CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 4281	**Date: April 19, 2019**
	Change Request 11261

SUBJECT: Update to Chapter 28 in Publication (Pub.) 100-04 to Provide Language-Only Changes for the New Medicare Card Project

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update Chapter 28 in Pub. 100-04 with the New Medicare Card Project-related language. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

EFFECTIVE DATE: May 20, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: May 20, 2019

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	28/20.1/Beneficiary Insurance Assignment Selection
R	28/70.6/Consolidation of the Claims Crossover Process
R	28/70.6.1/Coordination of Benefits Agreement (COBA) Detailed Error Report Notification Process
R	28/70.6.5/Coordination of Benefits Agreement (COBA) ASC X12 837 Coordination of Benefits (COB) Mapping Requirements as of July 2012
R	28/70.6.6/National Council for Prescription Drug Programs (NCPDP) Version D.0 Coordination of Benefits (COB) Requirements

III. FUNDING:

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

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

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 4281	Date: April 19, 2019	Change Request: 11261

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I. GENERAL INFORMATION

A. Background: The CMS is implementing changes to remove the Social Security Number (SSN) from the Medicare card. A new number, called the Medicare Beneficiary Identifier (MBI), will be assigned to all Medicare beneficiaries. This CR contains language-only changes for updating the New Medicare Card Project language related to the MBI in Chapter 28 of Pub. 100-04.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires removal of the SSN-based Health Insurance Claim Number (HICN) from Medicare cards within four years of enactment. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

B. Policy: MACRA of 2015.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11261.1	MACs shall be aware of the updated language for the New Medicare Card Project in Chapter 28 of Pub. 100-04.	X	X	X	X					

III. PROVIDER EDUCATION TABLE

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

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Tracey Mackey, 410-786-5736 or Tracey.Mackey@cms.hhs.gov , Kim Davis, 410-786-4721 or kimberly.davis@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

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

ATTACHMENTS: 0

20.1 - Beneficiary Insurance Assignment Selection

(Rev. 4281, Issued: 04- 19-19, Effective: 05-20-19, Implementation: 05-20-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Beneficiaries indicate that they have assigned their Medigap benefits to a participating physician/practitioner or supplier by signing block #13 on the Form CMS-1500. This authorization is in addition to their assignment of Medicare benefits as indicated by their signature in block #12.

Form CMS-1450 makes no provision for the provider to indicate that the beneficiary has assigned benefits because the Form CMS-1450 is used only for institutional claims, for which payment is typically assigned to the provider of services. For claims the institutional provider submits to A/B MACs (B) for physician payments for physician employees; hospitals, SNFs, HHAs, OPTs, CORFs, or ESRD facilities may maintain a beneficiary statement in file instead of submitting a separate statement with each claim. This authorization must be insurer specific.

If the beneficiary has a Medigap policy, the following statement should be signed:

	Beneficiary's Medicare *beneficiary identifier*
NAME OF BENEFICIARY	MEDIGAP POLICY NUMBER

I request that payment of authorized Medigap benefits be made either to me or on my behalf to _____ for any services furnished me by that physician/provider/supplier. I authorize any holder of medical information about me to release to (name of Medigap insurer) any information needed to determine these benefits or the benefits payable for related services.

Since the beneficiary may selectively authorize Medigap assignments, caution providers about routinely stamping *item* #13 of the Form CMS-1500 "signature on file." The Medigap assignment on file in the participating doctor/supplier's office must be insurer specific. However, it may state that the authorization applies to all occasions of services until it is revoked.
Effective with October 1, 2007, participating Part B physicians/practitioners and DMEPOS suppliers *now* will only include the CMS-assigned Medigap claim-based COBA ID on an incoming claim if confirmation that a beneficiary has authorized Medigap assignment has been obtained.

70.6 - Consolidation of the Claims Crossover Process

(Rev. 4281, Issued: 04- 19-19, Effective: 05-20-19, Implementation: 05-20-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Background – Medicare Claims Crossover Process—General

Through the Benefits Coordination & Recovery Center (BCRC), Medicare transmits outbound 837 Coordination of Benefit (COB) and Medigap claims to COB trading partners and Medigap plans, collectively termed "trading partners," on a post-adjudicative basis. This type of transaction, originating at individual A/B MACs and DME MACs following their claims adjudication activities, includes incoming claim data, as modified during adjudication if applicable, as well as payment data. All A/B MACs and

DME MACs are required to accept all ASC X12 837 segments and data elements permitted by the in-force applicable guides on an initial ASC X12 837 professional or institutional claim from a provider, but they are not required to use every segment or data element for Medicare adjudication. Segments and data elements determined to be extraneous for Medicare claims adjudication shall, however, be retained by the A/B MACs (Part B) and DME MACs within its store-and-forward repository (SFR). Incoming claims 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 will not be forwarded on to another payer as part of the Medicare crossover process. SFR data shall be re-associated with those data elements used in Medicare claim adjudication, as well as with payment data, to create an ASC X12 837 IG-compliant outbound COB/Medigap transaction. The shared systems shall always retain the data in the SFR for a minimum of 6 months.

The ASC X12 837 institutional and professional implementation guides require that claims submitted for secondary payment contain standard claim adjustment reason codes (CARCs) 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 (MSP) claims if the paid and adjusted amounts do not equal the billed amounts and if the claims lack standard CARCs to identify adjustments to the total amount billed.

As a rule, the shared system maintainers shall populate an outbound COB/Medigap file as an ASC X12 837 flat file with the Employer Identification Number (EIN)/Tax ID or SSN (for a sole practitioner) present in the provider's file, unless otherwise specified within §70.6.5 or §70.6.6 of this chapter. With the adoption of the National Provider Identifier (NPI), the shared system shall report qualifier XX in NM108 and the NPI value in NM109. The shared system shall report the provider's EIN/TAX ID within the REF segment of the billing provider loop, as appropriate. In addition, unless otherwise stated within §70.6.5 or §70.6.6 of this chapter, the shared systems shall populate the provider loops on outbound ASC X12 837 claims with the provider's first name, last name, middle initial, address, city, state and zip code as contained in the Medicare provider files, the information for which is derived from the Provider Enrollment Chain and Ownership System (PECOS).

Background—Specific COBA Crossover Process

The CMS has streamlined the claims crossover process to better serve its customers. Under the consolidated claims crossover process, trading partners execute national agreements called Coordination of Benefits Agreements (COBAs) with CMS's BCRC. Through the COBA process, each COBA trading partner will send one national eligibility file that includes eligibility information for each Medicare beneficiary that it insures to the BCRC. The BCRC will transmit the beneficiary eligibility file(s) to the Common Working File (CWF) via the HUBO maintenance transaction. The transaction is also termed the "Beneficiary Other Insurance (BOI)" auxiliary file. (See Pub.100-04, chapter 27, §80.4 for more details about the contents of the BOI auxiliary file.)

During August 2003, the CMS modified CWF to accept both the HUBO (BOI) transaction on a regular basis and COBA Insurance File (COIF) as a weekly file replacement. Upon reading both the BOI and the COIF, CWF applies each COBA trading partner's claims selection criteria against processed claims with service dates that fall between the effective and termination date of one or more BOI records.

Upon receipt of a BOI reply trailer (29) that contains (a) COBA ID (s) and other crossover information required on the Health Insurance Portability and Accountability Act (HIPAA) ASC X12 835 Electronic Remittance Advice (ERA), all A/B MACs and DME MACs shall send processed claims via an ASC X12 837 COB flat file or National Council for Prescription Drug Programs (NCPDP) file to the BCRC. The BCRC, in turn, will cross the claims to the COBA trading partner in the HIPAA ASC X12 837 or NCPDP formats,

following its validation that the incoming Medicare claims are formatted correctly and pass HIPAA or NCPDP compliance editing.

In addition, CMS shall arrange for the invoicing of COBA trading partners for crossover fees.

For more information regarding the COBA Medigap claim-based crossover process, which was enacted on October 1, 2007, consult §70.6.4 of this chapter.

I. A/B MAC (Part A, Part B, or Part HHH) or DME MAC Actions Relating to CWF Claims Crossover Exclusion Logic

A. Determination of Beneficiary Liability for Claims with Denied Services

Effective with the January 2005 release, the A/B MAC (Part B) and DME MAC shared systems shall include an indicator "L" (beneficiary is liable for the denied service[s]) or "N" (beneficiary is not liable for the denied service[s]) in an available field on the HUBC and HUDC queries to CWF for claims on which all line items are denied. The liability indicators (L or N) shall be reflected at the header or claim level rather than at the line level.

For purposes of applying the liability indicator L or N at the header/claim level and, in turn, including such indicators in the HUBC or HUDC query to CWF, the A/B MACs (Part B) and DME MAC shared systems shall follow these business rules:

- The L or N indicators are not applied at the header/claim level if any service on the claim is payable by Medicare;

- The "L" indicator is applied at the header/claim level if the beneficiary is liable for any of the denied services on a fully denied claim; and

- The "N" indicator is applied at the header/claim level if the beneficiary is not liable for all of the denied services on a fully denied claim.

Effective with October 2007, the CWF maintainer shall create a 1-byte beneficiary liability indicator field within the header of its HUIP, HUOP, HUHH, and HUHC Part A claims transactions (valid values for the field="L," "N," or space).

As A/B MACs (Part A) and A/B MACs (Part HHH) adjudicate claims and determine that the beneficiary has payment liability for any part of the fully denied services or service lines, they shall set an "L" indicator within the newly created beneficiary liability field in the header of their HUIP, HUOP, HUHH, and HUHC claims that they transmit to CWF. In addition, as A/B MACs (Part A) and A/B MACs (Part HHH) adjudicate claims and determine that the beneficiary has no payment liability for any of the fully denied services or service lines - that is, the provider must absorb all costs for the fully denied claims - they shall include an "N" beneficiary indicator within the designated field in the header of their HUIP, HUOP, HUHH, and HUHC claims that they transmit to CWF. NOTE: A/B MACs (Part A) and A/B MACs (Part HHH) shall not set the "L" or "N" indicator on partially denied/partially paid claims.

Upon receipt of an HUIP, HUOP, HUHH, or HUHC claim that contains an "L" or "N" beneficiary liability indicator, CWF shall read the COBA Insurance File (COIF) to determine whether the COBA trading partner wishes to receive "original" fully denied claims with beneficiary liability (crossover indicator "G") or without beneficiary liability (crossover indicator "F") or "adjustment" fully denied claims with beneficiary liability (crossover indicator "U") or without beneficiary liability (crossover indicator "T").

If CWF determines that the COBA trading partner wishes to exclude the claim, as per the COIF, it shall suppress the claim from the crossover process.

CWF shall post the appropriate crossover disposition indicator in association with the adjudicated claim on the HIMR detailed history screen (see §80.5 of this chapter).

In addition, the CWF maintainer shall create and display the new 1-byte beneficiary liability indicator field within the HIMR detailed history screens (INPL, OUTL, HHAL, and HOSL), to illustrate the indicator ("L" or "N") that appeared on the incoming HUIP, HUOP, HUHH, or HUHC claim transaction.

CWF Editing for Incorrect Values

If an A/B MAC (Part A) or A/B MAC (Part HHH) sends values other than "L," "N," or space in the newly defined beneficiary liability field in the header of its HUIP, HUOP, HUHH, or HUHC claim, CWF shall reject the claim back to the A/B MAC for correction. Following receipt of the CWF rejection, the A/B MAC (Part A) and A/B MAC (Part HHH) shall change the incorrect value placed within the beneficiary liability field and retransmit the claim to CWF.

B. Developing a Capability to Treat Entry Code "5" and Action Code "3" Claims As Recycled "Original" Claims For Crossover Purposes

Effective with July 2007, in instances when CWF returns an error code 5600 to an A/B MAC and DME MAC, thereby causing it to reset the claim's entry code to "5" and action code to "3," the MAC shall set a newly developed "N"(non-adjustment) claim indicator ("treat as an original claim for crossover purposes") in the header of the HUBC, HUDC, HUIP, HUOP, HUHH, and HUHC claim in the newly defined field before retransmitting the claim to CWF. The A/B MAC and DME MAC shared system shall then resend the claim to CWF.

Upon receipt of a claim that contains entry code "5" or action code "3" with a non-adjustment claim header value of "N," the CWF shall treat the claim as if it were an "original" claim (i.e., as entry code "1" or action code "1") for crossover inclusion or exclusion determinations. If CWF subsequently determines that the claim meets all other inclusion criteria, it shall mark the claim with an "A" ("claim was selected to be crossed over") crossover disposition indicator.

Following receipt of a Beneficiary Other Insurance (BOI) reply trailer (29) for the recycled claim, the A/B MACs' and DME MACs' shared systems shall ensure that, as part of their ASC X12 837 flat file creation processes, they populate the 2300 loop CLM05-3 (Claim Frequency Type Code) segment with a value of "1" (original). In addition, the A/B MACs' and DME MACs' shared systems shall ensure that, as part of their ASC X12 837 flat file creation process, they do not create a corresponding 2330 loop REF*T4*Y segment, which typically signifies "adjustment."

C. Developing a Capability to Treat Claims with Non-Adjustment Entry or Action Codes as Adjustment Claims For Crossover Purposes

Effective with July 2007, in instances where A/B MACs and DME MACs must send adjustment claims to CWF as entry code "1" or as action code "1" (situations where CWF has rejected the claim with edit 6010), they shall set an "A" indicator in a newly defined field within the header of the HUBC, HUDC, HUIP, HUOP, HUHH, or HUHC claim.

If A/B MACs and DME MACs send a value other than "A" or spaces within the newly designated header field within their HUBC, HUDC, HUIP, HUOP, HUHH, and HUHC claims, CWF shall apply an edit to reject the claim back to the MAC. Upon receipt of the CWF rejection edit, the MACs' systems shall correct the invalid value and retransmit the claim to CWF for verification and validation.

Upon receipt of a claim that contains entry code "1" or action code "1" with a header value of "A," the CWF shall take the following actions:

- Verify that, as per the COIF, the COBA trading partner wishes to exclude **either** adjustments,

monetary adjustments, non-monetary, **or both**; and

- Suppress the claim if the COBA trading partner wishes to exclude **either** adjustments, monetary adjustments, non-monetary, **or both**.

NOTE: The expectation is that such claims do not represent mass adjustments tied to the MPFS or mass adjustments-other.

If A/ B MACs and DME MACs receive a BOI reply trailer (29) on a claim that had an "A" indicator set in its header, the A/B MACs' or DME MACs' systems shall ensure that, as part of their ASC X12 837 flat file creation processes, they populate the 2300 loop CLM05-3 ("Claim Frequency Type Code") segment with a value that designates "adjustment" rather than "original" to match the 2330B loop REF*T4*Y that they create to designate "adjustment claim."

If an A/B MAC's or DME MAC's shared system does not presently create a loop 2330B REF*T4*Y to designate adjustments, it shall not make a change to do so as part of this instruction.

Correcting Invalid Claim Header Values Sent to CWF

If A/B MACs and DME MACs send a value other than "A," "N," or spaces within the newly designated header field within their HUBC, HUDC, HUIP, HUOP, HUHH, and HUHC claims, CWF shall apply an edit to reject the claim back to the A/B MAC or DME MAC. Upon receipt of the CWF rejection edit, the A/B MACs' or DME MACs' systems shall correct the invalid value and retransmit the claim to CWF for verification and validation.

D. CWF Identification of National Council for Prescription Drug Claims

Currently, the DME MAC shared system is able to identify, through the use of an internal indicator, whether a submitted claim is in the National Council for Prescription Drug Programs (NCPDP) format. Effective with January 2005, the DME MAC shared system shall pass an indicator "P" to CWF in an available field on the HUDC query when the claim is in the NCPDP format. The indicator "P" should be included in a field on the HUDC that is separate from the fields used to indicate whether a beneficiary is liable for all services that are completely denied on his/her claim.

The CWF shall read the new indicators passed via the HUBC or HUDC queries for purposes of excluding 100 percent denied claims with or without beneficiary liability and NCPDP claims. After applying the claims selection options, CWF will return a BOI reply trailer (29) to the A/B MAC or DME MAC only in those instances when the COBA trading partner expects to receive a Medicare processed claim from the BCRC.

Effective with July 2007, CWF shall reject claims back to DME MACs if their HUDC claim contains a value other than "P" in the established field used to identify NCPDP claims.

E. CWF Identification and Auto-Exclusion of ASC X12 837 Professional Claims That Contain Only Physician Quality Reporting Initiative (PQRI) Codes

Effective October 6, 2008, the CWF maintainer shall create space within the header of its HUBC claim transmission for a 1-byte PQRI indicator (valid values=Q or space).

In addition, CWF shall create a 2-byte field on page 2 of the HIMR claim detail in association with the new category "COBA Bypass" for the value "BQ," which shall designate that CWF auto-excluded the claim because it contained only PQRI codes (see §80.5 of this chapter for more details regarding the bypass indicator).

Prior to transmitting the claim to CWF for normal processing, the A/B MAC (Part B) shared system shall input the value "Q" in the newly defined PQRI field in the header of the HUBC when **all** service lines on a

claim contain PQRI (status M) codes.

Upon receipt of a claim that contains a "Q" in the newly defined PQRI field (which signifies that the claim contains only PQRI codes on all service detail lines, CWF shall auto-exclude the claim from the national COBA eligibility file-based and Medigap claim-based crossover processes. Following exclusion of the claim, CWF shall populate the value "BQ" in association with the newly developed "COBA Bypass" field on page 2 of the HIMR A/B MAC (Part B) and DME MAC claim detail screens.

Prior to October 6, 2008, all A/B MACs and DME MACs shall update any of their provider customer service materials geared towards crossover claims related inquiries to reflect the newly developed "BQ" by-pass value, which designates that CWF auto-excluded the claim because it only contained PQRI codes.

The Next Generation Desktop (NGD) contractor shall also modify its user screens and documentation to reflect the new "BQ" code.

F. CWF Identification and Exclusion of Claims Containing Placeholder National Provider Identifiers (NPIs)

Effective October 6, 2008, the CWF maintainer shall create space within the header of its HUIP, HUOP, HUHH, HUHC, HUBC, and HUDC claims transactions for a new 1-byte "NPI-Placeholder" field (acceptable values=Y or space).

In addition, the CWF maintainer shall create space within page two (2) of the HIMR detail of the claim screen for 1) a new category "COBA Bypass"; and 2) a 2-byte field for the indicator "BN." (See Pub. 100-04, chapter 27, §80.*5* for more details regarding the "BN" bypass indicator.)

NOTE: With the implementation of the October 2008 release, the CWF maintainer shall remove all current logic for placeholder provider values with the implementation of this new solution for identifying claims that contain placeholder provider values.

As A/B MACs and DME MACs adjudicate **non VA MRA** claims that fall within any of the NPI placeholder requirements, their shared system shall take the following combined actions:

1) Input a "Y" value in the newly created "NPI Placeholder" field on the HUIP, HUOP, HUHH, HUHC, HUBC, or HUDC claim transaction if a placeholder value exists on or is created anywhere within the SSM claim record. **NOTE**: The A/B MAC and DME MAC shared systems shall include spaces within the "NPI Placeholder" field when the claim does not contain a placeholder NPI value; **and**

2) Transmit the claim to CWF, as per normal requirements.

Upon receipt of claims where the NPI Placeholder field contains the value "Y," CWF shall auto-exclude the claim from the national COBA crossover process. In addition, CWF shall populate the value "BN" in association with the newly developed "COBA Bypass" field on page 2 of the HIMR Part B and DME MAC claim detail screen and on page 3 of the HIMR intermediary claim detail screen. (See Pub.100-04, chapter 27, §80.4 for more details.)

Prior to October 6, 2008, all A/B MACs and DME MACs shall update any of their provider customer service materials geared towards crossover claims related inquiries to reflect the newly developed "BN" by-pass value, which designates that CWF auto-excluded the claim because it contained a placeholder provider value.

The Next Generation Desktop (NGD) contractor shall also modify its user screens and documentation to reflect the new "BN" code.

G. New CWF Requirements for Other Federal Payers

Effective with October 3, 2011, the CWF maintainer shall expand its logic for "Other Insurance," which is COIF element 176, to include TRICARE for Life (COBA ID 60000-69999) and CHAMPVA (COBA ID 80214), along with State Medicaid Agencies (70000-79999), as entities eligible for this exclusion.

Through these changes, if either TRICARE for Life or CHAMPVA wishes to invoke the "Other Insurance" exclusion, and if element 176 is marked on the COIF for these entities, CWF shall suppress claims from the national COBA crossover process if it determines that the beneficiary has active additional supplemental coverage.

As part of this revised "Other Insurance" logic for TRICARE and CHAMPVA, CWF shall interpret "additional supplemental coverage" as including entities whose COBA identifiers fall in any of the following ranges:

00001-29999 (Supplemental);
30000-54999 (Medigap eligibility-based);
80000-80213 (Other Insurer); and
80215-88999 (Other Insurer).

The "Other Insurance" logic for State Medicaid Agencies includes all of the following COBA ID ranges:

00001-29999 (Supplemental);
30000-54999 (Medigap eligibility-based);
60000-69999 (TRICARE);
80000-80213 (Other Insurance)
80214 (CHAMPVA)
80215-88999 (Other Insurer).

NOTE: As of October 3, 2011, CWF shall now omit COBA ID range 89000-89999 as part of its Other Insurance logic for State Medicaid Agencies.

CWF shall mark claims that it excludes due to "Other Insurance" with crossover disposition indicator "M" when storing them within the CWF claims history screens. (See §80.5 of chapter 27 for additional information concerning this indicator.)

II. A/B MAC and DME MAC Actions Relating to CWF Claims Crossover Inclusion or Inclusion/Exclusion Logic

A. Inclusion of Two Categories of Mass Adjustment Claims for Crossover Purposes

All A/ B MACs and DME MACs shall continue to identify mass adjustment claims-MPFS and mass adjustment claims—other by including an "M" (mass adjustment claims—MPFS) or "O" (mass adjustment claims—other) within the header of the HUIP, HUOP, HUHH, HUHC, HUBC, and HUDC claim transactions, as specified in Pub.100-04, chapter 27, §80.*6*. (Refer to Pub.100-04, chapter 27, §80.*8* for CWF specific requirements relating to the unique inclusion of mass adjustment claims for crossover purposes.)

Effective January 5, 2009, the BCRC, at CMS's direction, modified the COIF to allow for the unique inclusion of mass adjustment claims—MPFS updates and mass adjustment claims—other. The CWF maintainer shall 1) create these new fields, along with accompanying 1-byte file displacement, within its version of the COIF; and 2) accept and process these new fields when the BCRC transmits them as part of its regular COIF updates.

Upon receipt of a HUIP, HUOP, HUHH, HUHC, HUBC, or HUDC claim transaction that contains an "M" or "O" mass adjustment indicator, CWF shall undertake all additional actions with respect to determination as to whether the claim should be included or excluded for crossover purposes as specified in chapter 27,

§80.8.

A/B MAC and DME MAC Flat File Requirements

Before the A/B MAC and DME MAC shared systems send "mass adjustment claims—MPFS" to the BCRC via an ASC X12 837 flat file transmission, they shall take the following actions with respect to the fields that correspond to the loop 2300 NTE01 and NTE02 segments on the ASC X12 837 COB flat file only if there was not a pre-existing 2300 NTE segment on the incoming Medicare claim:

1) Populate "ADD" in the field that corresponds to NTE01; and

2) Populate "MP," utilizing bytes 01 through 02, in the field that corresponds to NTE02.

Before the A/B MAC and DME MAC shared systems send "mass adjustment claims—other" to the BCRC via an ASC X12 837 flat file transmission, they shall take the following actions with respect to the fields that correspond to the loop 2300 NTE01 and NTE02 segments on the 837 COB flat file only if there was not a pre-existing 2300 NTE segment on the incoming Medicare claim:

1) Populate "ADD" in the field that corresponds to NTE01; and

2) Populate "MO," utilizing bytes 01 through 02, in the field that corresponds to NTE02.

B. Inclusion and Exclusion of Recovery Audit Contractor (RAC)-Initiated Adjustment Claims

Effective January 5, 2009, at CMS's direction, the BCRC modified the COIF to allow for the unique inclusion and exclusion of RAC-initiated adjustment claims. The CWF maintainer shall 1) create these new fields, along with accompanying 1-byte file dis-placement, within its version of the COIF; and 2) accept and process these new fields when the BCRC transmits them as part of its regular COIF updates. In addition, the CWF maintainer shall create a 1-byte RAC adjustment value in the header of its HUIP, HUOP, HUHH, HUHC, HUBC, and HUDC claims transactions (valid values="R" or spaces).

Through this instruction, all A/B MAC and DME MAC shared systems shall develop a method for uniquely identifying all varieties of RAC-requested adjustments, which occur as the result of post-payment review activities.

NOTE: Currently, fewer than five (5) MACs process RAC adjustments.

Prior to sending its processed 11X and 12X type of bill RAC-initiated adjustment transactions to CWF for normal verification and validation, the A/B MAC (Part A) and A/B MAC (Part HHH) shared system shall input the "R" indicator in the newly defined header field of the HUIP claim transaction if the RAC adjustment claim meets either of the following conditions:

1) The claim resulted in Medicare changing its payment decision from paid to denied (i.e., Medicare paid $0.00 as a result of the adjustment performed)**; or**

2) The claim resulted in a Medicare adjusted payment that falls below the amount of the inpatient hospital deductible.

Prior to sending RAC-initiated adjustment claims **with all other type of bill designations to CWF** for normal processing, the A/ B MAC (Part A) and A/B MAC (Part HHH) shared system shall input an "R" indicator in the newly defined header field of the HUOP, HUHH, and HUHC claim.

Prior to sending their processed RAC adjustment transactions to CWF for normal verification and validation, the A/B MAC (Part B) and DME MAC shared systems shall input the "R" indicator in the newly

defined header field of the HUBC and HUDC claim transactions.

Unique COBA ID Assignment to Trading Partners That Accept RAC-Initiated Adjustment Claims Only and Attendant A/B MAC and DME MAC Responsibilities

The BCRC will assign a unique COBA ID range (88000-88999) to COBA trading partners that elect to "include" RAC-initiated adjustment claims for crossover purposes and will not, at CMS's direction, charge the trading partner the standard crossover fee for that category of adjustment claims. Therefore, when A/B MACs and DME MACs receive a BOI reply trailer (29) on a claim that contains only a COBA ID in the range 88000 through 88999 (which designates RAC adjustment), the A/B MAC and DME MAC shall not expect payment for the claim.

Before the A/B MAC and DME MAC shared systems send "tagged" RAC-initiated adjustment claims to the BCRC via an ASC X12 837 flat file transmission, they shall take the following actions with respect to the fields that correspond to the loop 2300 NTE01 and NTE02 segments on the ASC X12 837 COB flat file only if there was **not** a pre-existing 2300 NTE segment on the incoming Medicare claim:

1) Populate "ADD" in the field that corresponds to NTE01; and

2) Populate "RA," utilizing bytes 01 through 02, in the field that corresponds to NTE02.

III. CWF Crossover Processes In Association with the Coordination of Benefits Contractor

A. CWF Processing of the COBA Insurance File (COIF) and Returning of BOI Reply Trailers

Effective July 6, 2004, the BCRC began to send initial copies of the COBA Insurance File (COIF) to the nine CWF host sites. The COIF contains specific information that will identify the COBA trading partner, including name, COBA ID, address, and tax identification number (TIN). It also contains each trading partner's claims selection criteria along with an indicator (Y=Yes or N=No) of whether the trading partner wishes its name to be printed on the Medicare Summary Notice (MSN). Effective with the October 2004 systems release, the COIF also contains a 1-digit Test/Production Indicator that will identify whether a COBA trading partner is in test (T) or production (P) mode. The CWF shall return that information as part of the BOI reply trailer (29) to A/B MACs and DME MACs.

Upon receipt of a claim, CWF shall take the following actions:

- Search for a COBA eligibility record on the BOI auxiliary record for each beneficiary and obtain the associated COBA ID(s) [NOTE: There may be multiple COBA IDs associated with each beneficiary.];

- Refer to the COIF associated with each COBA ID **NOTE**: The CWF shall pull the COBA ID from the BOI auxiliary record to obtain the COBA trading partner's name and claims selection criteria;

- Apply the COBA trading partner's selection criteria; and

- Transmit a BOI reply trailer to the A/B MAC and DME MAC only if the claim is to be sent, via 837 COB flat file or NCPDP file, to the BCRC to be crossed over.

B. BOI Reply Trailer and Claim-based Reply Trailer Processes

1. BOI Reply Trailer Process

For eligibility file-based crossover, all A/B MACs and DME MACs shall send processed claims

information to the BCRC for crossover to a COBA trading partner in response to the receipt of a CWF BOI reply trailer (29). A/B MACs and DME MACs will only receive a BOI reply trailer (29) under the consolidated crossover process for claims that CWF has selected for crossover after reading each COBA trading partner's claims selection criteria as reported on the weekly COIF submission.

When a BOI reply trailer (29) is received, the COBA assigned ID will identify the type of crossover (see the Data Elements Required for the BOI Aux File Record Table in Chapter 27, §24). Although each COBA ID will consist of a five-digit prefix that will be all zeroes, A/B MACs and DME MACs are only responsible for picking up the last five digits within these ranges, which will be right justified in the COBA number field. In addition to the trading partner's COBA ID, the BOI reply trailer shall also include the COBA trading partner name (s), an "A" crossover indicator that specifies that the claim has been selected to be crossed over, and a one-digit indicator ["Y"=Yes; "N"=No] that specifies whether the COBA trading partner's name should be printed on the beneficiary MSN. As discussed above, effective with the October 2004 systems release, CWF shall also include a 1-digit Test/Production Indicator on the BOI reply trailer (29) that is returned to the A/B MACs and DME MACs.

MSN Crossover Messages

Effective with the October 2004 systems release, the A/ B MACs and DME MACs began to receive BOI reply trailers (29) that contain an MSN indicator "Y" (Print trading partner name on MSN) or "N" (Do not print trading partner name on MSN).

When a COBA trading partner is in full production (Test/Production Indicator=P), the A/ B MAC and DME MAC shall read the MSN indicator returned on the BOI reply trailer (29). If the A/B MAC or DME MAC receives an MSN indicator "N," it shall print its generic crossover message(s) on the MSN rather than including the trading partner's name. Examples of existing generic MSN messages include the following:

(For all COBA ID ranges other than Medigap)

MSN #35.1 - "This information is being sent to private insurer(s). Send any questions regarding your benefits to them."

(For the Medigap COBA ID range)

MSN#35.2 - "We have sent your claim to your Medigap insurer. Send any questions regarding your Medigap benefits to them."

Beginning with the October 2004 systems release, A/B MACs and DME MACs shall follow these procedures when determining whether to update its claims history to show that a beneficiary's claim was selected by CWF to be crossed over.

- If the A/B MAC or DME MAC receives a BOI reply trailer (29) that contains a Test/Production Indicator "T," it shall not update its claims history to show that a beneficiary's claim was selected by CWF to be crossed over.

- If the A/B MAC or DME MAC receives a BOI reply trailer (29) that contains a Test/Production Indicator "P," it shall update its claims history to show that a beneficiary's claim was selected by CWF to be crossed over.

Effective January 5, 2009, when CWF returns a BOI reply trailer (29) to an A/B MAC and DME MAC that contains only a COBA ID in the range 89000 through 89999, the A/B MAC and DME

MAC shared system shall suppress all crossover information, including name of insurer and generic message#35.1, from all beneficiary MSNs.

A/B MACs and DME MACs shall not update their claims histories to reflect transference of "tagged" claims with COBA ID range 89000 through 89999 to the BCRC.

ASC X12 835 (Electronic Remittance Advice)/Provider Remittance Advice Crossover Messages

Beginning with the October 2004 release, when CWF returns a BOI reply trailer (29) that contains a "T" Test/Production Indicator to the A/B MACs and DME MACs, they shall not print information received from the BOI reply trailer (29) in the required crossover fields on the ASC X12 835 Electronic Remittance Advice or other provider remittance advices that are in production.

Beginning with the October 2004 release, when CWF returns a BOI reply trailer (29) that contains a "P" Test/Production Indicator to the A/B MACs and DME MACs, they shall use the returned BOI trailer information to take the following actions on the provider's 835 Electronic Remittance Advice:

a. Input code 19 in CLP-02 (Claim Status Code) in Loop 2100 (Claim Payment Information) of the 835 ERA (v. 4010-A1). [NOTE: Record "20" in CLP-02 (Claim Status Code) in Loop 2100 (Claim Payment Information) when Medicare is the secondary payer.]

b. Update the 2100 Loop (Crossover Contractor Name) on the 835 ERA as follows:

- NM101 [Entity Identifier Code]—Use "TT," as specified in the 835 Implementation Guide.

- NM102 [Entity Type Qualifier]—Use "2," as specified in the 835 Implementation Guide.

- NM103 [Name, Last or Organization Name]—Use the COBA trading partner's name that accompanies the first sorted COBA ID returned to you on the BOI reply trailer.

- NM108 [Identification Code Qualifier]—Use "PI" (Payer Identification)

- NM109 [Identification Code]—Use the first COBA ID returned to you on the BOI reply trailer. (See line 24 of the BOI aux. file record

Effective with January 5, 2009, if CWF returns only COBA ID range 89000 through 89999 on a BOI reply trailer (29) to an A/B MAC and DME MAC, the associated shared system shall suppress all crossover information (the entire 2100 loop) on the 835 ERA.

CWF Sort Routine for Multiple COBA IDs

Effective with October 3, 2011, when a beneficiary's claim is associated with more than one COBA ID (i.e., the beneficiary has more than one health insurer/benefit plan that pays after Medicare), CWF shall sort the COBA IDs and trading partner names in the following order on the returned BOI reply trailer (29): 1) Eligibility-based Medigap (30000-54999); 2) Medigap claim-based (55000-59999); 3) Supplemental (00001-29999); 4) Other Insurer (80000-80213); 5) Other Insurance (80215-88999); 6) TRICARE (60000-69999); 7) CHAMPVA (80124); 8) Medicaid (70000-79999); and 9) Other-Health Care Pre-payment Plan [HCPP] (89000-89999). When two or more COBA IDs fall in the same range (see element 24 of the "Data Elements Required for the BOI Aux File Record" Table in chapter 27, §80.4 for more details), CWF shall sort numerically within the same range.

IV. A/B MAC and DME MAC Actions Relating to the Transition to the ASC X12 837 Version 5010 and NCPDP Version D.O

A. CWF COIF and BOI Reply Trailer (29) Processes

Effective January 5, 2009, the BCRC , at CMS's direction, created a new 1-byte "5010 Test/Production Indicator" and a new 1-byte "NCPDP D.0 Test/Production Indicator" on the COBA Insurance File [COIF] (valid values= "N"—not applicable or not ready as yet; "T"—test; "P"—production). In addition, the CWF maintainer shall add a new "5010 Test/Production Indicator" and an "NCPDP D.0 Test/Production Indicator" to the BOI reply trailer (29) format. (See Pub.100-04 chapter 27, §80.*7* for additional details regarding CWF requirements relating to the new crossover claim formats.)

B. Transmission of the COB Flat File or NCPDP File to the BCRC

Regardless of whether a COBA trading partner is in test mode (Test/Production Indicator returned via the BOI reply trailer 29=T) or production mode (Test/Production Indicator returned via the BOI reply trailer 29=P), A/B MACs and DME MACs shall transmit all non-NCPDP claims received with a COBA ID via a BOI reply trailer to the BCRC in an ASC X12 837 flat file, as described in Transmittal AB-03-060. In a separate transmission, DME MACs shall send the claims received in the NCPDP file format to the BCRC. A/B MACs and DME MACs shall enter the 5-digit COBA ID picked up from the BOI reply trailer (29) in the 1000B loop of the NM1 segment in the NM109 field. In a situation where multiple COBA IDs are received for a claim, A/B MACs and DME MACs shall send a separate ASC X12 837 or NCPDP transaction to the BCRC for each COBA ID. A/B MACs and DME MACs shall perform the transmission at the end of their regular batch cycle, when claims are removed from their payment floor, to ensure crossover claims are not processed by the COBA trading partner prior to Medicare's final payment. Transmission to the BCRC shall occur via Connect: Direct or other CMS dictated connectivity.

Effective with October 4, 2005, when the A/B MAC and DME MAC shared systems transfer processed claims to the BCRC as part of the COBA process, they shall include an additional 1-digit alpha character ("T"=test or "P"=production) as part of the BHT03 identifier (Beginning of the Hierarchical Transaction Reference Identification) that is included within the ASC X12 837 flat file or NCPDP submissions. The shared systems shall determine that a COBA trading partner is in test or production mode by referring to the BOI reply trailer (29) originally received from CWF for the processed claim. (See §70.6.1 of this chapter for further details about the BHT03 identifier.)

Effective October 2, 2006, the Virtual Data Center (VDC), formerly the Enterprise Data Centers (EDCs), shall transmit a combined COBA "test" and "production" ASC X12 837 flat file and a combined "test" and "production" NCPDP file, as applicable, to the BCRC.

NOTE: This requirement changes the direction previously provided in October 2005 through the issuance of Transmittal 586.

Flat File Conventions for Transmission to the BCRC For Production COBA Crossover Claims Prior to July 2012

With respect to ASC X12 837 COB flat file submissions to the BCRC, A/B MACs (Part B) and DME MACs shall observe these process rules:

The following segments shall not be passed to the BCRC:

1. ISA (Interchange Control Header Segment);
2. IEA (Interchange Control Trailer Segment);
3. GS (Functional Group Header Segment); and
4. GE (Functional Group Trailer Segment).

The 1000B loop of the NM1 segment denotes the crossover partner. If multiple COBA IDs are received via the BOI reply trailer, the shared system shall ensure that a separate ASC X12 837 transaction should be submitted for each COBA ID received. As the crossover partner information will be unknown to the standard systems, the following fields should be formatted as indicated for the NM1 segment:

NM103—Use spaces; and
NM109—Include COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29).

The 2010BA loop denotes the subscriber information. If available, the subscriber name, address, and policy number should be used to complete the NM1, N3, and N4 segments. If unknown, the segments should be formatted as follows, with BCRC completing any missing information:

NM1 segment—For NM103, NM104, NM105, and NM107, use spaces;
NM1 segment—For NM109, include beneficiary's Medicare *beneficiary identifier*;
N3 segment—Use all spaces; and
N4 segment—Use all spaces.

The 2010BB loop denotes the payer name. Per the HIPAA Implementation Guide (IG), this loop should define the secondary payer when sending the claim to the second destination payer. Consequently, given that the payer related to the COBA ID will be unknown by the standard systems, the NM1, N3, and N4 segments should be formatted as follows, with BCRC completing any missing information:

NM1 segment—For NM103, use spaces;
NM1 segment—For NM109, include the COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29);
N3 segment—Use all spaces; and
N4 segment—Use all spaces.

The 2330B loop denotes other payers for the claim. If multiple COBA IDs are returned via the BOI reply trailer, payer information for the additional COBA IDs will be unknown. As with the 2010BB loop, the NM1 segment should be formatted as follows, with BCRC completing any missing information:

NM103—Use spaces; and
NM109—Include COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29).

The 2330B loop shall be repeated to allow for the inclusion of the name (NM103) and associated Trading Partner ID (NM109) for each existing trading partner.

The 2320 loop denotes other subscriber information. Within the SBR segment, the SBR03 and SBR04 segments are used to define the group/policy number and insured group name, respectively. If the information is available for these fields, those values should be propagated accordingly for both current trading partners and COBA trading partners. The BCRC will inspect these values for COBA related eligibility based claims and overlay as appropriate. Spaces should only be used for COBA-related situations.

SBR01—Treat as normally do.

With respect to ASC X12 837 COB flat file submissions to the BCRC, A/B MACs (Part A) and A/B MACs (Part HHH) shall observe these process rules:

As the ISA, IEA, and GS segments are included in the "100" record with other required segments, the "100" record must be passed to the BCRC. However, as the values for these segments will be recalculated, spaces may be placed in all of the fields related to the ISA, IEA, and GS segments.

The 1000B loop of the NM1 segment denotes the crossover trading partner. If multiple COBA IDs are received via the BOI reply trailer, the A/B MAC or DME MAC system shall ensure that a separate 837 transaction should be submitted for each COBA ID received. As the crossover trading partner information will be unknown to the standard systems, the following fields should be formatted as follows for the NM1 segment on the"100" record:

NM103—Use spaces; and
NM109—Include COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29).

The 2010BA loop denotes the subscriber information. If available, the subscriber name, address, and policy number should be used to complete the NM1, N3, and N4 segments. If unknown, the segments should be formatted as follows for the "300" record, with BCRC completing any missing information:

NM1 segment – For NM103, NM104, NM105, and NM107, use spaces;
NM1 segment—For NM109, include beneficiary's Medicare *beneficiary identifier*;
N3 segment—Use all spaces; and
N4 segment—Use all spaces.

The 2010BC loop denotes the payer name. Per the HIPAA IG, this loop should define the secondary payer when sending the claim to the second destination payer. Consequently, since the payer related to the COBA ID will be unknown to the standard systems, the NM1, N3, and N4 segments should be formatted as follows for the "300" record, with BCRC completing any missing information:

NM1 segment—For NM103, use spaces;
NM1 segment—For NM109, include COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29);
N3 segment—Use all spaces; and
N4 segment—Use all spaces.

The 2330B loop of the "575" record denotes other payers for the claim. If multiple COBA IDs are returned via the BOI reply trailer, payer information for the additional COBA IDs will be unknown. As with the 2010BC loop, the NM1 segment should be formatted as follows, with BCRC completing any missing information:

NM103—Use spaces; and
NM109—Include COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29).

The 2330B loop shall be repeated to allow for the inclusion of the name (NM103) and associated Trading Partner ID (NM109) for each existing trading partner.

The 2320 loop denotes other subscriber information. Within the SBR segment, the SBR03 and SBR04 segments are used to define the group/policy number and insured group name, respectively. If the information is available for these fields, those values should be propagated accordingly. The BCRC will inspect these values for COBA related eligibility based claims and overlay as appropriate. Spaces should only be used for COBA-related situations.

SBR01—Treat as normally do.

C. BCRC Processing of COB Flat Files or NCPDP Files

When an A/B MAC and DME MAC receives the reject indicator "R" via the Claims Response File, it is to retransmit the entire file to the BCRC. If the A/B MAC or DME MAC receives an acceptance indicator "A," this confirms that its entire COB flat file or NCPDP file transmission was accepted. Once COB flat files or NCPDP files are accepted and translated into the appropriate outbound format(s), BCRC will cross the claims to the COBA trading partner. The format of the Claims Response File that will be returned to

each A/B MAC and DME MAC by the BCRC, following its COB ASC X12 837 flat file or NCPDP file transmission, appears in the table below. (See §70.6.1 for specifications regarding the receipt and processing of the BCRC Detailed Error Reports.)

Claims Response File Layout (80 bytes)

Field	Name	Size	Displacement	Description
1	A/B MAC or DME MAC Number	5	1-5	A/B MAC or DME MAC Identification Number
2	Transaction Set Control Number/ Batch Number	9	6-14	Found within the ST02 data element from the ST segment of the ASC X12 837 flat file or in field 806-5C from the batch header of the NCPDP file.
3	Number of claims	9	15-23	Number of Claims contained in the ASC X12 837 flat file or NCPDP file. This is a numeric field that will be right justified and zero-filled.
4	Receipt Date	8	24-31	Receipt Date of ASC X12 837 flat file or NCPDP file in CCYYMMDD format
5	Accept/Reject indicator	1	32	Indicator of either the acceptance or rejection of the ASC X12 837 flat file or NCPDP file. Values will either be an "A" for accepted or "R" for rejected.
6	Filler	48	33-80	Spaces

Claims response files will be returned to A/B MACs and DME MACs after receipt and initial processing of a claim file. Thus, for example, if an A/B MAC or DME MAC sends a COB flat file daily via the VDC, the BCRC will return a claim response file to that entity on a daily basis.

ASC X12 COB 837 flat files and NCPDP files that will be transmitted by the VDC on behalf of each A/B MAC and DME MAC, as applicable, to the BCRC will be assigned the following file names, regardless of whether a COBA trading partner is in test or production mode:

PCOB.BA.NDM.COBA.Cxxxxx.PARTA(+1) [Used for Institutional Claims]
PCOB.BA.NDM.COBA.Cxxxxx.PARTB(+1) [Used for Professional Claims]
PCOB.BA.NDM.COBA.Cxxxxx.NCPDP(+1). [Used for Drug Claims]

Note that "xxxxx" denotes the A/B MAC or DME MAC number.

A/B MACs and DME MACs shall perform the ASC X12 837 flat file and NCPDP file transmission at the end of the regular batch cycle, when claims come off the payment floor, to ensure crossover claims are not processed by the trading partner prior to Medicare's final payment.

Files transmitted by the VDC to the BCRC shall be stored for 51 business days from the date of transmission.

The file names for the Claims Response File returned to the A/B MAC and DME MAC via the VDC will be created as part of the NDM set-up process.

Outbound COB files transmitted by BCRC to the COBA trading partners will be maintained for 50 business days following the date of transmission.

E. The COBA Medigap Claim-Based Process Involving CWF

Refer to §70.6.4 of this chapter for more information regarding this process.

F. COBA Customer Service Issues

1. Customer Service

   a. A/ B MACs and DME MACs shall use the BCRC and CMS COBA Problem Inquiry Request Form to identify and send COBA related problems and issues to the COB contractor for research.

      In order to track trading partner requests for research of 837 ASC X12 issues, CMS requires A/B MACs and DME MACs to submit a COBA Problem Inquiry Request Form to the BCRC or CMS. This process is being implemented to reduce the number of duplicate issues being researched and to ensure your requests are processed timely. The standard form enables CMS and BCRC to track issues through completion and manage the process of addressing post-COBA production issues. Upon receipt the submitter shall receive a response from the BCRC with the assigned contact information.

      CMS is also requiring A/B MACs and DME MACs to use the COBA Problem Inquiry Request Form when requesting a BCRC representative to research a COBA issue. The combined BCRC-CMS COBA Problem Inquiry Request Form appears below.

A/B MAC and DME MAC: COBA PROBLEM INQUIRY REQUEST FORM

(Completed by Submitter – control number if applicable Write in this column only

MAC ID# (Enter the A/B MAC or DME MAC ID # assigned by CMS)		
MAC Reference ID (If applicable - BHT03)		
Reported By (Enter submitter's last name, first name)		
Date Submitted (Enter current date – MM/DD/YR)		
Contact # (Enter submitter's phone #)		
E-mail Address (Enter submitter's e-mail address)		
COBA ID #		

Description of Problem (Check applicable category)

☐ **HIPAA Error Code**

ICN Date (Date file was transmitted to the BCRC)	
HIPAA Error Code(s)	
Part A/Part B/NCPDP Claim	

☐ **Technical Issue** (Claims file transmission failures)

File Name	
Transmission Date	

Summary of Issue- Provide detail of problem and note if back-up information will be faxed, e.g., Sample Claims to be Faxed on MM/DD/YR. Indicate whether you would like your issue on the next HIPAA issues log **– do not include any PHI information on this form if sent via email.** All PHI information must be submitted via fax to the BCRC to the attention of your BCRC representative at 646-458-6761. **Do not include PHI information on the fax cover sheet.** Claim examples of issues to be addressed must include the beneficiary Medicare *beneficiary identifier* and the claim ICN/DCN.

BCRC USE ONLY. Date: Ticket #:

V. Identification of Mass Adjustments for COBA Crossover Purposes

All A/B MACs and DME MACs and their shared systems shall develop a method for differentiating "mass adjustments tied to the Medicare Physician Fee Schedule (MPFS) updates" and "all other mass adjustments" from all other kinds of adjustments and non-adjustment claims.

NOTE: For appropriate classification, all adjustments that do not represent "mass adjustments-MPFS" or "mass adjustments-other" shall be regarded as "other adjustments.") DME MACs and their shared system shall only be required to identify mass adjustments-other, which represents a current functionality available within VMS. This is because DME MACs do not use pricing from the MPFS when processing their claims.

Working Definition of "Mass Adjustment"

For COBA crossover purposes, a "mass adjustment" refers to an action that an A/B MAC or DME MAC undertakes using special software (e.g., Super-Op Events or Express Adjustments) to pull together claims with the anticipated purpose of making monetary changes to a high number of those claims. If, however, A/B MACs and DME MACs do not have special software to perform high volume adjustments (i.e., typically adjustments to 100 or more claims), but instead must perform their high volume adjustments manually, this action also fulfills the definition of a "mass adjustment."

Inputting a One-Byte Header Value on Claim Transactions to Designate Mass Adjustment and

Associated Processes

Before A/B MACs and DME MACs cable their claims to CWF for verification and validation, they shall populate a 1-byte "mass adjustment" indicator in the header of their HUBC, HUDC, HUIP, HUOP, HUHH, or HUHC entry code "5" or action code "3" claim transactions. The CWF maintainer shall create a new 1-byte field within the header of its HUBC, HUDC, HUIP, HUOP, HUHH, or HUHC claims transactions for this purpose.

A/ B MACs and DME MACs shall determine whether the "M" or "O" indicator applies in relation to a given claim at the point that they initiate a mass adjustment action on that claim using a manual process or an automated adjustment process; e.g., Super Op Events or Express Adjustments. Upon making this determination, the A/B MACs and DME MACs and their shared systems shall populate one (1) of the following mass adjustment claim indicators, specific to the particular claim situation, within the header of the A/B MACs or DME MACs' processed claims that they will cable to CWF for verification and validation:

"M"—if mass adjustment claim tied to an MPFS update; **or**
"O"—if mass adjustment claim-other.

If A/B MACs and DME MACs send values other than "M" or "O" within the newly designated field within the header of their HUBC, HUDC, HUIP, HUOP, HUHH, or HUHC entry code "5" or action code "3" claims, CWF shall apply an edit to reject the claims back to the MAC. Upon receipt of the CWF rejection edit, the shared systems shall correct the invalid value and retransmit the claims to CWF for verification and validation.

VI. Special ASC X12 835 Remittance Advice and MSN Requirements for Health Care Pre-Payment Plans (HCPPs) and Health Maintenance Organization (HMO) Cost Plans that Receive Crossover Claims

Effective January 5, 2009, at CMS's direction, the BCRC assigned all COBA HCPP and HMO Cost Plan participants a unique 5-byte COBA ID that falls within the range 89000 through 89999. The CWF system shall accept the reporting of this COBA ID range.

Upon receipt of a BOI reply trailer (29) that contains only a COBA ID in the range 89000 through 89999, the A/B MAC and DME MAC shared systems shall suppress all crossover information (including name of the insurer; generic message; and specific code (for ASC X12 835, code MA-18; for MSN, code 35.1) indicating that the claim will be crossed over) from the associated ASC X12 835 remittance advice and beneficiary MSN. (See §70.6.1 of this chapter for A/B MAC or DME MAC requirements relating to the BCRC Detailed Error Report processes and receipt of claims that contain COBA ID range 89000 through 89999.)

VII. Special Suppression Requirements for Part A Credit Claim Portion of Debit-Credit Claim Pairing

Effective with the April 2009 release, the A/B MAC (Part A) and A/B MAC (Part HHH) shared system shall suppress sending the credit claim portion of the debit-credit pairing (that transaction which cancels the original claim) associated with each affiliated A/B MAC's (A, HHH) adjustment claims to the BCRC. Upon suppressing the credit claim, the A/B MAC (Part A) and A/B MAC (Part HHH) system shall mark the claims history of its affiliate MAC to reflect this action.

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

(Rev. 4281, Issued: 04- 19-19, Effective: 05-20-19, Implementation: 05-20-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new

Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Effective with the July 2005 release, CMS implemented an automated process to notify physicians/ practitioners, suppliers, and providers that specific claims that were previously tagged by the Common Working File (CWF) for crossover will not be crossed over due to claim data errors. Claims transmitted via ASC X12 837 flat file by the A/B MAC and DME MAC shared systems to the Benefits Coordination & Recovery Center (BCRC) may be rejected at the flat file level, at a HIPAA ASC X12 pre-edit validation level, or by trading partners as part of a financial dispute arising from an invoice received.

Effective with the April 2005 release, the A/B MAC and DME MAC shared systems began to populate the BHT 03 (Beginning of Hierarchical Reference Identification) portion of their ASC X12 837 COB flat file submissions to the BCRC with a unique 22-digit identifier. This unique identifier will enable the BCRC to successfully tie a claim that is rejected by the BCRC at the flat file or HIPAA ASC X12 pre-edit validation levels as well as claims disputed by trading partners back to the original ASC X12 837 flat file submissions.

Effective October 4, 2005, A/ B MACs and DME MACs and their shared systems began to receive notification via the BCRC Detailed Error Reports, whose file layout structures appear below, that a COBA trading partner is in test or production mode via the BHT 03 identifier that is returned from the BCRC.

Effective April 3, 2011, all A/B MACs and DME MACs shall include an extra 1-byte "Original versus Adjustment Claim Indicator" value within the BHT03 identifier on all ASC X12 837 institutional and professional claims they transmit to the *BCRC* for crossover purposes. The BCRC shall, in turn, return this value to the appropriate A/B MAC and DME MAC via the BCRC Detailed Error Report process. In addition, the DME MAC shared system shall send an additional 1-byte value (defined as "reserved for future use") as spaces in field 504-F4 (Message) of the NCPDP flat file sent to the BCRC. The BCRC shall, in turn, also return this value to the appropriate DME MAC via the BCRC Detailed Error Report process.

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

Effective with April 7, 2014, CMS has added 2 new 1-byte Original versus Adjustment indicators to the suite of possible options for position 23 of the BHT03 identifier, as reflected below.

A. Inclusion of the Unique 23-Digit Identifier on the ASC X12 837 Flat File and NCPDP File

1. Populating the BHT 03 Portion of the ASC X12 837 Flat File

The A/B MAC and DME MAC shared systems shall populate the BHT 03 (Beginning of Hierarchical Transaction Reference Identification; **field length=30 bytes**) portion of their ASC X12 837 flat files that are sent to the BCRC for crossover with a 23-digit Contractor Reference Identifier (CRI). The identifier shall be formatted as follows:

a. A/B MAC or DME MAC number (9-bytes; until the 9-digit MAC number is used, report the 5-digit MAC number, left-justified, with spaces for the remaining 4 positions);

b. Julian date as YYDDD (5 bytes);

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

d. Claim version indicator (2 bytes, numeric, to denote claim version)
**Acceptable values = 50 (for ASC X12 claims), and 20 (for NCPDP D.0 claims);

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

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

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

O - for original claims;

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

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

S - for mass adjustment claims—all others;

R - for RAC adjustment claims*;*

A - for routine adjustment claims, not previously classified*;* and
C – for CMS-directed mass adjustment action (use specified by CMS).

The following indicator is only applicable to FISS-generated claims:
V - Void/cancel only claim

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

2. NCPDP 23-Digit Unique Identifier

Effective April 3, 2011, the DME MAC shared system shall also adopt a unique 23-digit format, referenced directly above under “Populating the BHT 03 Portion of the ASC X12 837 Flat File.” However, prior to April 7, 2014, the system shall populate the unique 23-digit identifier (defined as “future use”) with spaces in field 504-F4 (Message) within the NCPDP file (field length=35 bytes). The DME MAC shared system shall populate the unique identifier, left justified, in the field. Spaces shall be used for the remaining bytes in the field.

Effective April 7, 2014, the DME MAC shared system shall ensure that its DME MACs have the ability to 1) execute actions that will result in the transmission of their HUDC claims to CWF with Mass Adjustment Indicator set to “O”; and 2) transmit mass adjusted NCPDP D.0 COB claims to the BCRC under a 504-F04 (Message) field identifier of "C" (CMS-directed mass adjustment action) or "P" (mass adjustments tied to Affordable Care Act or Congressional/legislative mandate) as appropriate to the situation.

In addition, the DME MAC shared system shall ensure that all NCPDP D.0 crossover claims will now be sent to the BCRC with the 23rd byte 504-F04 (Message) field indicator completed, when appropriate, as indicated below.

O -- for all "original" NCPDP D.0 claims transmitted;

A-- for "routine adjustment claims" transmitted; and

R-- for recovery audit claims (RAC) adjustment claims transmitted.

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

The A/B MAC and DME MAC shared systems shall accept the BCRC Institutional, Professional, and NCPDP Detailed Error Reports received from the BCRC. The formats for each of the Detailed Error Reports appear below.

Beginning with July 2007, all A/B MAC and DME MAC systems shall no longer interpret the percentage values received for ASC X12 837 institutional and professional claim “222” and “333” errors via the BCRC Detailed Error Reports as if the values contained a 1-position implied decimal (e.g., “038”=3.8 percent). DME MACs shall also no longer interpret the percentage values received for NCPDP claims for “333” errors via the BCRC Detailed Error Report for such claims as if the values should contain a 1-position implied decimal.

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

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

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

BCRC Detailed Error Report

Institutional Error File Layout - (Detail Record)

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

Institutional Error File Layout - (Summary Record)

Field	Description	Field Size	Record Location
1	Date	8	1-8
2	Total Number of Claims for Processing Date	10	9-18
3	Number of '111' Errors	10	19-28
4	Number of '222' Errors	10	29-38
5	Percentage of '222' Errors	3	39-41

Field	Description	Field Size	Record Location
6	Number of '333' Errors	10	42-51
7	Percentage of '333' Errors	3	52-54
8	Filler	19	55-73
9	Summary Record ID Error Source Code	3	74-76 ('999')
10	Filler	524	77-600

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

BCRC Detailed Error Report

Professional Error File Layout - (Detail Record)

Field	Description	Field Size	Record Location
1	Date	8	1-8
2	Control Number	9	9-17
3	COBA ID	10	18-27
4	Subscriber ID/Medicare ID	12	28-39
5	Claim DCN/ICN	14	40-53
6	Record Number	9	54-62
7	Record/Loop Identifier	6	63-68
8	Segment	3	69-71
9	Element	2	72-73
10	Error Source Code	3	74-76 ('111', '222', '333')
11	Error/Trading Partner Dispute Code	6	77-82
12	Filler	100	83-182
13	Field Contents	50	183-232
14	BHT 03 Identifier	30	233-262 (23 bytes used)
15	Claims DCN/ICN	23	263-285
16	Error Description	300	286-858
17	Filler	15	586-600

Professional Error File Layout – (Summary Record)

Field	Description	Field Size	Record Location
1	Date	8	1-8
2	Total Number of Claims for Processing Date	10	9-18
3	Number of '111' Errors	10	19-28
4	Number of '222' Errors	10	29-38
5	Percentage of '222' Errors	3	39-41
6	Number of '333' Errors	10	42-51
7	Percentage of '333' Errors	3	52-54
8	Filler	19	55-73
9	Summary Record ID Error Source Code	3	74-76 ('999')
10	Filler	524	77-600

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

BCRC Detailed Error Report

NCPDP Error File Layout - (Detail Record)

Field	Description	Field Size	Record Location
1	Date	8	1-8
2	Batch Number	7	9-15
3	COBA ID	5	16-20
4	Medicare ID	12	21-32
5	CCN	14	33-46
6	Record Number	9	47-55
7	Batch Record Type	2	56-57
8	Segment ID	2	58-59
9	Error Source Code	3	60-62 ('111', or '333')

Field	Description	Field Size	Record Location
10	Error/Trading Partner Dispute Code	6	63-68
11	Error Description	100	69-168
12	Field Contents	50	169-218
13	Unique File Identifier	30	219-248 (23 bytes used)
14	CCN	23	249-271
15	Filler	18	272-289

NCPDP Error File Layout - (Summary Record)

Field	Description	Field Size	Record Location
1	Date	8	1-8
2	Total Number of Claims for Processing Date	10	9-18
3	Number of '111' Errors	10	19-28
4	Number of '333' Errors	10	29-38
5	Percentage of '333' Errors	3	39-41
6	Filler	18	42-59
7	Summary Record ID Error Source Code	3	60-62 ('999')
10	Filler	524	63-289

If the BCRC has rejected back to the A/B MAC and DME MAC shared system for 2 or more COBA Identification Numbers (IDs), the shared system shall receive a separate error record for each COBA ID. Also, if a file submission from a shared system to the BCRC contains multiple provider, subscriber, or patient level errors for one COBA ID, the shared system will receive a separate error record for each provider, subscriber, or patient portion of the file on which errors were found.

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

1. Error Source Code

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

2. Time Frames for Notification of All MACs Financial Management Staff and Providers

A/B MACs and DME MACs, or their shared systems, shall provide notification to MAC financial management staff for purposes of maintaining an effective reconciliation of crossover fee/ complementary credits received within five (5) business days of receipt of the BCRC Detailed Error Report.

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

a) **Special Automated Provider Correspondence**

A/B MACs and DME MACs, or their shared systems, shall also take the following actions indicated below only when they determine via the Beneficiary Other Insurance (BOI) reply trailer (29) that a COBA trading partner is in crossover production mode with the BCRC (Test/Production Indicator=P). After an A/B MAC or DME MAC, or its shared system, has received a BCRC Detailed Error Report that contains claims with error source codes of “111” (flat file error) “222” (HIPAA ASC X12 error), or “333” (trading partner dispute), it shall take the following two specified actions within five (5) business days:

1. Notify the physician/practitioner, supplier, or provider via automated letter from your internal correspondence system that the claim did not cross over. The letter shall include specific claim information, not limited to, Internal Control Number (ICN)/Document Control Number (DCN), *Medicare beneficiary identifier*, Medical Record Number (for Part A only), Patient Control Number (only if it is contained in the claim), beneficiary name, date of service, and the date claim was processed.
2. Effective with July 2007, A/B MACs and DME MACs and their systems shall ensure that, in addition to the standard letter language (the claim(s) was/were not crossed over due to claim data errors and was/were rejected by the supplemental insurer), their A/B MACs' and DME MACs' special provider letters/reports, which are generated for '222' and '333' error rejections in accordance with CR 4277, now include the following additional elements, as derived from the BCRC Detailed Error Report: 1) HIPAA H-series rejection code or other rejection code, and 2) the rejection code's accompanying description.

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

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

   Effective with October 1, 2007, all A/B MACs and DME MACs shall modify their special provider notification letters that are generated for "111," "222," and "333" error situations to include the following standard language within the opening paragraph of their letters: "This claim(s) was/were not crossed over due to claim data errors or was/were rejected by the supplemental insurer."

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

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

b) Special Exemption from Generating Provider Notification Letters

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

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

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

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

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

1) Suppress generation of the special provider letters; and

2) Not update their affiliated A/B MACs and DME MACs' claims histories to indicate that the BCRC will **not** be crossing the affected claims over.

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

(Rev. 4281, Issued: 04- 19-19, Effective: 05-20-19, Implementation: 05-20-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

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

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

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

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

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

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

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

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

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

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

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

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

Scenario 4: If a provider, physician/practitioner, or supplier submits an ASC X12 837 current version institutional or professional claim to an A/B MAC (A), A/B MAC (HH), or DME MAC and if that entity receives a Common Working File (CWF) Beneficiary Other Insurance (BOI) reply trailer (29) that contains an "N" current version Test/Production indicator and a "P" future version indicator, the affected shared systems shall: 1) create nothing in terms of a current version COB claim; and 2) create a "production" future version non-SFR COB claim.

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

The shared system shall produce a future version "skinny" claim, without SFR content, in the event that a claim that an A/B MAC or DME MAC originally adjudicated in the current version format is later released from suspense status or is adjusted during a time frame when a COBA trading partner has moved to the ASC

X12 837 future version production (that is, the BOI reply trailer 29 contains a "P" future version Test/Production indicator).

In addition, as of the mandatory cutover date to the future version claim transaction, all shared systems shall have the capability of repairing claims that previously errored out in the current version format prior to the cutover date, doing so in the future version COB claim format on and after January 1, 2012.

ADDRESSING INCOMING PAPER CLAIMS FOR OUTBOUND COB PURPOSES

Scenario 1: During the transitional period, if a provider, physician/practitioner, or supplier submits a hard-copy claim (paper Form CMS-1450 or Form CMS-1500) or, as applicable, enters a direct-data-entry (DDE) claim to an A/B MAC (A), A/B MAC (HH), or DME MAC and if that entity receives a CWF BOI reply trailer (29) that contains a "P" current version Test/Production indicator and a "T" future version indicator, the affected shared system shall: 1) produce a "skinny" non-SFR current version "production" COB claim; and 2) produce a "skinny" non-SFR future version "test" COB claim.

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

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

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

IMPORTANT: For all scenarios, if the inbound claim's format is the same as the outbound claim, the shared system shall produce crossover claims with full SFR claim content as part of their A/B MACs (A,B, HH)' or DME MACs' ASC X12 837 COB flat file transmissions to the BCRC.

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

A. ASC X12 837 Institutional COB Claim Mapping Rules

Effective with the testing and implementation of the HIPAA ASC X12 837 institutional claim (new and now current version), the Fiscal Intermediary Shared System (FISS) shall observe the following business rules for mapping of the ASC X12 837 COB (institutional) flat file:

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

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

2. The shared system shall map the claim version (version 005010X223A2 upon adoption of the 5010 Errata changes) in the field of the ASC X12 837 5010 COB flat file that corresponds to the ST03 segment.

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

   a. Normal claims submission to the BCRC—use "00"; and
   b. COBA claims repair process—use "18."

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

   a. 23 bytes for non-COBA recovery claims as follows:

   Bytes 1-9—A/B MAC (A or HH) ID (9 bytes; A/B MAC (A or HH) ID, or, 5 bytes left justified, followed by 4 spaces);
   Bytes 10-14—Julian Date (5 bytes, expressed as "YYDDD");
   Bytes 15-19—Sequence Number (5 bytes, starting with "00001"; should increment for each ST-SE envelope);
   Bytes 20-21—Claim Version Indicator (2 bytes; value =50 for 5010 claims); and
   Byte 22—Test/Production Indicator (1 byte; valid values="T"—test; "P"—production).
   Byte 23—Original versus Adjustment Claim Indicator (1 byte)
   Valid values:

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

   O—for original claims;

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

   M—for non-Affordable Care Act mass adjustments tied to Medicare Physician Fee Schedule (MPFS);S—for mass adjustment claims—all others; R—for RAC adjustment claims;

   A—for routine adjustment claims, not previously classified;
   Additionally, as of April 7, 2014:

   C – for CMS-directed mass adjustment action (use specified by CMS).

   V—for void/cancel only claim

   b. 23 bytes for COBA recovery claims as follows:

   Bytes 1-9—A/B MAC (A or HH) ID (9 bytes; A/B MAC (A or HH) ID, or, 5 bytes left justified, followed by 4 spaces);
   Bytes 10-14—Julian Date (5 bytes, expressed as "YYDDD");
   Bytes 15-19—Sequence Number (5 bytes, starting with "00001"; should increment for each ST-SE envelope);
   Bytes 20-21—Claim Version Indicator (2 bytes; values=50 for 5010 claims); and
   Byte 22—COBA recovery indicator (1 byte; indicator =R).
   Byte 23—Original versus Adjustment Claim Indicator (1 byte) (NOTE: For valid values see II.A.4.a directly above.)

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

   a. PER01—populate “1C”;
   b. PER02—populate “BCRC EDI Department”;
   c. PER03—populate “TE”; and
   d. PER04—populate “6464586740.”

6. The 1000-B loop NM1 (Receiver Name) denotes the crossover trading partner. If an A/B MAC (A, HHH) 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 shared systems, the shared systems shall format the following fields as indicated:

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

7a. To populate the 2010AA NM1 (Billing Provider Name), 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 A/B MAC (A or HH)’s internal provider file;
   d. NM108—populate “XX”; and
   e. NM109—populate NPI value, as derived from the incoming claim.

   For 2010AA N3 and N4 segments, FISS shall derive the required segments from the A/B MAC (A or HH)’s internal provider file.

7b. If the incoming claim is paper Form CMS-1450 or 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 A/B MAC (A or HH)’s internal provider file;
   d. NM108—populate “XX”; and
   e. NM109—derive NPI from Form Locator (FL) 56 of the Form CMS-1450 claim or applicable DDE field.

   For 2010AA N3 and N4 segments, FISS shall derive the required segments from FLs 1 and 2 of the Form CMS-1450 claim or internal provider file as necessary.

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

a. NM101—populate “87”;
b. NM102—populate “2”; and
c. NM103—derived from A/B MAC (A or HH)’s internal provider file.

For 2010AB N3 and N4 segments, FISS shall derive the required segments from the A/B MAC (A or HH)’s internal provider file.

8b. If the incoming claim is paper Form CMS-1450 or 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 A/B MAC (A or HH)’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 A/B MAC (A or HH)’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 A/B MAC (A or HH)’s front-end) to the equivalent 837 COB flat as follows:
a. For PRV01—populate “BI”;
b. For PRV01—populate “PXC”; and
c. For PRV03—populate taxonomy code value from incoming claim.

10b. If the incoming claim is paper Form CMS-1450 or DDE entered, 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 Form CMS-1450 claim form or as derived from the appropriate field from the online DDE screen.

NOTE: The only reason why the 2310A PRV cannot be included on the 837 COB flat file is that the Form CMS-1450 claim and DDE claim entry screens can only accommodate Bill-to Provider taxonomy code reporting.

11. 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 A/B MAC (A or HH)’s internal provider files. If the information is not available, or is available in incomplete form (i.e., fewer digits than required), the shared system shall <u>not</u> create the 2010AA PER loop within the 837 new current version 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 "CI."

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 the beneficiary's Medicare *beneficiary identifier*.

2010BA N3—Subscriber Address:

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

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

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

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

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

2330A—NM1:

a NM101—populate "IL";
b. NM102—populate "1";
c. NM103—derive from internal beneficiary eligibility file;
d. NM104—derive from internal beneficiary eligibility file;

e. NM105—derive from internal beneficiary eligibility file if available; otherwise populate spaces;
f. NM108—populate "MI"; and
g. NM109—populate the beneficiary's Medicare *beneficiary identifier*.

2330A-N3:

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

2330A-N4:

Upon implementation of the 5010 Errata, the shared system shall not attempt to gap-fill or systems-fill any elements (N401—N407) within this segment. Also, if these elements are available but are incomplete, the shared system shall not create the N4 segment tied to loop 2330A within the ASC X12 837 COB flat file.

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

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

2010BB—NM1:

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

2010BB-N3 & 2010BB-N4:

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

17. FISS shall not create the 2010AC loop within the 837 new version 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 new version 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 ASC X12 837 COB flat file fields.)

19. The 2330B loop denotes other payers for the claim following Medicare. All should note that there will always be one (1) 2330B that denotes Medicare as a payer, with 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 BCRC completing missing information:

2nd and additional iterations of 2330B—NM1:

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

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

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

21. FISS shall always send at least one (1) complete iteration of 2320, 2330A, and 330B on all ASC X12 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 Form CMS-1450 claim or DDE entry, or as necessary from the A/B MAC (A or HH)'s internal provider files. FISS shall always populate the NM108 segment with "XX" and shall derive the NPI from the Form CMS-1450 claim or DDE entry screen.

23. When the incoming claim is paper, Form CMS-1450 or DDE entered, FISS shall continue with all other mapping practices not otherwise addressed above when creating the outbound "skinny" 837 COB flat file. [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 Form CMS-1450 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 ASC X12 837 COB flat file that corresponds to loop 2400, REF02, where REF01=6R, as per the Implementation Guide.

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

Map the value "9" (Information Not Available) to the field corresponding to 2300 CL101 on the ASC X12 837 COB flat file if the incoming claim is received in a claim format other than the new, now current version, and the CWF BOI reply trailer 29 indicator for "the new, now current version" returned to the A/B MAC (A or HH) for the claim= "T" or "P."

B. ASC X12 837 Professional COB Claim Mapping Rules

Effective with the testing and implementation of the Health Insurance Portability and Accountability Act (HIPAA) ASC X12 837 professional new and now current version, the Multi-Carrier System (MCS, the A/B MAC (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 new and now current version COB (professional) flat file:

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

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

2. The shared system shall map the claim version (new and now current version) in the field of the ASC X12 837 new version COB flat file that corresponds to the ST03 segment.

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

a. Normal claims submission to the BCRC—use "00"**;** and
b. COBA claims repair process—use "18."

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

a. 23 bytes for non-COBA recovery claims as follows:

Bytes 1-9—A/B MAC (B) or DME MAC ID (9 bytes; A/B MAC or DME MAC ID, or 5 bytes left justified, followed by 4 spaces);
Bytes 10-14—Julian Date (5 bytes, expressed as "YYDDD");
Bytes 15-19—Sequence Number (5 bytes, starting with "00001"; should increment for each ST-SE envelope);
Bytes 20-21—Claim Version Indicator (2 bytes; values=50 for 5010 claims); and
Byte 22—Test/Production Indicator (1 byte; valid values="T"—test; "P"—production); and
Byte 23—Original versus Adjustment Claim Indicator (1 byte)-Valid Values are:

E—for reprocessed claims that formerly included an electronic prescribing (e-RX) negative adjustment amount;
O—for original claims;
P— for Affordable Care Act or other congressional imperative mass adjustments;
M—for non-Affordable Care Act mass adjustments tied to Medicare Physician Fee Schedule (MPFS);
S—for mass adjustment claims—all others;
R—for RAC adjustment claims; and
A—for routine adjustment claims, not previously classified.
Additionally, as of April 7, 2014:
C – for CMS-directed mass adjustment action (use specified by CMS);
V—for void/cancel only claim

b. 23 bytes for COBA recovery claims as follows:

Bytes 1-9—A/B MAC (B) or DME MAC ID (9 bytes; A/B MAC (B) or DME MAC ID, left justified, or 5 bytes followed by 4 spaces);

Bytes 10-14—Julian Date (5 bytes, expressed as "YYDDD");
Bytes 15-19—Sequence Number (5 bytes, starting with "00001"; should increment for each ST-SE envelope);
Bytes 20-21—Claim Version Indicator (2 bytes; values=50 for 5010 claims); and
Byte 22—COBA recovery indicator (1 byte; indicator =R)
Byte 23—Original versus Adjustment Claim Indicator (1 byte)

(NOTE: See II.B.4.a directly above for valid values.)

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

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

6. The 1000-B loop NM1 (Receiver Name) denotes the crossover trading partner. If the A/B MAC (B) or DME MAC receives multiple COBA IDs via the BOI reply trailer (29), the shared system shall submit a separate ASC X12 837 transaction for each COBA ID received. Since crossover trading partner information will be unknown to the shared systems, the shared system shall format the following fields as indicated:

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

7a. For all 2000A, 2310B, and 2420A PRV (Billing Provider Specialty Information) segments, the A/B MAC (B) and DME MAC shared systems shall map the taxonomy code values reported in PRV01 through PRV03 on the incoming electronic claim to the corresponding fields within the ASC X12 837 COB flat file. If the values reported for these loops on the incoming claim are incomplete or syntactically incorrect, the shared system shall <u>not</u> create the loop and associated segments.

7b. The A/B MAC (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 A/B MAC (B) shared system shall <u>not</u> map a 2420A-level reported PRV segment if the incoming electronic claim contains a single detail line.

8. The A/B MAC (B) and DME MAC shared systems shall derive information for 2010AA PER 03, PER04, PER05, and PER06 if such information is present and syntactically complete within the A/B MAC (B) or DME MAC's internal provider files. If such information is unavailable or incomplete, the affected shared systems shall <u>not</u> create the 2010AA PER loop on the ASC X12 837 new version professional COB flat file.

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

10a. For 2320 SBR01, in situations where there is only one (1) payer that is primary to Medicare, 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 "*CI*."

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

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

2010BA NM1—Subscriber Name:

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

2010BA N3—Subscriber Address:

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

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

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

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

(2) 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 the beneficiary's Medicare *beneficiary identifier* here if the policy number is unavailable on the incoming claim.

2010BA N3—Subscriber Address:

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

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

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

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

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

2330A—NM1:

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

2330A-N3:

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

2330A-N4:

Upon implementation of the 5010 Errata, the A/B MAC (B) and DME MAC shared systems shall not attempt to gap-fill or systems-fill any elements (N401—N407) within this segment. Also, if

these elements are available but are incomplete, the shared systems shall not create the N4 segment tied to loop 2330A within the ASC X12 837 COB flat file.

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

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

2010BB—NM1:

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

2010BB-N3 & 2010BB-N4:

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

15. The shared system shall **not** create the 2000C or the 2010CA loops within the ASC X12 837 new version professional COB flat file.

16. If the shared system notes the presence of other payers within 2320 SBR and 2330B loops that had made no financial determination on a claim prior to Medicare, as in the case of Medicare secondary payer (MSP) situations, the shared system shall not move those loops to the ASC X12 837 new version COB professional flat file.

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

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

2nd and additional iterations of 2330B—NM1:

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

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

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

19. The shared system shall always send at least one (1) complete iteration of 2320, 2330A, and 2330B on all ASC X12 837 COB flat files.

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

a. REF01, always map "F5";

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

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

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

****IMPORTANT:** **The shared system shall create an outbound** new version "skinny" claim, as derived from paper/hard copy claim input, in the same manner that it now does in creating the current in-use (prior to new version) claim, unless otherwise specified above or below.

1. The shared system shall **always** map NDC codes keyed from hard-copy claims to the field that corresponds to 2410 LIN03 on the ASC X12 837 new version COB professional flat file. In addition, the shared system shall auto-plug the appropriate qualifier that designated NDC within the field that corresponds to 2410 LIN02.

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

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

III. Gap-Filling Requirements for ASC X12 837 New Version COB Files (Effective July 2012)

A. ASC X12 837 Institutional COB Claims

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

2. FISS shall universally gap-fill or systems-fill required individual address elements, when not otherwise obtainable, for Subscriber-related loops as follows:

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

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

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

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

5a. If the shared system has valid city, state, and 5-byte ZIP code information available, it shall only gap-fill or system-fill the +4 ZIP code component, where required, with "9998" when creating outbound ASC X12 837 COB claim files.

5b. The shared system shall continue to send full ZIP code content (9-bytes) on outbound ASC X12 837 COB claim files, if available, for creation of situational N403 segments.

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

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

8. If the incoming claim is paper Form CMS-1450 or DDE-entered and the dosage information necessary to populate 2410 CTP05-1 is not available, FISS shall always default to the value of "F2."

9. If the incoming claim is paper or electronic, FISS shall map "non-specific procedure code" within the ASC X12 837 new version COB flat file field that corresponds to loop 2400 SV202-7 (non-specific composite medical procedure description) if a non-specific procedure code description is required, as per the Implementation Guide, and the associated procedure code is defined as "not otherwise classified." (See the following link for the latest listing of not otherwise classified procedure codes: *https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html?DLSort=0&DLEntries=10&DLPage=1&DLSortDir=descending&DLFilter=NOC*

10. FISS shall not attempt to gap-fill or systems-fill the N4 segment (now situational) within the field corresponding to loop 2330B on the ASC X12 837 new version COB flat file. In addition, if information needed to create the N4 segment is available but is incomplete, FISS shall not create the loop 2330B N4 segment.

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

B. ASC X12 837 Professional COB Claims

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

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

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

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

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

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

5a. If the A/B MAC (B) and DME MAC shared systems have valid city, state, and 5-byte ZIP code information available, they shall only gap-fill or system-fill the +4 ZIP code component, where required, with "9998" when creating outbound ASC X12 837 COB claim files.

5b. The A/B MAC (B) and DME MAC shared system shall continue to send full ZIP code content (9-bytes) on outbound ASC X12 837 COB claim files, if available, for creation of situational N403segments

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

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

8a. In association with paper-submitted Part B ambulance claims, the A/B MAC (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 A/B MAC (B) shared system shall map "Xs" to the **minimum** standard required for the field.

For N401—N403: The A/B MAC (B) shared system shall undertake the following actions:

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

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

9. The shared system shall map "UN" in the ASC X12 837 new version COB flat file field that corresponds to loop 2410 (CTP) and segment CPT04 only when the 2410 (CTP) CTP04 segment is either blank or contains a non-valid value.

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

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

12a. Following adjudication of both electronic and paper billed claims, the shared system shall discontinue the practice of applying gap-fill values of all "9s" within the ASC X12 837 new version COB flat file field that corresponds to 2410 LIN03 if the incoming claim contains an incomplete or non-valid national drug code (NDC). If an incoming paper claim contains a syntactically non-valid NDC code that the A/B MAC (B) or DME MAC subsequently keys, the shared system shall not attempt to gap-fill the field that corresponds to 2410 LIN03 on the ASC X12 837 new version COB flat file.

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

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

14. If the incoming claim is paper or electronic, the shared system shall map "non-specific procedure code" within the ASC X12 837 COB flat file field that corresponds to loop 2400 SV202-7 (non-specific composite medical procedure description) if a non-specific procedure code description is required, as per the Implementation Guide, and the associated procedure code is defined as "not otherwise classified." (See the following link for the latest listing of not otherwise classified procedure codes:
https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html?DLSort=0&DLEntries=10&DLPage=1&DLSortDir=descending&DLFilter=NOC

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

16. The A/B MAC (B) shared system shall populate 99 as a gap-fill/default value for loop 2300 (CLM) segment CLM05-1 (Facility Type Code) within the corresponding field of the ASC X12 837 new version COB flat file.

17. For ambulance claims, the A/B MAC (B) shared system shall map LB in the ASC X12 837 new version COB flat file field the corresponds to 2400 CR101 if that field would otherwise contain spaces where there is a value (weight) present in 2400 CR102.

18. Also, for ambulance claims, the A/B MAC (B) shared system shall produce spaces in the field that corresponds to loop 2400 CR101 when loop 2400 CR102 on the incoming claim is blank.

19. All shared systems shall not attempt to gap-fill or systems-fill the N4 segment (now situational) within the field corresponding to loop 2330B on the ASC X12 837 COB flat file. In addition, if information needed to create the N4 segment is available but is incomplete, the shared systems shall not create the loop 2330B N4 segment.

IV. Other ASC X12 837 New Version COB Requirements

A. Complementary Credits

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

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

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

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

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

70.6.6 - National Council for Prescription Drug Programs (NCPDP) Version D.0 Coordination of Benefits (COB) Requirements

(Rev. 4281, Issued: 04- 19-19, Effective: 05-20-19, Implementation: 05-20-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

I - BASIC REQUIREMENTS

Prior to the mandatory cut-over to the NCPDP new batch telecommunications claim version, the DME MAC shared system shall develop a current, in-use format "skinny" non-SFR claim format to accommodate those situations where COBA trading partners are unable to accept pharmacy-submitted claims in the NCPDP new version format. In addition, the DME MAC shared system shall develop an NCPDP new version "skinny" non-SFR format that addresses the scenario of claims originally adjudicated in the NCPDP current, in-use format and later adjusted after the NCPDP new version format is required in association with all incoming and outgoing NCPDP new version claims.

The DME MAC shared system shall also develop an NCPDP new version "skinny" non-SFR format that addresses the scenario of claims that a DME MAC originally adjudicated in the NCPDP current, in-use format but suspended for a period of time that meets or transcends the date by which the NCPDP new version format is required in association with all incoming and outgoing NCPDP new version claims.

II - NCPDP New Version Mapping Requirements

With respect to the NCPDP new version COB flat file submissions to the Benefits Coordination & Recovery Center (BCRC), the ViPS Medicare System (VMS) maintainer shall observe the following business rules for mapping:

A. General

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

   a.) Bytes 1-9—Contractor ID (9 bytes; DME MAC ID, or, 5 bytes left justified, followed by spaces);

   b.) Bytes 10-14—Julian Date (5 bytes, expressed as "YYDDD");

   c.) Bytes 15-19—Sequence Number (5 bytes, starting with "00001"; should increment for each ST-SE envelope);

   d.) Bytes 20-21—Claim Version Indicator (2 bytes; values= 20 for NCPDP version D.0 claims); and

   e.) Byte 22—Test/Production Indicator (1 byte; valid values="T"—test; "P"—production).

B. Transmission/Transaction Header Segment

1. Create 101-A1 ("BIN assigned number") with spaces.

2. Create the claim version release number (102-A2) within the Transmission/Transaction Header Segment.

3. Populate the appropriate transaction code (103-A3), the processor control number (104-A1), and transaction count value (109-A9).

4. Always map the service provider ID qualifier corresponding to the national provider identifier (NPI) in 202-B2.

5. Always map the supplier's NPI in 201-B1 ("Service Provider ID").

6. Map date of service from incoming claim for 401-D1.

7. Map 110-AK ("Software Vendor/Certification ID") from incoming claim.

   IMPORTANT: For "skinny" NCPDP current, in use claim scenarios, where the incoming claim is the current, in use version NCPDP, the shared system shall map "unknown" in 110-AK.

C. Transmission Insurance Segment

1. Map the beneficiary's Medicare *beneficiary identifier* in 302-C2 ("Cardholder ID").

2. Map 312-CC and 313-CD ("Cardholder's First and Last Names") using information from the DME MAC's internal eligibility file.

3. Do not create 301-C1 ("Group ID"), as CMS no longer authorizes claims-based transfers to Medicaid State Agencies.

4. Do not create 336-8C ("Facility ID"), even in "skinny" claim situations.

5. For Medigap claim-based crossover purposes only, the shared system shall continue to populate the Medigap claim-based COBA ID (range 55000-55999) in the flat file field corresponding to 301-C1 (Group ID), as derived from the incoming claim.

   In addition, the shared system shall populate the Medigap policy ID in the newly created 359-2A (Medigap ID) element, as derived from the incoming claim.

6. Always map an "A" value for element 361-2D ("Provider Accept Assignment Indicator").

7. Do **not** create elements 115-N5, 116-N6, 314-CE, 303-C3, and 306-C6.

8. Create 524-F0 ("Plan ID") in the future only when CMS directs.

D. Transmission Patient Segment

1. Create element 331-CX ("Patient ID Qualifier") as appropriate.

2. Create 307-C7 ("Place of Service") based upon the incoming claim.

3. Always map the beneficiary's Medicare *beneficiary identifier* in 332-CY ("Patient ID").

4. Map elements 304-C4, 305-C5, 310-CA, and 311-CB from the DME MAC's internal beneficiary eligibility file.

5. Map elements 322-CM, 323-CN, 324-CO, and 325-CP from the DME MAC's internal beneficiary eligibility file. (*--See Gap Filling Requirements in Attachment B to address situations where the beneficiary's line-1 address, as derived from the DME MAC's internal beneficiary eligibility file, is blank or incomplete.)

6. Map 326-CQ ("Patient Phone Number") and 350-HN ("Patient E-mail Address") from incoming claim. (**Assumption:** CEDI will ensure these values are syntactically correct as a condition of inbound claim acceptance.)

7. Do not create element 335-2C ("Pregnancy Indicator") on the NCPDP new version COB file.

E. Transaction Prescriber Segment

1. Map element 466-EZ ("Prescriber ID Qualifier") from the incoming claim.

2. Always map "01" for element 468-2E ("Primary Care Provider ID Qualifier").

3. Map the NPI, as derived from the incoming claim, in element 421-DL ("Primary Care Provider ID").

4. Map the supplier's name, as derived from the DME MAC's internal provider files, for 470-4E ("Primary Care Provider Last Name").

5. Map 411-DB based upon adjudicated claim data.

6. Map 427-DR ("Prescriber Last Name") and 364-2J ("Prescriber First Name") from the DME MAC's internal supplier files.

7. Map 365-2K ("Prescriber Address"), 366-2M ("Prescriber City"), 367-2N ("Prescriber State"), 368-2P ("Prescriber Zip"), and 498-PM ("Prescriber Phone Number") based upon the availability

of these elements in the SFR. (See Attachment B for special gap-filling requirements that will come into play for NCPDP skinny mapping.)

F. Transaction COB/Other Payments Segment

1. Map element 337-4C from the incoming claim.

2. Prepare element 338-5C to appropriately qualify deductible or co-insurance remaining. (NOTE: In the case of adjustment claims, where the DME MAC used 98 or 99 previously, the shared system shall populate the NCPDP new version equivalent qualifying value on the COB flat file.)

3. Map value "05" for element 339-6C in relation to Medicare's role as payer of the claim.

4. Map the DME MAC's workload identifier (e.g., 16003) in element 340-7C.

5. Map the Internal Control Number (element 993-A7) as received from CEDI and as a result of claim adjudication.

6. Map the following out on the COB flat file only if received on the incoming claim: 443-E8, 341-HB, 342-HC, 431-DV, 471-5E, 472-6E.

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

8. Do not map 392-MU, 393-MV, and 394-MW, as these are not used for Medicare purposes.

9. Do not create any portion of the Transaction Workers' Compensation Segment.

G. **Transaction Claim Segment**

1. Map 343-HD, 344-HF, and 345-HG based upon availability on the data on the incoming claim.

2. Create 455-EM and 402-D2 as required, without gap-filling.

3. Create 403-D3, 405-D5, 406-D6, and 407-D7 as required, without gap-filling.

4. Create all of the following if received on the incoming claim: 408-D8, 414-DE, 415-DF, 418-DI, 419-DJ, 420-DK, 453-EJ, 445-EA, 446-EB, and 457-EP. (**NOTE:** Gap-filling of 453-EJ with spaces is acceptable if the shared system is also concurrently gap-filling 445-EA with spaces.)

5. Create procedure modifier count (458-SE) based upon claim adjudication.

6. Create procedure modifier code as appropriate.

7. Map 442-E7 and 426-E1 as required, without gap-filling.

8. Create 456-EN, 420-DK, 308-C8, and 429-DT to the COB file if received on the incoming claim.

9. Map 454-EK (now required in certain situations) and 600-2B if received on the incoming claim.

10. Do not create 461-EU, 462-EV, 463-EW, 464-EX, 354-NX, 357-NV, 995-E2, 996- G1, and 147-U7 if received on the incoming claim.

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

H. Transaction Compound Segment

1. Create all of the following required elements without gap-filling: 447-EC, 448-ED, 449-EE, 450-EF, 451-EG, 488-RE, and 489-TE.

2. Create the following based upon claims adjudication: 412-DC, 423-DN, 426- DQ, 433-DX, 438-E3, 478-H7, 47-H8, 480-H9.

3. Create the following if received on the incoming claim: 490-UE, 362-2G, and 363-2H.

I. Transaction Pricing Segment

1. Create the following required elements without gap-filling: 409-D9 and 430-DU.

2. Create the following based upon claims adjudication: 412-DC, 423-DN, 426- DQ, 433-DX, 438-E3, 478-H7, 47-H8, 480-H9.

3. Do not create 482-GE, 483-HE, and 484-JE.

J. Transaction Prior Authorization Segment - Do not create for COB flat file.

K. Transaction Clinical Segment

1. Create all situational elements indicated only if received.

2. Do not create "Transaction Additional Doc" segment or Additional Documentation Type ID (369-2Q), as they relate to passage of CMN information, which is no longer supported.

L. Transaction Facility Segment

Create associated elements only if received; otherwise, do not attempt to gap-fill.

M. Narrative Segment.

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

III. NCPDP New Version Gap-Filling Requirements

The DME MAC shared system shall observe the following gap-filling requirements when creating NCPDP new version COB flat files for transmission to the BCRC:

A. For rare instances where there is not a valid base 5-byte zip code available to populate a required zip code field, VMS shall populate "96941" within the field corresponding to that segment on the NCPDP new version COB flat file.

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

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

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

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

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

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

SPECIAL NOTE: When DME MACs encounter particular gap-filling scenarios that are not specifically addressed above, their shared system shall deploy the current gap-fill requirements for the creation of required NCPDP current, in use version COB flat file data content when creating NCPDP new version COB flat files for transmission to the BCRC.

IV. Medigap Claim-Based Crossover Processes Involving NCPDP New Version Claims

In advance of their acceptance of incoming NCPDP new version claims, all DME MACs shall inform their affiliate "participating" suppliers that they may initiate Medigap claim-based crossover processes by taking the following steps:

- Continue to enter the Medigap claim-based COBA ID (range 55000 to 59999) in the existing 301-C1 (Group ID) portion of the "Transmission Insurance Segment"; and

- Now report the beneficiary's Medigap policy number in the newly developed 359-2A (Medigap ID) portion of the Transmission Claim Segment.

V. DME MAC NCPDP New Version Cut-Over Requirements

The *BCRC* shall effectuate cut-over of COBA trading partners to the NCPDP new claim format through actions taken via the COIF.

Upon receipt of a CWF BOI reply trailer (29) that contains a "P" NCPDP new version indicator and an "N" current, in-use (or old version) NCPDP format indicator, VMS shall cease creation of NCPDP current, in-use (or old version) full COB claim or NCPDP current, in use (or old version) non-SFR skinny COB claims as well as transmission of these files to the *BCRC*.

VI. Dual BCRC Detailed Error Reports During The Transitional Period and Accompanying New "222" Errors

During the NCPDP new version transitional period, all DME MACs shall accept and process two *BCRC* Detailed Error Reports—one generated by the *BCRC* for claims transmitted by the DME MACs in the current, in-use (or old) version NCPDP COB flat file format, and another generated by the *BCRC* for claims transmitted by the DME MACs in the new version NCPDP COB flat file format.

The DME MAC shared system now accept "222" error conditions as part of the *BCRC* Detailed Error Report for NCPDP claims, as may be referenced in §70.6.1 of this chapter. In this vein, the DME MAC

shared system shall not effectuate changes to expand the error description field portion of the *BCRC* NCPDP Detailed Error Report to accommodate receipt of the new "222" errors.

Effective with July 2012, the *BCRC* will return the following new "222" errors to DME MACs via the *BCRC* NCPDP Detailed Error Reports:

- N22230—NCPDP current, in use or old version "production" claim received, but the COBA trading partner is not accepting that version NCPDP "production" claims;

- N22231—Current, in use or old version NCPDP "test" claim received, but the COBA trading partner is not accepting that version NCPDP "test" claims;

- N22232—NCPDP new version "production" claim received, but the COBA trading partner is not accepting NCPDP new version "production" claims; and

- N22233—NCPDP new version "test" claims received, but the COBA trading partner is not accepting new version NCPDP "test" claims.

IMPORTANT: The BCRC shall not begin applying "222" editing to incoming claims until 14 calendar days after a COBA trading partner's production cut-over to the NCPDP new version format have elapsed. The DME MACs shall not attempt to repair claims that the BCRC returns via the BCRC Error Reports with error codes N22230 through N22233, regardless of error percentage.

All DME MACs shall create special provider letters to their affiliate supplier, in accordance with §70.6.1 of this chapter, for "production" claims with error codes N22230 or N22232.

VII. NCPDP New Version Claims Repair Processes

The DME MACs, working with their shared system, shall initiate new version NCPDP COB claims repair actions when: 1) the error percentage for "333" errors equals or exceeds four (4) percent; and 2) they receive even one (1) "111" error as noted on the BCRC Detailed Error Reports.

As part of their process to initiate a claims repair, the DME MACs shall alert their shared system or Data Center, as per established protocol. The DME MACs shall also suppress generation of their provider notification letters, in accordance with §70.6.1 of this chapter, for up to 14 days.

If the DME MACs determine that the timeframes for effectuating claim repairs for "111" or "333" errors fall outside of acceptable CMS parameters (e.g., will take 30-60 days or longer) or if the volume of affected claims is low (1,000 claims or less per week), the DME MACs shall allow for the release of their special provider notification letters to affected suppliers. Any DME MACs that wish to effectuate a repair of NCPDP "production" claims whose error percentage falls below four (4) percent shall contact a member of the CMS COBA team before attempting that action. As a rule, CMS will grant approval for such a repair if the volume of errored claims justifies that action and if the time frame for repair is acceptable.

While DME MACs will not be expected to initiate the repair of "test" NCPDP claims, they shall continue to: 1) monitor the BCRC Detailed Error Reports; and 2) notify their shared systems of errors returned so that necessary shared system changes to improve HIPAA compliance rates may be realized.

IMPORTANT: The DME MAC shared system shall apply NCPDP non-SFR "skinny" logic to claim repair situations where they originally transmitted claims to the BCRC prior to January 1, 2012, in the NCPDP prior version claim format.