CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 455	**Date: March 10, 2009**
	Change Request 6308

NOTE: Transmittal 437, dated February 6, 2009 is rescinded and replaced by Transmittal 455, dated March 10, 2009. Through this correction, CMS is effectuating minor changes to 1) remove all 837 Medicare secondary payer and provider late filing penalty COB balancing requirements and "111' Detailed Error Report requirements; 2) clarify item 8 of Attachment A, as well as items 3 and 6 of Attachment B. All other information remains the same.

Subject: Health Insurance Portability and Accountability Act (HIPAA) 837 5010 Coordination of Benefits (COB) Requirements--Multi-Carrier Systems (MCS)

I. SUMMARY OF CHANGES: Through this change request, CMS outlines for the Part B shared system its high-level requirements for analysis and design that are tied to the larger implementation of Health Insurance Portability and Accountability Act (HIPAA) 837 5010 coordination of benefits requirements. The Part B shared system shall fully implement the HIPAA 837 5010 COB requirements during October 2009.

New / Revised Material
Effective Date: April 1, 2009, and July 1, 2009 (for analysis and design); October 1, 2009 (for full 5010 COB implementation)
Implementation Date: April 6, 2009, and July 6, 2009 (for analysis and design); October 5, 2009 (for full 5010 COB implementation)

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

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

R/N/D	Chapter / Section / Subsection / Title
N/A	

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

SECTION B: For Medicare Administrative Contractors (MACs):

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:

One-Time Notification

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

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 455	Date: March 10, 2009	Change Request: 6308

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SUBJECT: Health Insurance Portability and Accountability Act (HIPAA) 837 5010 Coordination of Benefits (COB) Requirements---Multi-Carrier System (MCS)

Effective Date: April 1, 2009, and July 1, 2009 (for analysis and design); October 1, 2009 (for full 5010 COB implementation)

Implementation Date: April 6, 2009, and July 6, 2009 (for analysis and design); October 5, 2009 (for full 5010 COB implementation)

I. GENERAL INFORMATION

A. Background: Following receipt of a Common Working File (CWF) Beneficiary Other Insurance (BOI) reply trailer (29), Medicare contractors' shared systems transmit to the Coordination of Benefits Contractor (COBC) Medicare paid claims data in an 837 flat file that contains Health Insurance Portability and Accountability Act (HIPAA) 837 4010-A1required content. At present, Medicare Part B contractors accept incoming hard copy claims (CMS-1500), under defined circumstances, for claims adjudication purposes. Upon adjudication of these claims, these contractors' shared systems create an 837 COB flat file that contains a "skinny" version of the 4010-A1 claim format and transmit that file to the COBC.

Through this instruction, CMS is requesting that the multi-carrier system (MCS) utilize the HIPAA 837 5010 COB requirements herein as part of analysis and design during April 2009 and as part of coding/full implementation during October 2009. **This instruction is specific to MCS only.** The CMS will develop a separate 837 5010 COB requirements instruction for the fiscal intermediary shared system (FISS) and the VIPS Medicare system (VMS) that allows for implementation across the July and October 2009 systems releases.

B. Policy: During the 837 5010 transitional period, if a physician or supplier submits an 837 4010-A1 professional claim to a Medicare contractor and if that Medicare contractor receives a Common Working File (CWF) Beneficiary Other Insurance (BOI) reply trailer (29) that contains a "P" Test/Production (4010-A1) indicator and a "T" 5010 indicator, MCS 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" claim in the 5010 837 COB flat file format for the "test" 5010 claim and transmit the file to the COBC. If a physician or supplier submits a HIPAA 837 5010 professional claim to a Medicare contractor and if the Medicare contractor receives a CWF BOI reply trailer (29) that contains a "P" Test/Production indicator and a "T" 5010 indicator, MCS shall: 1) produce a "skinny" non-SFR claim in the 4010-A1 837 COB flat file for transmission to the COBC; and 2) produce an 837 5010 COB flat file that contains a claim with full SFR content for transmission to the COBC. If the Part B contractor receives a BOI reply trailer 29 that contains a "P" Test/ Production indicator and an "N" 5010 indicator, MCS shall: 1) create an 837 COB flat file with 4010-A1 content for transmission to the COBC; and 2) create nothing in terms of an 837 5010 COB flat file. MCS shall produce a 5010 "skinny" claim, without SFR content, in the event that a claim that a Medicare Part B contractor originally adjudicated in the 4010-A1 format is later released from suspense status or is adjusted

during a timeframe when a COBA trading partner has moved to 837 5010 production (that is, the BOI reply trailer 29 contains a "P" 5010 Test/Production indicator). If a physician or supplier submits a hard-copy (paper CMS-1500) claim to a Medicare Part B contractor, the Part B shared system shall create a "skinny" non-SFR 4010-A1 claim as well as a "skinny" non-SFR 5010 claim if the Part B contractor receives a CWF BOI reply trailer (29) with a "P" Test/ Production indicator and a "T" 5010 indicator. **IMPORTANT:** For all scenarios, if the inbound claim's format is the same as the outbound claim, MCS shall produce crossover claims with full SFR claim content as part of their contractors' 837 COB flat file transmissions to the COBC.

Upon receipt of a BOI reply trailer (29) that contains a "P" 837 5010 indicator, MCS shall ensure that its affiliate contractors are able to 1) book complementary credits for the affected claim; and 2) transmit the "production" claim to the COBC after it has finalized on the contractor's payment floor. Following receipt of a BOI reply trailer (29) that contains a "T" 837 5010 indicator, MCS shall ensure that its 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.

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

Additional requirements pertaining to the 4010-A1 and 5010 transitional period and the COBC Detailed Error Report processes, claims repair and recovery processes, as well as cutover activities will be addressed as part of a separate future instruction. CMS will also provide a complete listing of the business level edits that COBC will apply to incoming 837 5010 COB flat files as part of this separate instruction.

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	
6308.1	The Part B shared system shall create versions of the outbound 837 COB flat files in accordance with the requirements outlined within the first paragraph of the above "Policy" section.							X			
6308.2	The Part B shared system shall develop a 5010 "skinny" non-SFR format that addresses the scenario of claims originally adjudicated in the 4010-A1 format and later adjusted after the HIPAA 837 5010 format is required for all electronic claims transactions.							X			
6308.2.1	The Part B shared system shall also develop a 5010 "skinny" non-SFR format that addresses the scenario of claims that a contractor originally adjudicated in the							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	
	4010-A1 format but suspended for a period of time that meets or transcends the date by which the HIPAA 837 5010 format is required for all electronic claims transactions.										
6308.3	The Part B shared system shall develop a 4010-A1 "skinny" non-SFR claim format to accommodate those situations where COBA trading partners are unable to accept provider-submitted claims in the 837 5010 format.							X			
6308.3.1	Unless otherwise specified, the Part B shared system shall utilize existing gap-fill requirements for 837 4010-A1 claims (including gap-fill requirements applied to incoming paper claims) when creating "skinny" 4010-A1 non-SFR claims for transmission to the COBC.							X			
6308.4	Upon receipt of a BOI reply trailer (29) that contains a "P" 837 5010 indicator, the shared system shall 1) book complementary credits for the affected claim; and 2) transmit the "production" claim to the COBC after it has finalized on the contractor's payment floor.							X			
6308.4.1	Upon receipt of a BOI reply trailer (29) that contains a "T" 837 5010 indicator, the shared system shall 1) not book complementary credits for that version of the claim; and 2) transmit the "test" claim to the COBC after it has finalized on the contractor's payment floor.							X			
6308.5	The Part B shared system shall implement all mapping requirements as found in Attachment A.							X			
6308.5.1	The Part B shared system shall implement the electronic and "paper input to 837 5010" gap-fill requirements as outlined in Attachment B.							X			
6308.5.2	Unless specified otherwise, the Part B shared system shall utilize the same gap-filling requirements for creation of the 5010 "skinny" non-SFR format as it now employs in the creation of the 4010-A1 "skinny" non-SFR format, where the incoming claim is hard copy/paper. (**NOTE:** The MCS maintainer is advised to consult Attachment A, to ensure that previous gap-fill scenarios are not now folded into overall flat-file mapping requirements, wherein actual values are expected.)							X			
6308.6	The Part B shared system shall assume that all Medigap claim-based crossover requirements, as stipulated in							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	
	change requests 5601 and 6037, will be unchanged as the result of the 837 5010 COB implementation.										
6308.7	The COBC will effectuate cut-over of COBA trading partners to the HIPAA 5010 format through actions taken on the COIF.										X COBC
6308.7.1	Upon receipt of a CWF BOI reply trailer (29) that contains a "P" 5010 indicator, MCS shall cease creation of 4010-A1 full COB or 4010-A1 non-SFR skinny COB claims as well as transmission of these files to the COBC.							X			

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	
	. **N/A** .										

IV. SUPPORTING INFORMATION

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

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

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

V. CONTACTS

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

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.

Attachments

ATTACHMENT A

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

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

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

With respect to the 837 5010 Professional COB flat file submissions to the COB Contractor (COBC), the multi-carrier system (MCS) supporting A/B MACs shall observe the following business rules for mapping:

1) The following segments shall **not** be passed to the COBC:
   a) ISA (Interchange Control Header Segment);
   b) IEA (Interchange Control Trailer Segment);
   c) GS (Functional Group Header Segment); and
   d) GE (Functional Group Trailer Segment).

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

3) The BHT02 (Beginning of the Hierarchical Transaction—Transaction Set Purpose Code) shall be passed either with value 00 or 18 under the following circumstances:
   a) Normal claims submission to the COBC—use "00"; and
   b) COBA claims repair process—use "18."

4) The BHT03 (Beginning of the Hierarchical Transaction—Reference Identification or Originator Application Transaction ID) shall contain identifiers populated as follows:
   a) 22 bytes for **non-COBA recovery** claims as follows:
      Bytes 1-9—Contractor ID (9 bytes; contractor ID, left justified, followed by 4 spaces);
      Bytes 10-14—Julian Date (5 bytes, expressed as "YYDDD");
      Bytes 15-19—Sequence Number (5 bytes, starting with "00001"; should increment for each ST-SE envelope);
      Bytes 20-21—Data Center ID (2 bytes); and
      Byte 22—Test/Production Indicator (1 byte; valid values="T"—test; "P"—production).

   b) 22 bytes for **COBA recovery** claims as follows:
      Bytes 1-9—Contractor ID (9 bytes; contractor ID, left justified, followed by 4 spaces);
      Bytes 10-14—Julian Date (5 bytes, expressed as "YYDDD");
      Bytes 15-19—Sequence Number (5 bytes, starting with "00001"; should increment for each ST-SE envelope);
      Bytes 20-21—Data Center ID (2 bytes); and
      Byte 22—COBA recovery indicator (1 byte; indicator =R).

5) The 1000-A PER (Submitter EDI Contact Information) shall be populated as follows:
   a) PER01—populate "1C";
   b) PER02—populate "COBC EDI Department";

c) PER03—populate “TE”; and
d) PER04—populate “6464586740.”

6) The 1000-B loop NM1 (Receiver Name) denotes the crossover trading partner. If the A/B MAC or DMAC receives multiple COBA IDs via the BOI reply trailer (29), the contractor 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;
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 2420-A PRV (Billing Provider Specialty Information) segments, the Part B shared system shall map the taxonomy code values as reported in PRV01 through PRV03 on the incoming electronic claim to the corresponding fields within the 837 COB flat file. If the values reported for these loops on the incoming claim are incomplete **or** syntactically invalid, the Part B shared system shall **not** create the loop and associated segments.

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

8) The Part B shared system shall derive information for 2010AA PER 03, PER04, PER05, and PER06 if such information is present within the contractor’s internal provider files. *If such information is unavailable or is available in incomplete form (i.e., fewer digits than required), the Part B shared system shall **not** create the 2010AA PER loop within the 837 professional COB flat file. (See also item 3 of Attachment B for gap-filling policy.)*

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

10a) For 2320 SBR01, in situations where there is only one (1) payer that is primary to Medicare, the Part B shared system shall apply “P” to any payer that is primary before Medicare; “S” for Medicare as the secondary payer; and “U” for all supplemental payers after Medicare.
SPECIAL NOTE: If, for example, a claim contains at least two (2) primary payers before Medicare, MCS shall reflect the primary payer as 2320 SBR01as “P”; the secondary payer as 2320 SBR01 = “S”; the tertiary payer; and, Medicare, as 2320 SBR01 = “T”. MCS shall reflect all additional supplemental payers as 2320 SBR01 = “U.”

10b) For 2000B SBR01 (element 1138), the Part B shared system shall apply “U” for all other supplemental payers after Medicare.

11) For additional 2000B requirements, the Part B shared system shall take the following actions:
a) SBR03—map spaces;

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 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 systems shall populate the NM1, N3, and N4 segments as follows:

2010BA_NM1—Subscriber Name:

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

2010BA_N3—Subscriber Address:

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

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

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

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

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

2010BA_NM1—Subscriber Name:

a) NM101—populate "IL";
b) NM102—populate "1";
c) NM103—derive from internal beneficiary eligibility file;
d) NM104—derive from internal beneficiary eligibility file;
e) NM105—derive from internal beneficiary eligibility file if available; otherwise populate spaces;
f) NM108—populate "MI"; and
g) NM109—populate beneficiary policy number as derived from Item 9-D of CMS-1500 claim or 2330A NM109 of the incoming 837 professional claim. The shared system shall only populate HICN here if the policy number is unavailable on the incoming claim.

2010BA_N3—Subscriber Address:

a) *N301—derive from internal beneficiary eligibility file;

b) N302—derive, as necessary, from internal beneficiary eligibility file; otherwise populate spaces.
(*--See Gap Filling Requirements in Attachments B and C to address situations where the beneficiary's line-1 address, as derived from the contractor's internal beneficiary eligibility file, is blank or incomplete.)

2010BA N4—Subscriber City/State/Zip Code:
a) N401—derive from internal beneficiary eligibility file;
b) N402—derive from internal beneficiary eligibility file;
c) N403—derive from internal beneficiary eligibility file; and
d) N407—derive, if available, from internal beneficiary eligibility file; otherwise populate spaces.

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

2330A—NM1:
a) NM101—populate "IL";
b) NM102—populate "1";
c) NM103—derive from internal beneficiary eligibility file;
d) NM104—derive from internal beneficiary eligibility file;
e) NM105—derive from internal beneficiary eligibility file if available; otherwise populate spaces;
f) NM108—populate "MI"; and
g) NM109—populate HICN.

2330A-N3:
a) *N301—derive from internal beneficiary eligibility file; and
b) N302—derive, as necessary, from internal beneficiary eligibility file as necessary; otherwise populate spaces.
(*--See Gap Filling Requirements in Attachments B to address situations where the beneficiary's line-1 address, as derived from the contractor's internal beneficiary eligibility file, is blank or incomplete.)

2330A-N4:
a) N401—derive from internal beneficiary eligibility file; and
b) N402, N403, N404, N407—derive from internal beneficiary eligibility file if available and applicable; otherwise populate spaces.

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

2010BB—NM1:
a) NM101—populate "PR";
b) NM102—populate "2";
c) NM103—populate spaces;
d) NM108—populate "PI"; and
e) NM109—populate the COBA ID (5 digit COBA ID as obtained from the BOI reply trailer 29).

2010BB-N3 & 2010BB-N4:
a) N301 & N302—populate spaces;
b) For N401, N402, N403, N404, N407, populate spaces.

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

16) If the Part B 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) In the absence of information on the incoming claim, the Part B shared system shall continue to map the claim's date of service within the 2300 DTP (Date of Onset of Current Illness or Symptoms) DTP03 segment, when required.

18) 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 Part B shared system completing all required information for NM101, NM102, NM103, NM108, NM109, as well as the N3 and N4 segments.

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

2nd and additional iterations of 2330B—NM1:

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

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

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

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

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

a) For REF01, always map "F5";
b) For REF02, map "Y" if the COBA ID returned via the BOI reply trailer (29)=55000 through 55999 (Medigap Claim-based);
c) For REF02, map "N" if the COBA ID returned via the BOI reply trailer (29)=anything except for 55000 through 55999.

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

****IMPORTANT: The Part B 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 Part B 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 Part B 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 Part B contractor shall continue to utilize this value for purposes of deriving the information necessary to populate all required segments associated with 2310C (Service Facility Name). The Part B contractor shall continue to not create the 2310C loop if block 32 on the incoming paper claim is blank.

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

ATTACHMENT B

837 5010 COB Gap-Fill Requirements

Gap-Fill Requirements for 837 5010 COB Professional Claims

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

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

3) For any situation involving a provider-oriented PER segment (e.g., 2010AA), if the telephone number available within the contractor's internal provider file is incomplete, the Part B shared system shall ***not*** *attempt to gap-fill missing values and shall follow the mapping directive provided in Attachment A, item 8.*

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

5) In instances where the date of admission, when required, must be gap-filled, the Part B shared system shall continue to utilize the claim's earliest service date to satisfy that requirement for 2300 DTP03 in association with claims whose place of service (POS) code is 21, 51, or 61.

6) In association with paper-submitted claims, the Part B shared system shall gap-fill the *N3 and* N4 portion*s* of loop 2310E and 2310F as follows for the segments shown**:**

i) For the required N301 segment, MCS shall gap-fill all Xs to the minimum required length;

ii) For the required N4 segments, MCS shall gap-fill the segments as follows:

a. N401 (City)—populate "Cityville";

b. N402 (State Code)—populate "MD";

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

7) 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.

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

9) 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.

10) The Part B 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.

11) The Part B 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.

12) 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.

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

14) 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 Part B shared system shall gap-fill all required segments with "Xs." The Part B 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.

15) If the incoming claim is paper, the Part B shared system shall map "not otherwise classified" within the 837 5010 COB flat file field the corresponds to loop 2400 SV101-7 (composite medical procedure—description).