



**Coordination of Benefits Agreement (COBA)
Companion Guide for**

**National Council for Prescription Drug Programs
(NCPDP) Batch Version D.0 COB/Crossover Claims**

For Use by
All COBA Trading Partners

Developed by
The Division of Medicare Benefits Coordination within the Centers
for Medicare & Medicaid Services (CMS)

Version 2.2

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Confidentiality Statement

The collection of this information is authorized by Section 1862(b) of the Social Security Act (codified at 42 U.S.C 1395y(b)) (see also 42, C.F.R. 411.24). The information collected will be used to identify and recover past conditional and mistaken Medicare primary payments and to prevent Medicare from making mistaken payments in the future for those Medicare Secondary Payer situations that continue to exist. The Privacy Act (5 U.S.C. 552a(b)), as amended, prohibits the disclosure of information maintained by the Centers for Medicare & Medicaid Services (CMS) in a system of records to third parties, unless the beneficiary provides a written request or explicit written consent/authorization for a party to receive such information. Where the beneficiary provides written consent/proof of representation, CMS will permit authorized parties to access requisite information.

I. Summary of Version 2.2 Updates

The following represents changes to the COBA NCPDP D.0 Companion Guide:

To ensure that mass-adjusted claims identified as SMRC-related are transmitted to the BCRC, a new identifier “Z” will be added in the 23rd-byte position of the Message Trailer (504-F4) for NCPDP D.0 COB claims (Section V.A).

II. Introduction

The Coordination of Benefits Agreement (COBA) National Council for Prescription Drug Programs (NCPDP) Batch Version D.0 COB/Crossover Claims provides COBA trading partners information for preparing and testing Medicare NCPDP D.0 batch COB transactions with the Benefits Coordination & Recovery Center (BCRC). This guide includes seven sections.

Referenced documents and forms are available for download at the following URL:

<https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/COBA-Trading-Partners/HIPAA-5010-COB-Claims/HIPAA-5010-COB-Claims-page.html>

III. Getting Started—Preparing to Test Medicare NCPDP D.0 COB Claims

As a COBA trading partner representative that is preparing your organization for testing NCPDP D.0 COB claims with the Benefits Coordination & Recovery Center (BCRC), your first step is to download and complete the “COBA Technical Readiness Assessment.” This document may be downloaded at the following URL:

<https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/COBA-Trading-Partners/HIPAA-5010-COB-Claims/HIPAA-5010-COB-Claims-page.html>

If you already completed this document in association with your testing of HIPAA 5010, you would only need to complete it again if you neglected to address your planned NCPDP D.0 testing timeframes when previously completing the form. COBA trading partners will most likely not need to obtain new COBA identifiers (IDs) to test NCPDP D.0 COB transactions with the BCRC. Potential reasons for needing to obtain “test” COBA IDs may include the COBA trading partner’s desire to vary claims selection criteria for receipt of NCPDP D.0 COB claims as compared with the criteria selected for NCPDP 5.1 crossover claims.

SPECIAL NOTE: It remains true that trading partners are not required to accept NCPDP claims via the COBA crossover process.

Your designated BCRC electronic data interchange (EDI) representative should be able to assist you with set-up for NCPDP D.0 COB claims testing. Questions concerning what connectivity options are available to you in connection with NCPDP D.0 COB testing may be referenced in the *COBA Implementation User Guide*. At this point in time, CMS is offering the same options available to COBA trading partners as part of their current NCPDP 5.1 COB claims crossover process.

COBA trading partners that have questions about available claims selection criteria should consult Chapter 2 of the *COBA Implementation User Guide*.

COBA trading partners should not make payment on Medicare-transmitted NCPDP D.0 COB “test” claims. They should, however, use these claims to gauge the possible need for front- or back-end systems changes that will enable them to receive these claims in production mode.

IV. High-Level Overview of Changes from NCPDP 5.1 to NCPDP D.0 Batch Versions

A. New Field for Medigap Identifier

The Committee responsible for modifying the National Council for Prescription Drug Programs telecommunication batch and real-time claims formats has accommodated a long-standing Medicare need through its version D.0, batch 1.2 changes. Specifically, in those instances where the Medigap insurer does not provide an eligibility file to the COB Contractor to trigger crossover claims but instead allows the retail pharmacy to input necessary information on the incoming NCPDP D.0 claim to trigger claims crossover, the retail chain pharmacy will now place the Medigap policy number within element 359-2A in the Transmission Insurance Segment. As indicated in Section V, the Medigap insurer's 5-byte Medigap claim-based COBA ID will continue to be reflected in element 301-C1 ("Group ID") within the same segment.

B. New Provider Accepts Assignment Indicator

Under NCPDP version 5.1, Medicare did not reflect the provider assignment indicator independently on the COB/crossover claim. The NCPDP D.0 has added a provider accept assignment indicator field as element 361-2D in the Transmission Insurance Segment. As indicated below, Medicare will always populate this field.

C. New Field for Qualifying Deductible and Co-Insurance Amounts Remaining and Indication Where These Monetary Amounts Will Appear

Under NCPDP version D.0, any co-insurance or deductible amounts remaining after Medicare's payment of the claim for Part B drugs will no longer be qualified by 98 or 99, respectively. These amounts previously were reported within the 431-DV, with qualifiers reflected in 342-HC, as elements in the Transaction COB/Other Payments Segment. The NCPDP Committee has now created a new field for the deductible and co-insurance qualifiers for use within the NCPDP D.0 batch transaction. Therefore, Medicare will now qualify the Part B deductible and/or co-insurance amounts as follows within a brand-new field 351-NP ("Other Payer-Patient Responsibility Amount Qualifier") created within the NCPDP D.0 batch claim:

- 01=Deductible amount owed;
- 07=Co-insurance amount owed.

These amounts will also appear within the Transaction COB/Other Payments Segment.

In addition, the actual monetary amount(s) for the Part B deductible and/or co-insurance attributable to Part B drugs billed via the NCPDP D.0 claim will now be reflected within 352-NQ ("Other Payer Patient Responsibility Amount"), which is also within the Transaction COB/Other Payments Segment.

D. Allowed Amount Discontinued

As of October 2011, THE DME MAC SHARED SYSTEM discontinued reporting Medicare's allowed amount on outbound NCPDP D.0 claims. This action was taken to ensure consistency between NCPDP D.0 COB claims and Health Insurance Portability and Accountability Act version 5010A1 837 professional COB claims.

E. New Values Used to Qualify Medicare's Paid Amount

Under NCPDP version D.0, Medicare will now qualify its paid amount with 07 in the 342- HC element ("Other Payer Paid Qualifier") within the Transaction COB/Other Payments Segment. The Medicare paid amount will be reflected within element 431-DV within the Transaction COB/Other Payments Segment.

V. NCPDP D.0 COB Mapping

A. General

The 504-F4 ("Message") Trailer portion of the file will contain a 23-byte identifier populated 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 batch envelope);
- Bytes 20-21—2-byte Claim Version Indicator;
- Byte 22—Test/Production Indicator (1 byte; valid values= "T"—test; "P"—production); and
- Byte 23—File indicator identifying Claim Type = "Z" (which identifies and transmits Supplemental Medical Review Contractor (SMRC) mass adjustment claims to the BCRC for invoicing).

B. Transmission/Transaction Header Segment

The Medicare Durable Medical Equipment Medicare Administrative Contractor (DME MAC) shared system will format this segment as follows:

- 1) The COBA trading partner's designated receiver ID will be reflected in 880-K7 (Receiver ID).
- 2) The claims version release number will be populated in 102-A2 within the Transmission/Transaction Header Segment. Values will be populated as follows:
 - '12' for the Transmission Header; and
 - 'D0' for the Transaction Header.
- 3) The value 'B1' will appear in 103-A3; the process control number will appear in 104- A1; and the transaction count value will appear in 109-A9.

NOTE: For "skinny" NCPDP claims, the DME MAC shared system will reflect 'UNKNOWN' in 104-A1.

- 4) The provider ID qualifier corresponding to the national provider identifier (NPI) will be populated in 202-B2.
- 5) The supplier's NPI will appear in 201-B1 ("Service Provider ID").
- 6) The "from date of service" will be taken from the incoming claim and populated in 401-D1.
- 7) Element 110-AK ("Software Vendor/Certification ID") will be mapped from the incoming claim.

IMPORTANT: For “skinny” NCPDP claim scenarios, where the incoming claim is NCPDP 5.1 but the COBA trading partner is seeking an NCPDP version D.0 claim for crossover purposes, the shared system will map “unknown” in 110-AK.

C. Transmission Insurance Segment

The Medicare DME MAC shared system will format this segment as follows:

- 1) Map the beneficiary’s Medicare ID (Medicare Beneficiary Identifier [MBI] or Health Insurance Claim Number [HICN]) in 302-C2 (“Cardholder ID”).

SPECIAL NOTE: For claim-based Medigap claims, this field will contain the Medigap policy number, as is true under NCPDP 5.1, with the Medicare ID (MBI or HICN) being reported in element 332- CY within the Patient Segment.

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

Location of COBA IDs within the NCPDP D.0 COB Claims

- 1) Up through files created on February 8, 2012, for Medigap claim-based crossover purposes only, the DME MAC shared system will 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 will populate the Medigap policy ID in the newly created 359-2A (“Medigap ID”) element, as derived from the incoming claim.

IMPORTANT NOTE: Up through files created on February 8, 2012, for COBA eligibility file-based crossovers, the DME MAC shared system will map spaces to element 301-C1.

Therefore, the DME MAC shared system maps the trading partner’s COBA ID to 301-C1, regardless of whether the entity is participating in the Medigap claim-based crossover process or in the COBA eligibility file-based crossover process.

- 2) Map a “Y” [assigned] value for element 361-2D (“Provider Accept Assignment Indicator”). **NOTE:** Possible values for this element include Y or N.

D. Transmission Patient Segment

The Medicare DME MAC shared system will format this segment as follows:

- 1) Element 307-C7 (“Place of Service”) will be mapped from the first service line of the Medicare-adjudicated claim.
- 2) The Medicare ID (MBI or HICN) will be mapped in 332-CY (“Patient ID”). A qualifier of ‘99’ is mapped to qualify the Medicare ID (MBI or HICN) in element 331-CX. **NOTE:** CMS switched to mapping ‘09’ within element 331-CX as of CY 2012.
- 3) Map elements 304-C4, 305-C5, 310-CA, and 311-CB from the DME MAC’s data store.
- 4) Map elements 322-CM, 323-CN, 324-CO, and 325-CP from the DME MAC’s data store.

See Chapter VIII Gap-Filling Requirements 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.

- 5) Map 326-CQ (“Patient Phone Number”) and 350-HN (“Patient E-mail Address”) from incoming claim if received.
- 6) Map any one (1) of the following values, as derived from the incoming Medicare claim for “patience residence,” in element 384-4X:

- 0=Not Specified
- 1=Home
- 2=Skilled Nursing Facility
- 3=Nursing Facility
- 4=Assisted Living Facility
- 5=Custodial Care Facility
- 6=Group Home
- 7=Inpatient Psychiatric Facility - Not applicable to Pharmacy Benefits
- 8=Psychiatric Facility – Partial Hospitalization - Not applicable to Pharmacy Benefits
- 9=Intermediate Care Facility/Mentally Retarded
- 10=Residential Substance Abuse Treatment Facility - Not applicable to Pharmacy Benefits
- 11=Hospice
- 12=Psychiatric Residential Treatment Facility - Not applicable to Pharmacy Benefits
- 13=Comprehensive Inpatient Rehabilitation Facility - Not applicable to Pharmacy Benefits
- 14=Homeless Shelter - Not applicable to Pharmacy Benefits
- 15=Correctional Institution

NOTE: The above values are subject to change. These elements will be taken from the NCPDP’s External Code List.

E. Transaction Prescriber Segment

The Medicare DME MAC shared system will format this segment as follows:

- 1) Map element 466-EZ (“Prescriber ID Qualifier”) from the adjudicated Medicare claim.
Valid qualifiers are ‘01’ for NPI and ‘06’ for UPIN. **NOTE:** Value 01 will only appear on NCPDP D.0 crossover claims.
- 2) Always map “01” for element 468-2E (“Primary Care Provider ID Qualifier”).
NOTE: This element, and the corresponding element 421-DL, will **not** be mapped out for skinny claims.
- 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 incoming claim if reported, for 470-4E (“Primary Care Provider Last Name”). **NOTE:** If this element is not reported, the element is not created.

- 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 Chapter VIII Gap-Filling Requirements for those requirements that will come into play for NCPDP skinny mapping.)**

F. Transaction COB/Other Payments Segment

IMPORTANT NOTE: The Medicare DME MAC shared system reflects other COB payers, which are independent of the current COB receiver of the claim, within this area of the claim. The system reflects the Medicare contractor ID in element 340-7C, with qualifier 99 appearing in 339-6C. All other fields in these occurrences of payer information are defaulted to spaces/zeros.

The Medicare DME MAC shared system will format this segment as follows:

- 1) Map element 337-4C from the incoming claim.
NOTE: The DME MAC system will increase this number by 1 when applying the Medicare payment amounts.
- 2) Prepare element 342-HC with qualifier “7” for Paid Amount. **NOTE:** Medicare will also use “7” as a qualifier for the primary payer’s obligated to accept as payment in full [OTAF] amount in situations where Medicare is the secondary payer. Medicare will reflect the monetary amount of the OTAF within element 431-DV.
- 3) Map “1” within 351-NP to qualify the Medicare Part B deductible applied; and map “7” to qualify the Part B co-insurance amount owed.
- 4) Reflect the Medicare Part B deductible amount and/or Part B co-insurance amount within 352-NQ.
NOTE: Elements 351-NP and 352-NQ will always be mapped.
- 5) Map value “05” for element 339-6C in relation to Medicare’s role as payer of the claim.
- 6) Map the DME MAC’s workload identifier (e.g., 16003) in element 340-7C.
- 7) Map the Internal Control Number (element 993-A7) as received from CEDI and as a result of claim adjudication.
- 8) 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.

When filling in the fields/elements listed for Medicare’s payment, the DME MAC shared system will:

- A. Place the cycle payment date within element 443-E8.
- B. Count the number of payment types it will be reporting and place this amount within element 341-HB.

- C. Complete the code value in element 342-HC, with its associated amount reflected in element 431-DV for each payment amount reported.

SPECIAL NOTE: Under NCPDP D.0 COB, the DME MAC shared system will qualify the Medicare paid amount within element 342-HC with value 07.

- D. Complete the total number of rejects being reported by Medicare in element 471- 5E, with each reject code being listed within element 472-6E.
- 9) 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.

G. Transaction Claim Segment

The Medicare DME MAC shared system will format this segment as follows:

- 1) Map 343-HD, 344-HF, and 345-HG based upon availability of the data on the incoming claim.
- 2) Create 455-EM and 402-D2 as required, without gap-filling, as derived from the incoming claims data.
- 3) Create 403-D3, 405-D5, 406-D6, and 407-D7 as required, without gap-filling, as derived from the Medicare adjudicated claim.
- 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 436-E1 as required, without gap-filling.
- 8) Create 456-EN, 420-DK, and 429-DT to the COB file if received on the incoming claim.
- 9) For element 308-C8, THE DME MAC SHARED SYSTEM will map “02” to this element when the paid amount on the adjudicated claim is greater than zeroes. THE DME MAC SHARED SYSTEM will, however, map “04” to this element when the paid amount is equal to zeroes.
- 10) Map 600-28 if received on the incoming claim.
- 11) Always create 391-MT (“Patient Assignment Indicator”) on the COB flat file. **NOTE:** CEDI will reject NCPDP claims with this element missing at the DME MAC’s front end.

H. Transaction Compound Segment

The Medicare DME MAC shared system will format this segment as follows:

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

- 2) Create the following if received on the incoming claim and/or if considered as part of Medicare claims adjudication: 490-UE, 362-2G, and 363-2H.

I. Transaction Pricing Segment

The Medicare DME MAC shared system will format this segment as follows:

- 1) Create the following required elements without gap-filling: 409-D9 and 430-DU.
- 2) Create the following based upon availability of the data on incoming claims: 412-DC, 423-DN, 426-DQ, 433-DX, 438-E3, 478-H7, 479-H8, and 480-H9.

J. Narrative Segment

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

VI. Information Regarding Skinny Claims

The DME MAC shared system will not produce the following segments for outbound NCPDP D.0 skinny COB claims:

- 02—Pharmacy
- 06—Workers' Compensation
- 08—DUR-PPS
- 09—Coupon
- 14—Additional Documentation (not valid for Medicare)
- 16—Narrative

NOTE: Some of these segments will also **not** be produced as part of normal NCPDP D.0 COB file creation processes. See Section VII, for more information

VII. Elements That Will Not Appear on NCPDP D.0 COB Claims

The CMS and its Medicare contractors have determined that they will **not** create the below elements and/or entire segments, shown in accordance with segment placement, on their outbound NCPDP D.0 COB claims. However, if the field is a count of the number of occurrences that follow, the DME MAC shared system will send the field with a value of zero (0).

A. Transmission Insurance Segment

- Elements 115-N5, 116-N6, 314-CE, 303-C3, and 306-C6

B. Facility Segment

- 336-8C (“Facility ID”), even in “skinny” claim situations

C. Transmission Patient Segment

- Element 335-2C (“Pregnancy Indicator”)

D. Transaction COB/Other Payments Segment

- Elements 392-MU, 393-MV, and 394-MW, as these are not used for Medicare purposes
- The Transaction Workers' Compensation Segment

E. Transaction Claim Segment

- Elements 461-EU, 462-EV, 463-EW, 464-EX, 354-NX, 357-NV, 995-E2, 996-G1, and 147-U7

F. Transaction Pricing Segment

- Elements 482-GE, 483-HE, and 484-JE

G. Transaction Prior Authorization Segment—Not created

H. Workers' Compensation Segment—Not created

I. Additional Documentation Segment—Not created

VIII. Gap-Filling Requirements

The gap-filling requirements listed below will be applied, as necessary, by the DME MAC shared system when creating outbound NCPDP D.0 COB claims.

- A. For all instances of the 325-CP element within the Transmission Patient Segment, the DME MAC shared system (THE DME MAC SHARED SYSTEM) will populate a 9-byte zip code. If only 5 bytes of the zip code can be obtained, the shared system will populate "9998" after the concluding character of the 5-byte zip code that is available (e.g., 211019998).
- B. When there is **not** a valid zip code available to complete a 325-CP element, THE DME MAC SHARED SYSTEM will populate "96941" within the field corresponding to that segment on the NCPDP D.0 COB flat file.
- C. 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, THE DME MAC SHARED SYSTEM will populate this element with an initial "X" followed by 29 spaces.
- D. The shared system will 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 will 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 will initialize elements 364-2J, 365-2K, 366- 2M, and 367-2N to spaces as a gap-fill measure.
- G. For "skinny" processing, the shared system will initialize elements 498-PM and 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 will initialize element 427-DR to spaces.

Appendix A: Previous Version History

Version 2.1

- All “HICN” field names have been changed to “Medicare ID,” and the fields have been configured to accept either the HICN or the new Medicare Beneficiary Identifier (MBI).
- The revised CMS Confidentiality Statement has been added.
- Updated the CMS logo per CMS branding guidelines.
- Updated the CMS.gov URLs.