (1 byte; valid values="T"—test; "P"—production).

   b) 22 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—Data Center ID (2 bytes); and
      Byte 22—COBA recovery indicator (1 byte; indicator =R).

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 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 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 file fields 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: :
   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. (See also item 3 in Attachment C.) .

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 the 2000B SBR01 (element 1138), FISS 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.

(*--See Gap Filling Requirements in Attachment C to address situations where the beneficiary's line-1 address, as derived from the contractor's internal beneficiary eligibility file, is blank or incomplete.)

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.

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.

(*--See Gap Filling Requirements in Attachments C to address situations where the beneficiary's line-1 address, as derived from the contractor's internal beneficiary eligibility file, is blank or incomplete.)

2330A-N4:

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;
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. 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;
b) For N401, N402, N403, N404, N407, populate spaces.

21) FISS shall always send at least one (1) complete iteration of 2320, 2330A, and 2330B 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 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 screen. FISS shall always populate the NM108 segment with "XX" and shall derive the NPI from the UB04 claim or DDE 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) In association with incoming electronic claims, the Part A shared system shall migrate Line Item Control Number data from the SFR to loop 2400, REF02, where REF01=6R within the equivalent fields of the 5010 COB flat file.

ATTACHMENT B

837 5010 Coordination of Benefits (COB) Flat File Mapping Business Rules

Business Rules for A/B Medicare Administrative Contractors (MACs)
for 837 5010 Professional COB Flat Files

(NOTE: The mapping rules below are applicable whether the incoming claim to Medicare is electronic or paper/hard-copy CMS-1500 claims)

With respect to the 837 5010 Professional COB flat file submissions to the COB Contractor (COBC), the DME MAC shared system shall observe the following business rules for mapping:

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 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) 22 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—Data Center ID (2 bytes); and
      Byte 22—Test/Production Indicator (1 byte; valid values="T"—test; "P"—production).

   b) 22 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—Data Center ID (2 bytes); and
      Byte 22—COBA recovery indicator (1 byte; indicator =R).

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 DME MAC 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).

7) For all 2000A, 2310B, and 2420A PRV (Billing Provider Specialty Information) segments, the 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 invalid, the DME MAC shared system shall **not** create the loop and associated segments.

8) The 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 share system shall **not** create the 2010AA PER loop on the 837 5010 professional COB flat file. (See also item 3 in Attachment D.)

9) The Part B shared system shall derive all provider specific information necessary to populate the NM1 and N3 and N4 segments of such loops as 2010AA, 2010AB, 2310B from each contractor's internal provider files. In addition, where a provider's tax ID is required within a secondary REF segment, the Part B 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 the 2000B SBR01 (element 1138), the DME MAC shared system shall always apply a "U" for all other supplemental payers after Medicare.

11) For additional 2000B requirements, the DME MAC 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 DME MAC 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;
b) N302—derive, as necessary, from internal beneficiary eligibility file; otherwise populate spaces.

(*--See Gap Filling Requirements in Attachment D to address situations where the beneficiary's line-1 address, as derived from the contractor's internal beneficiary eligibility file, is blank or incomplete.)

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.

(2) For Medigap claim-based crossover (COBA ID=55000 through 59999 only), the DME MAC 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 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.

(*--See Gap Filling Requirements in Attachment D to address situations where the beneficiary's line-1 address, as derived from the contractor's internal beneficiary eligibility file, is blank or incomplete.)

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.

13) The DME MAC 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.

(*--See Gap Filling Requirements in Attachment D to address situations where the beneficiary’s line-1 address, as derived from the contractor’s internal beneficiary eligibility file, is blank or incomplete.)

2330A-N4:

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

16) If the DME MAC 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 DME MAC 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 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 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 DME MAC 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 DME MAC shared system shall take the action indicated below in accordance with the applicable scenario:

a) For REF01, always map "F5";

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

c) For 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 DME MAC 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 DME MAC 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 DME MAC 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 DME MAC contractor shall continue to utilize this value for purposes of deriving the information necessary to populate all required segments associated with 2310C (Service Facility Name). The DME MAC contractor 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 billed to DME MACs), the shared system shall auto-plug the value "F2."

ATTACHMENT C

837 5010 COB Gap-Fill Requirements

Gap-Fill Requirements for 837 5010 COB Institutional Claims

1) For all instances of the N403 segment, where created, the Part A shared system (FISS) shall populate a 9-byte zip code. If only 5-bytes of the zip code can be obtained, the shared system shall populate four (4) additional zeroes after the concluding character of the 5-byte zip code that is available (e.g., 211010000).

2) When there is **not** a valid zip code available to complete an N403 segment, when required, FISS shall populate "969410000" within the field corresponding to that segment on the 837 5010 COB flat file.

3) When the shared system determines that it has data within its internal provider files 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.

4) 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 segment.

5) 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."

6) 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>.)

ATTACHMENT D

837 5010 COB Gap-Fill Requirements

Gap-Fill Requirements for 837 5010 COB Professional Claims

As Created by DME MACs

1) For all instances of the N403 segment, where created, the DME MAC shared system shall populate a 9-byte zip code. If only 5-bytes of the zip code can be obtained, the shared system shall populate four (4) additional zeroes after the concluding character of the 5-byte zip code that is available (e.g., 211010000).

2) When there is **not** a valid zip code available to complete an N403 segment, when required, the DME MAC shared system shall populate "969410000" within the field corresponding to that segment on the 837 5010 COB flat file.

3) When the shared system determines that it has data within its internal provider files 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.

4) 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 DME MAC shared system shall apply "Xs" to satisfy the **minimum** length requirements of the N301 segment.

5) The DME MAC 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.

6) The DME MAC 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.

7) Following adjudication of both electronic and paper billed claims, the DME MAC 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 DME MAC subsequently keys, the DME MAC shared shall **not** attempt to gap-fill the field that corresponds to 2410 LIN03 on the 837 5010 COB flat file.

8) 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 DME MAC shared system shall gap-fill all required segments with "Xs." The DME MAC 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.

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>.)

Medicare Claims Processing Manual

Chapter 24 – General EDI and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims

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(Rev.1720, 04-24-09)

40.4 - COB Trading Partner and *Contractor* Crossover Claim Requirements

(Rev.1720, Issued: 04-24-09, Effective: 10-01-09, Implementation: 10-05-09)

A. X12 837 COB and Medigap Claims

Outbound 837 Coordination of Benefit (COB) and Medigap claims are sent to COB trading partners and Medigap plans *through the national Coordination of Benefits Agreement crossover process* on a post-adjudicative basis. This type of transaction includes incoming claim data, as modified during adjudication if applicable, as well as payment data. All Medicare contractors are required to accept all 837 segments and data elements permitted by those implementation guides on an initial 837 professional or institutional claim from a provider, but *they* are **not** required to use every segment or data element for Medicare adjudication. Those supplemental segments and data elements shall be retained, however, because they could be needed by a Medicare COB trading partner or a Medigap Plan. The shared systems shall maintain a store-and-forward repository (SFR) for retention of such supplemental data. Data shall be subjected to standard syntax and applicable *Implementation Guide (*IG*)* edits prior to being deposited in the SFR to assure non-compliant data are not sent to another payer. SFR data shall be re-associated with those data elements used in Medicare claim adjudication as well as with payment data in order to create an 837 IG-compliant outbound COB/Medigap transaction. The shared systems shall retain the data in the SFR for a minimum of 6 months.

The 837 version 4010A1 institutional and professional implementation guides require that claims submitted for secondary payment contain standard claim adjustment reason codes to explain adjudicative decisions made by the primary payer. For a secondary claim to be valid, the amount paid by the primary payer plus the amounts adjusted by the primary payer shall equal the billed amount for the services in the claim. A tertiary payer to which Medicare may forward a claim may well need all data and adjustment codes Medicare receives on a claim. A tertiary payer could reject a claim forwarded by Medicare if the adjustment and payment data from the primary payer or from Medicare did not balance against the billed amounts for the services and the claim. As a result, shared systems shall reject inbound Medicare Secondary Payer claims if the paid and adjusted amounts do not equal the billed amounts at the line and claim level and if the claim lacks standard claim adjustment reason codes to identify the adjustments performed.

The shared system maintainers shall populate an outbound COB/Medigap file as an 837 flat file with the Tax ID or SSN (for a sole practitioner) present in the provider's file. Once the National Provider Identifier (NPI) is available, *the shared system shall report* qualifier XX in NM108 and the NPI in NM109. *T*he *shared system shall report the* taxpayer identification number in the REF segment of the billing provider loop.

The shared systems shall populate outbound claims with the provider's first name, last name, middle initial, address, city, state and zip code as contained in the Medicare provider files.

Under the Coordination of Benefits Agreement (COBA) eligibility file-based crossover process, each COBA trading partner specifies the types of claims it wants the COBC to transfer. Examples of claims most frequently excluded from the crossover process are:

- Fully denied claims;
- Adjustment claims;
- MSP claims; and
- Claims that are fully paid without deductible or co-insurance remaining.

The COBC is the single contractor responsible for COB trading partner agreements and transmission of COB/Medigap claims to Coordination of Benefits Agreement (COBA) trading partners. Refer to Chapter 28, §70.6 and accompanying subsections of this manual for further details about specific Medicare contractor crossover-related responsibilities when interacting with the COBC. Each shared system will generate COB/Medigap flat files for its Medicare contractors and will forward those flat file records to the COBC. The COBC's translator will translate those flat files into outbound 837 COB/Medigap transactions.

HIPAA required that any payer that conducts electronic COB including in Medicare's case, electronic Medigap transactions, for other than retail pharmacy drug claims use the X12 837 version 4010A1 format for COB by October 16, 2003 (subsequently extended by the ASCA extension request process and the Medicare HIPAA contingency period). HIPAA did **not** give payers the option to exclude claims received on paper or received in a pre-HIPAA electronic format from compliancy requirements for X12 837 version 4010A1 COB/Medigap transactions. An inbound claim received on paper could lack data elements, or contain data that do not meet the data attribute (alpha-numeric, numeric, minimum or maximum lengths, etc.) requirements needed to prepare a HIPAA-compliant outbound X12 837 COB/Medigap transaction, however. Paper claims do not contain as many data requirements as the claim versions adopted as the national standards under HIPAA.

In most cases, electronic claims received with invalid data are rejected, but in limited cases such as for a claim received on paper, a claim could be accepted and adjudicated that lacks one or more pieces of data needed for a HIPAA-compliant COB/Medigap transaction. It is also possible to receive invalid data from the Medicare Common Working File (CWF) database. For example, a State abbreviation in an address transferred from the Social Security Administration (SSA) for Medicare enrollment might contain one letter rather than two in the State abbreviation. A one letter State abbreviation violates the X12 requirements that two letters appear in a State abbreviation, but due to the Medicare prohibition against modification of beneficiary addresses supplied by SSA, the shared system is left with a dilemma. Such errors cannot be

corrected unless the beneficiary contacts SSA and requests correction, but this is not a priority for many beneficiaries since they receive their SSA payments electronically.

When a paper claim does not contain data necessary to create a HIPAA compliant outbound X12N 837 HIPAA COB/Medigap claim, the shared systems maintainers (other than MCS) and the contractors that use MCS shall gap-fill alphanumeric data elements with Xs and numeric data elements with 9s. For example, a 5-character alphanumeric data element would contain "XXXXX" and a 5-character numeric data element would contain "99999."

When paper claims do **not** contain a required telephone number to create a HIPAA compliant outbound X12 837 HIPAA COB/Medigap transaction, the shared system maintainers (other than MCS) and MCS Carriers shall gap fill the phone number data element with "8009999999," *except as directed otherwise below under "C. 837 4010-A1 to 5010 COB Transitional Period Requirements."*

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Data elements with pre-defined IG values, such as qualifiers, and data elements that refer to a valid code source shall not be gap filled. Paper claims do not usually contain qualifiers but do contain explicit field names that provide information equivalent to qualifiers or that identify valid code sources. For COB/Medigap purposes, those field names shall be mapped to the appropriate qualifier or code source for reporting to trading partners and Medigap plans in the 837 version 4010A1 format.

B. NCPDP COB/Medigap Transactions

The NCPDP has approved the following use of qualifiers in the Other Payer Paid Amount field for reporting Medicare COB/Medigap amounts:

"07" = Medicare Allowed Amount
"08" = Medicare Paid Amount
"99" = Deductible Amount
"99" = Coinsurance Amount
"99" = Co-Payment Amount

NOTE: The first occurrence of "99" will indicate the Deductible Amount.

The second occurrence of "99" will indicate the Coinsurance Amount.

The third occurrence "99" will indicate the Co-Payment Amount.

C. 837 4010-A1 to 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, without SFR content, 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 timeframe 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.*

D. MAPPING OF 837 5010 COB FLAT FILES

Mapping of the 837 5010 COB Institutional Flat File

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 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. *22 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—Data Center ID (2 bytes); and
   Byte 22—Test/Production Indicator (1 byte; valid values="T"—test; "P"—production).

   b. *22 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—Data Center ID (2 bytes); and
   Byte 22—COBA recovery indicator (1 byte; indicator =R).

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.

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:

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.

Mapping of the 837 5010 COB Professional Flat File

With respect to the 837 5010 Professional COB flat file submissions to the COB Contractor (COBC), the Multi-Carrier System (MCS) and VIPS Medicare System (VMS) shall observe the following business rules for mapping on behalf of their affiliate A/B MAC (or carrier if applicable) or DME MAC:

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 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. ***22 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—Data Center ID (2 bytes); and
      Byte 22—Test/Production Indicator (1 byte; valid values="T"—test; "P"—production).

   b. ***22 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—Data Center ID (2 bytes); and
Byte 22—COBA recovery indicator (1 byte; indicator =R).

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, 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.

(2) 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.

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:

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"non-SFR 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."*

E. Gap-Filling Requirements Relating to 837 5010 COB Flat Files

Gap-Filling Requirements for 837 5010 Institutional COB Claims

1. *For all instances of the N403 segment, where created, the Part A shared system (FISS) shall populate a 9-byte zip code. If only 5-bytes of the zip code can be obtained, the shared system shall populate four (4) additional zeroes after the concluding character of the 5-byte zip code that is available (e.g., 211010000).*
2. *When there is **not** a valid zip code available to complete an N403 segment, when required, FISS shall populate "969410000" within the field corresponding to that segment on the 837 5010 COB flat file.*

3. *When the shared system determines that it has the data within its provider files 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.*

4. *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.*

5. *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."*

6. *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>.)

Gap-Filling Requirements for 837 5010 Professional COB Claims

1. *For all instances of the N403 segment, where created, the shared system shall populate a 9-byte zip code. If only 5-bytes of the zip code can be obtained, the shared system shall populate four (4) additional zeroes after the concluding character of the 5-byte zip code that is available (e.g., 211010000).*

2. *When there is **not** a valid zip code available to complete an N403 segment, when required, the shared system shall populate "969410000" within the field corresponding to that segment on the 837 5010 COB flat file.*

3. *When the shared system determines that it has the data within its provider files 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.*

4. *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 segment.*

5. *In association with paper-submitted Part B ambulance claims, the Part B shared system shall apply gap-filling of 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 satisfy the **minimum** field length for street address;*

   ***For the N401-N403 segments:** The Part B shared system shall map as follows:*

   a. *N401 (City)—populate "Cityville";*

   b. *N402 (State Code)—populate "MD"; and*

   c. *N403 (Postal Zone/Zip Code)—populate "969410000."*

6. *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.*

7. *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.*

8. *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.*

9. *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.*

10. *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.*

11. *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>.)

SPECIAL NOTE: *All Medicare contractors and shared systems shall refer to Pub.100-04, Chapter 28, §70.6.1.1 for the specific editing that COBC will apply to incoming 837 5010 COB flat files and for purposes of avoiding the incurrence of "111" errors.*

Medicare Claims Processing Manual
Chapter 28 - Coordination With Medigap, Medicaid, and Other Complementary Insurers

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(Rev.1720, 04-24-09)

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

(Rev.1720, Issued: 04-24-09, Effective: 10-01-09, Implementation: 10-05-09)

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, without SFR content, 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 timeframe 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 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. 22 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—Data Center ID (2 bytes); and
    Byte 22—Test/Production Indicator (1 byte; valid values="T"—test; "P"—production).

b. 22 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—Data Center ID (2 bytes); and
Byte 22—COBA recovery indicator (1 byte; indicator =R).

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.

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:

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.*

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 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. ***22 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—Data Center ID (2 bytes); and
Byte 22—Test/Production Indicator (1 byte; valid values="T"—test; "P"—production).

b. 22 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—Data Center ID (2 bytes); and
Byte 22—COBA recovery indicator (1 byte; indicator =R).

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, 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.

(2) 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.

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:

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 populate a 9-byte zip code. If only 5-bytes of the zip code can be obtained, the shared system shall populate four (4) additional zeroes after the concluding character of the 5-byte zip code that is available (e.g., 211010000).*

2 *When there is **not** a valid zip code available to complete an N403 segment, when required, FISS shall populate "969410000" within the field corresponding to that segment on the 837 5010 COB flat file.*

3. *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.*

4. *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.*

5. *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."*

6. *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>.)*

B. 837 Professional COB Claims

1. *For all instances of the N403 segment, where created, the shared system shall populate a 9-byte zip code. If only 5-bytes of the zip code can be obtained, the shared system shall populate four (4) additional zeroes after the concluding character of the 5-byte zip code that is available (e.g., 211010000).*

2. *When there is **not** a valid zip code available to complete an N403 segment, when required, the shared system shall populate "969410000" within the field corresponding to that segment on the 837 5010 COB flat file.*

3. *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.*

4. *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.*

5. *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 "969410000."*

6. *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.*

7. *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.*

8. *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.*

9a. *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.*

9b. 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.

*10. 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.*

11. 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>.)

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.