CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1920	**Date: February 19, 2010**
	Change Request 6816

SUBJECT: Modifications to Gap-Filling Requirements for the Health Insurance Portability Accountability Act (HIPAA) 837 version 5010 Coordination of Benefits (COB) Claims Transactions and National Council for Prescription Drug Programs (NCPDP) Version D.0 Claim Files

I. SUMMARY OF CHANGES: Through this instruction, the Centers for Medicare and Medicaid Services (CMS) updates a limited subset of its previously issued gap-filling or system-fill requirements for outbound HIPAA 837 5010 COB claims and NCPDP D.0 COB claims.

NEW/REVISED MATERIAL
EFFECTIVE DATE: July 1, 2010
IMPLEMENTATION DATE: July 6, 2010

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	28/70/70.6.5/ Coordination of Benefits Agreement (COBA) 5010 Coordination of Benefits (COB) Requirements
R	28/70/70.6.6/ National Council for Prescription Drug Programs (NCPDP) Version D.0 Coordination of Benefits (COB) Requirements

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

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not 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

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1920	Date: February 19, 2010	Change Request: 6816

SUBJECT: Modifications to Gap-Filling Requirements for the Health Insurance Portability Accountability Act (HIPAA) 837 version 5010 Coordination of Benefits (COB) Claims Transactions and National Council for Prescription Drug Programs (NCPDP) Version D.0 Claim Files

Effective Date: July 1, 2010

Implementation Date: July 6, 2010

I. GENERAL INFORMATION

A. Background: The Centers for Medicare & Medicaid Services (CMS) previously outlined its complete HIPAA 837 version 5010 and NCPDP D.0 COB mapping and gap-filling or system-filling requirements within Change Requests (CRs) 6308, 6374, and 6664. Following CMS' recent release of its HIPAA 5010 COB Companion Guide to the supplemental payer industry, an external stakeholder organization alerted CMS that its proposed gap-fill strategy for bytes 6-9 of all provider loop N403 (Postal Zone/Zip Code) segments should be reconsidered. The CMS has investigated this point and has arrived at an acceptable United State Postal Service (USPS) default value. Clearly, the need for gap-filling of the zip code segment of the various provider data fields on outbound 837 COB claims will be rare due to the availability of Finalist zip-code + 4 software within the Provider Enrollment, Chain, and Ownership System (PECOS), which represents Medicare's source system for its internal physician, supplier, and provider enrollment and demographics data. However, it will be necessary in certain qualified circumstances.

B. Policy: All shared systems shall universally gap-fill or system-fill **required** address information, when not otherwise obtainable, for all loops as follows: N401 (City Name) = Cityville; N402 (State or Province Code) = MD; and N403 (Postal Zone/Zip Code) = 96941. For all instances where the shared systems create the N403 segment on the outbound 837 COB flat file for transmission to the COBC, they shall ensure that they create a 5-byte base zip code + 4 for the field equivalent to N403**, when required,** on the flat file. Specifically, the Part A shared system shall gap-fill or system-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). The Part B and Durable Medical Equipment Medicare Administrative Contractor (DME MAC) shared systems shall gap-fill or system-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). All shared systems shall discontinue the approach, as previously required through CRs 6308 and 6374, to gap-fill or system-fill the +4 zip code component for all N403 segments with 0000. In addition, if the shared systems have valid city, state, and 5-byte zip code information available, they shall only gap-fill or system-fill the +4 zip code component**, where required,** with 9998 when creating outbound 837 COB claim files for transmission to the COBC.

The Part B shared system shall additionally update its internal gap-fill tables to be consistent with the minimum byte standards reflected in Attachment A.

The DME MAC shared system shall only map the base 5-byte zip code for all required zip code elements on the NCPDP D.0 flat file. If gap or system-filling of any required 5-byte zip code becomes necessary, the DME MAC shared system shall map 96941 for the affected element(s) on the NCPDP D.0 flat file that it generates for transmission to the COBC.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement.

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6816.1	All shared systems shall universally gap-fill or system-fill **required** address information, when not otherwise obtainable, for all loops as follows: N401 (City Name) = Cityville; N402 (State or Province Code) = MD; and N403 (Postal Zone/Zip Code) = 96941.						X	X	X		
6816.2	For all instances where the shared systems create the N403 segment on the outbound 837 COB flat file for transmission to the COBC, they shall ensure that they create a 5-byte base zip code + 4 for the field equivalent to N403**, when required,** as per the Technical Report Type 3 (TR-3) Guide, on the flat file.						X	X	X		
6816.2.1	The Part A shared system shall gap-fill or system-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 for the N403 segment of the indicated loops.)						X				
6816.2.2	The Part B and Durable Medical Equipment Medicare Administrative Contractor (DME MAC) shared systems shall gap-fill or system-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 for the N403 segment of the indicated loops.)							X	X		
6816.2.3	All shared systems shall discontinue the approach, as previously required through CRs 6308 and 6374, to gap-fill or system-fill the +4 zip code component for all N403 segments with 0000.						X	X	X		
6816.2.4	If the shared systems have valid city, state, and 5-byte zip code information available, they shall only gap-fill or system-fill the +4 zip code component**, where required,** with 9998 when creating outbound 837 COB claim files for transmission to the COBC.						X	X	X		

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6816.2.5	The shared systems shall continue to send full zip code content (9-bytes) on outbound 837 COB claim files if available for creation of situational N403 segments.						X	X	X		
6816.3	The Part B shared system shall additionally update its internal gap-fill tables to be consistent with the minimum byte standards reflected in Attachment A.							X			
6816.3.1	The Part B shared system shall ensure that, as reflected in Attachment B of CR 6308, it has coded for the following gap-fill scenarios: 1) 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; 2) Populate 99 as a gap-fill/default value for loop 2300 (CLM) segment CLM05-1 (Facility Type Code) within the corresponding field of the 837 5010 COB flat file; 3) Map LB in the 837 5010 COB flat file field that corresponds to 2400 CR101 if that field would otherwise contain spaces where there is a value (weight) present in 2400 CR102 (**NOTE:** applies to ambulance claims); and 4) Produce spaces in the field that corresponds to loop 2400 CR101 when loop 2400 CR102 on the incoming claim is blank (**NOTE:** applies to ambulance claims).							X			
6816.4	The DME MAC shared system shall only map the base 5-byte zip code for all required zip code elements on the NCPDP D.0 flat file.								X		
6816.4.1	If gap or system-filling of any required 5-byte zip code becomes necessary, the DME MAC shared system shall map 96941 for the affected element(s) on the NCPDP D.0 flat file that it generates for transmission to the COBC.								X		
6816.5	As specified in CR 6658, all shared systems shall populate bytes 20 and 21 of the Beginning of the Hierarchical Transaction Reference Identification										X CMS

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	(BHT03) file identifier with either the value 40 for 4010A1 claims or 50 for 5010 claims, as appropriate. (**NOTE:** Requirement illustrated due to need for manual change; this requirement was completed under CR 6658.)										
6816.5.1	The DME MAC shared system shall also replace the 2-byte "Data Center ID" component of the 22-byte file identifier reported in the 504 F4 (Message Trailer) field of outbound NCPDP D.0 COB claims with either the value 11 (NCPDP 5.1 claims) or 20 (NCPDP D.0 claims), as appropriate. (**NOTE:** Requirement illustrated due to need for manual change; this requirement was completed under CR 6658.)										X CMS

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	None.										

IV. SUPPORTING INFORMATION

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

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: Attachment A

V. CONTACTS

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

VI. FUNDING

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

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

Section B: *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.

ATTACHMENT A: *Part B Shared System Additional Mapping and Gap-Fill Logic For HIPAA 5010 COB Claim*

ATTACHMENT A

Part B Shared System
Additional Mapping and Gap-Fill Logic
For HIPAA 5010 COB Claims

For HIPAA 5010 COB flat file creation purposes, the Part B shared system shall ensure that:

1) All NM108 elements shall always have a minimum value of 2 bytes;

2) 2400 SV105 always has a minimum value of 2 bytes;

3) 2300 CLM05-1 always has a minimum value of 2 bytes;

4) All of the following data elements have a minimum value of 2 bytes:

   2010CA N402
   2310C N402
   2310E N402
   2310F N402
   2330A N402
   2330B N402
   2420C N402
   2420H N402
   2420E N402
   2420G N402

5) 2300 HI01-1 has a minimum value of 2 bytes;

6) 2310C NM104 and NM105 are not used; therefore, MCS shall set the gap-fill action to "N/A";

7) 2400 SV101-2 has a minimum value of 5 bytes;

8) 2400 SV501-2 has a minimum value of 5 bytes, with 6816X being used as the gap-fill value;

9) 2400 SV502 has a minimum value of 2 bytes;

10) The N403 minimum value should be 5 for all of the following loop: 2010CA, 2310C, 2310E, 2310F, 2330A, 2330B, 2420C, 2420G, and 2420H; and

11) The following diagnosis-related 2300 HI-level segments shall have a minimum

value of 2 bytes, subject to requirements for highest level of specificity, as per the relevant code-set:

2300 HI 0102
2300 HI 0202
2300 HI 0302
2300 HI 0402
2300 HI 0502
2300 HI 0602
2300 HI 0702
2300 HI 0802
2300 HI 0902
2300 HI 1002
2300 HI 1102
2300 HI 1202

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

(Rev. 1920, Issued: 02-19-10; Effective Date; 07-01-10 Implementation Date: 07-06-10)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The shared system shall produce a 5010 "skinny" claim, without SFR content, in the event that a claim that a Medicare contractor originally adjudicated in the 4010-A1 format is later released from suspense status or is adjusted during a time frame when a COBA trading partner has moved to 837 5010 production (that is, the BOI reply trailer 29 contains a "P" 5010 Test/Production indicator).

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

ADDRESSING INCOMING PAPER CLAIMS FOR OUTBOUND COB PURPOSES

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

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

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

Scenario 4: Finally, if a provider or supplier submits a hard-copy claim (paper UB-04 or CMS-1500) or, as applicable, enters a DDE claim to a Medicare Part A contractor or DME MAC and if the Medicare contractor receives a CWF BOI reply trailer (29) that contains a "N" 4010-A1 Test/Production indicator and a "P" 5010 indicator, the affected shared system shall: 1) produce nothing in terms of a 4010-A1 COB claim; and 2) produce a "skinny" non-SFR 5010 "production" COB claim.

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

II. General 5010 COB Flat File Mapping Requirements

A. 837 Institutional COB Claim Mapping Rules

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

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

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

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

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

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

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

    a. 22 bytes for non-COBA recovery claims as follows:

    Bytes 1-9—Contractor ID (9 bytes; contractor ID, left justified, followed by 4 spaces);
    Bytes 10-14—Julian Date (5 bytes, expressed as "YYDDD");
    Bytes 15-19—Sequence Number (5 bytes, starting with "00001"; should increment for each ST-SE envelope);
    Bytes 20-21—Claim Version Indicator (2 bytes; values=40 for 4010A1 and 50 for 5010 claims); and
    Byte 22—Test/Production Indicator (1 byte; valid values="T"—test; "P"—production).

b. 22 bytes for COBA recovery claims as follows:

Bytes 1-9—Contractor ID (9 bytes; contractor ID, left justified, followed by 4 spaces);
Bytes 10-14—Julian Date (5 bytes, expressed as "YYDDD");
Bytes 15-19—Sequence Number (5 bytes, starting with "00001"; should increment for each ST-SE envelope);
Bytes 20-21—Claim Version Indicator (2 bytes; values=40 for 4010A1 and 50 for 5010 claims); and
Byte 22—COBA recovery indicator (1 byte; indicator =R).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. For PRV01—populate "BI";
b. For PRV01—populate "PXC"; and
c. For PRV03—populate taxonomy code as derived from the keying of FL 81cc(a) of the UB04 claim form or as derived from the appropriate field from the online DDE screen.

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

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

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

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

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

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

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

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

2010BA NM1—Subscriber Name:

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

2010BA N3—Subscriber Address:

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

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

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

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

2330A—NM1:

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

2330A-N3:

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

2330A-N4:

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

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

2010BB—NM1:

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

2010BB-N3 & 2010BB-N4:

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

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

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

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

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

2nd and additional iterations of 2330B—NM1:

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

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

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

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

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

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

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

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

B. 837 Professional COB Claim Mapping Rules

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

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

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

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

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

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

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

a. **22 bytes for non-COBA recovery claims as follows:**

Bytes 1-9—Contractor ID (9 bytes; contractor ID, left justified, followed by 4 spaces);
Bytes 10-14—Julian Date (5 bytes, expressed as "YYDDD");
Bytes 15-19—Sequence Number (5 bytes, starting with "00001"; should increment for each ST-SE envelope);
Bytes 20-21—Claim Version Indicator (2 bytes; values=40 for 4010A1 and 50 for 5010 claims); and
Byte 22—Test/Production Indicator (1 byte; valid values="T"—test; "P"—production).

b. 22 bytes for COBA recovery claims as follows:

Bytes 1-9—Contractor ID (9 bytes; contractor ID, left justified, followed by 4 spaces);
Bytes 10-14—Julian Date (5 bytes, expressed as "YYDDD");
Bytes 15-19—Sequence Number (5 bytes, starting with "00001"; should increment for each ST-SE envelope);

Bytes 20-21—Claim Version Indicator (2 bytes; values=40 for 4010A1 and 50 for 5010 claims); and
Byte 22—COBA recovery indicator (1 byte; indicator =R).

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

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

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

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

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

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

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

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

provider's tax ID is required within a secondary REF segment, the shared system shall also derive this information from each contractor's internal provider files.

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

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

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

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

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

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

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

2010BA NM1—Subscriber Name:

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

2010BA N3—Subscriber Address:

a. N301—derive from internal beneficiary eligibility file; and

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

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

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

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

2010BA NM1—Subscriber Name:

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

2010BA N3—Subscriber Address:

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

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

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

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

2330A—NM1:

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

2330A-N3:

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

2330A-N4:

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

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

2010BB—NM1:

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

2010BB-N3 & 2010BB-N4:

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

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

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

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

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

2nd and additional iterations of 2330B—NM1:

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

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

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

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

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

a. REF01, always map "F5";

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

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

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

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

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

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

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

III. Gap-Filling Requirements for 837 5010 COB Files

A. 837 Institutional COB Claims

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

2. The Part A shared system shall universally gap-fill or system-fill required address information, when not otherwise obtainable, for all loops as follows:

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

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

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

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

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

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

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

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

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

B. 837 Professional COB Claims

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

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

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

3. The Part B and DME MAC shared systems shall gap-fill the +4 zip code component with 9998 when the actual +4 zip code component is unavailable when creating the N403 in association with loops 2010AA (Billing Provider), 2310C (Service Facility—claim level),

and 2420C (Service Facility—service line level). (**NOTE:** The full 9-byte zip code is required **only** for the N403 segment of the indicated loops.)

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

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

5b. The Part B and DME MAC shared system shall continue to send full zip code content (9-bytes) on outbound 837 COB claim files, if available, for creation of situational 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 equivalent field on the 5010 COB flat file.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

IV. Other 837 5010 COB Requirements

A. Complementary Credits

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

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

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

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

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

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

(Rev. 1920, Issued: 02-19-10; Effective Date; 07-01-10 Implementation Date: 07-06-10)

I. Transitional Scenarios

During the NCPDP D.0 transitional period, the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) through their shared system shall accommodate the following multi-faceted scenarios with respect to creation of NCPDP COB flat files:

Scenario 1: If a supplier submits an NCPDP 5.1 claim to a DME MAC, and if that contractor receives a Common Working File (CWF) Beneficiary Other Insurance (BOI) reply trailer (29) that contains a "P" NCPDP 5.1 Test/Production indicator and a "T" NCPDP D.0 indicator, the shared system shall: 1) create an NCPDP COB flat file that contains full NCPDP 5.1 store-and-forward (SFR) content for the "production" claim for transmission to the COBC; and 2) create a "skinny" non-SFR claim in the NCPDP D.0 flat file format and transmit the claim to the COBC.

Scenario 2: If a supplier submits an NCPDP 5.1 claim to a DME MAC, and if that contractor receives a CWF BOI reply trailer (29) that contains a "P" NCPDP 5.1 Test/Production indicator and an "N" NCPDP D.0 indicator, the shared system shall: 1) create an NCPDP COB flat file that contains full NCPDP 5.1 SFR content for the "production" claim for transmission to the COBC; and 2) create nothing in terms of an NCPDP D.0 COB claim.

Scenario 3: If a supplier submits an NCPDP 5.1 claim to a DME MAC, and if that contractor receives a CWF BOI reply trailer (29) that contains an "N" NCPDP 5.1 Test/Production indicator and a "T" NCPDP D.0 indicator, the shared system shall: 1) create nothing in terms of an NCPDP 5.1 COB flat file; and 2) create a "skinny" non-SFR "test" claim in the NCPDP D.0 flat file format for transmission to the COBC.

Scenario 4: If a supplier submits an NCPDP 5.1 claim to a DME MAC, and if that contractor receives a CWF BOI reply trailer (29) that contains an "N" NCPDP 5.1 Test/Production indicator and a "P" NCPDP D.0 indicator, the shared system shall: 1) create nothing in terms of an NCPDP 5.1 COB flat file; and 2) create a "skinny" non-SFR "production" claim in the NCPDP D.0 flat file format for transmission to the COBC.

Scenario 5: If a supplier submits an NCPDP D.0 claim to a DME MAC, and if that contractor receives a CWF BOI reply trailer (29) that contains a "P" NCPDP 5.1 Test/Production indicator and a "T" NCPDP D.0 indicator, the shared system shall: 1) produce a "skinny" NCPDP 5.1 batch 1.1 COB claim for transmission to the COBC; and 2) produce an NCPDP D.0 COB "test" claim with full SFR content for transmission to the COBC.

Scenario 6: If a supplier submits an NCPDP D.0 claim to a DME MAC, and if that contractor receives a CWF BOI reply trailer (29) that contains a "P" NCPDP 5.1 Test/Production indicator and an "N" NCPDP D.0 indicator, the shared system shall: 1) produce a "skinny" non-SFR "production" NCPDP 5.1 claim for transmission to the COBC; and 2) create nothing in terms of an NCPDP D.0 COB claim.

Scenario 7: If a supplier submits an NCPDP D.0 claim to a DME MAC, and if that contractor receives a CWF BOI reply trailer (29) that contains an "N" NCPDP 5.1 Test/Production indicator and a "T" NCPDP D.0 indicator, the shared system shall: 1) produce nothing in terms of an NCPDP 5.1 COB claim; and 2) create an NCPDP D.0 COB flat file that contains full NCPDP D.0 SFR content for the "test" claim for transmission to the COBC.

Scenario 8: If a supplier submits an NCPDP D.0 claim to a DME MAC, and if that contractor receives a CWF BOI reply trailer (29) that contains an "N" NCPDP 5.1 Test/Production indicator and a "P" NCPDP D.0 indicator, the shared system shall: 1) produce nothing in terms

of an NCPDP 5.1 COB claim; and 2) create an NCPDP D.0 claim with full SFR content for COBA "production" purposes. (**NOTE:** This will be the profile of a COBA trading partner that has cut-over to NCPDP D.0 COB production.)

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

II. BASIC REQUIREMENTS

Prior to the mandatory cut-over to NCPDP D.0, the DME MAC shared system shall develop an NCPDP 5.1 "skinny" non-SFR claim format to accommodate those situations where COBA trading partners are unable to accept provider-submitted claims in the NCPDP D.0 format. In addition, the DME MAC shared system shall develop an NCPDP D.0 "skinny" non-SFR format that addresses the scenario of claims originally adjudicated in the NCPDP 5.1 format and later adjusted after the NCPDP D.0 format is required in association with all incoming and outgoing NCPDP D.0 claims.

The DME MAC shared system shall also develop an NCPDP D.0 "skinny" non-SFR format that addresses the scenario of claims that a contractor originally adjudicated in the NCPDP 5.1 format but suspended for a period of time that meets or transcends the date by which the NCPDP D.0 format is required in association with all incoming and outgoing NCPDP D.0 claims.

III. NCPDP D.0 Mapping Requirements

With respect to the NCPDP D.0 COB flat file submissions to the COB Contractor (COBC), 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; contractor ID, 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= 11 for NCPDP version 5.1 claims and 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 claim scenarios, where the incoming claim is NCPDP 5.1, the shared system shall map "unknown" in 110-AK.

C. Transmission Insurance Segment

1. Map the beneficiary's Health Insurance Claim Number (HICN) in 302-C2 ("Cardholder ID").

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

3. 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 HICN 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 D.0 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 quality 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 D.0 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.
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, given that VMS currently does not produce these as part of the NCPDP 5.1 COB flat file.

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 D.0 batch claim.

IV. NCPDP D. O Gap-Filling Requirements

The DME MAC shared system shall observe the following gap-filling requirements when creating NCPDP D.0 COB flat files for transmission to the COBC:

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 837 5010 COB flat file.

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

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

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

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

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

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

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 5.1 COB flat file data content when creating NCPDP D.0 COB flat files for transmission to the COBC.

V. COBA Contractor Financial Processes Relating to NCPDP D.0 Claims

A. During the transitional period (January through December 2011), the DME MACs shall **not** book complementary credits if the Common Working File (CWF) returns a Beneficiary Other Insurance (BOI) reply trailer 29 that contains values of NCPDP 5.1=T **or** N **and** NCPDP D.0 values of T or N.

B. The DME MACs shall book complementary credits if the CWF BOI reply trailer (29) contains a value of "P" for **either** claim version NCPDP 5.1 **or** NCPDP D.0 during the transitional period.

VI. Medigap Claim-Based Crossover Processes Involving NCPDP D.0 Claims

In advance of their acceptance of incoming NCPDP D.0 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.

VII. DME MAC NCPDP D.0 Cut-Over Requirements

The COB Contractor (COBC) shall effectuate cut-over of COBA trading partners to the NCPDP D.0 format through actions taken via the COIF.

Upon receipt of a CWF BOI reply trailer (29) that contains a "P" NCPDP D.0 indicator and an "N" NCPDP5.1 indicator, VMS shall cease creation of NCPDP 5.1 batch 1.1 full COB or NCPDP 5.1 batch 1.1 non-SFR skinny COB claims as well as transmission of these files to the COBC.

IX. Dual COBC Detailed Error Reports During The Transitional Period and Accompanying New "222" Errors

During the NCPDP D.0 transitional period, all DME MACs shall accept and process two COBC Detailed Error Reports—one generated by the COBC for claims transmitted by the DME MACs in the NCPDP 5.1 COB flat file format, and another generated by the COBC for claims transmitted by the DME MACs in the NCPDP D.0 COB flat file format.
The DME MAC shared system now accept "222" error conditions as part of the COBC 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 COBC NCPDP Detailed Error Report to accommodate receipt of the new "222" errors.

The COBC will return the following new 222 errors to Medicare contractors via the COBC NCPDP Detailed Error Reports:

- N22230—NCPDP 5.1 "production" claim received, but the COBA trading partner is not accepting NCPDP 5.1 "production" claims;

- N22231—NCPDP 5.1 "test" claim received, but the COBA trading partner is not accepting NCPDP 5.1 "test" claims;

- N22232—NCPDP D.0 "production" claim received, but the COBA trading partner is not accepting NCPDP D.0 "production" claims; and

- N22233—NCPDP D.0 "test" claims received, but the COBA trading partner is not accepting NCPDP D.0 "test" claims.

IMPORTANT: The COBC 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 D.0 format have elapsed. The DME MACs shall **not** attempt to repair claims that the COBC returns via the COBC 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.

X. NCPDP D.0 Claims Repair Processes

The DME MACs, working with their shared system, shall initiate NCPDP D.0 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 COBC 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 D.0 "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 Medicare contractors will not be expected to initiate the repair of "test" 5010 claims, they shall continue to: 1) monitor the COBC 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 D.0 non-SFR "skinny" logic to claim repair situations where they originally transmitted claims to the COBC prior to January 1, 2012, in the NCPDP 5.1 claim format.

XI. Installation of Cut-over Date Parameter Logic to Address Conversion of Older Claim Formats

To ensure appropriate cutover to the NCPDP D.0 COB flat file format, the DME MAC shared system shall develop new date parameter logic to become operational as of January 1, 2012. The shared system shall ensure that the new logic addresses all of the following scenarios:

A. Repairing any errored NCPDP 5.1 claims in the NCPDP D.0 claim format;
B. Converting claims held in suspense from a NCPDP 5.1 format to the NCPDP D.0 claim format;
C. Converting previously adjudicated NCPDP 5.1 claims to the NCPDP D.0 "skinny" non-SFR COB claim format in adjustment claim situations; and
D. Converting claims held in "provider alert status" from an NCPDP 5.1 format to the NCPDP D.0 "skinny' non-SFR COB claim format.