Medicare Learning Network
MLN Matters
CMS
Information for Medicare Fee-for-Service Health Care Professionals

Related Change Request (CR) #: N/A MLN Matters Number: SE0504
Related CR Release Date: N/A

The Centers for Medicare & Medicaid Services (CMS) Consolidation of the Claims Crossover Process

Provider Types Affected

All Medicare physicians, providers, and suppliers

Provider Action Needed

Physicians, providers, and suppliers should note that this special edition article is to inform you of system changes to implement a switch from 1) Medicare intermediaries, carriers, and Durable Medical Equipment Regional Carriers (DMERCs) crossing supplemental claims to supplemental insurers to 2) a single entity, the Coordination of Benefits Contractor (COBC), doing the same from one location.

Background

The Centers for Medicare & Medicaid Services (CMS) is consolidating the Medicare claims crossover process under a special Coordination of Benefits Contractor (COBC) by means of the Coordination of Benefits Agreement (COBA) initiative.

Currently, supplemental payers/insurers (including eligibility-file-based Medigap, Medicaid and employer plans) must sign multiple crossover agreements with Part A intermediaries and Part B carriers and Durable Medical Equipment Regional Carriers (DMERCs) to accomplish an automatic, or eligibility-file-based, crossover to other insurers that pay after Medicare has made its payment decision on a claim.

In the future (under the new consolidated claims crossover process) supplemental payers/insurers will sign one national crossover agreement and work directly with the COBC (which represents CMS). The supplemental payer/insurer will:

- Send eligibility files to identify its covered members; and
- Receive outbound HIPAA ANSI X-12N 837 Coordination of Benefits (COB) claims and National Council for Prescription Drug Programs (NCPDP) claims for use in calculating their secondary payment liability.

On July 6, 2004, CMS began testing the consolidated crossover process with approximately ten supplemental payers/insurers. Note the following:

- Testing is focused on the outbound HIPAA ANSI X-12 837N COB claims that are translated from Medicare's Part A intermediary, Part B carrier, and DMERC processed claims.

- Initial -implementation will take place after successful testing is completed, and the 10 supplemental payers/insurers will be moved to full COBA crossover production through one entity, the COBC.
- Throughout the course of fiscal year 2005, CMS will begin transitioning all supplemental payers/insurers from the existing eligibility file-based crossover process to the national COBA process.

Detailed requirements for 1) eligibility file-based crossover and 2) claim-based (mandatory Medigap) crossover were previously issued by CMS in Change Request (CR) 3109 (Transmittal 98), and CMS subsequently issued CR 3218 (Transmittal 138) to communicate the new implementation strategy for the COBA initiative. Transmittal 138 may be accessed at *http://www.cms.hhs.gov/transmittals/Downloads/R138CP.pdf* on the CMS website.

CR 3218 (Transmittal 138) provided:

- Major changes to many of the requirements previously published in CR 3109 (Transmittal 98) and
- Moved the implementation of claim-based crossover to a future date.

Physician, Provider, and Supplier Action

NOTE: Physicians, providers, and suppliers will not need to take any new actions with respect to the COBA automatic (or eligibility-file-based) crossover process.

The key difference between the existing automatic crossover process and the new COBA automatic crossover process is that, when a supplemental payer/insurer provides CMS with specific claim types and member information for those claims they wish to receive, the claims will be crossed over to the supplemental payers/insurers only after the claims have left the Medicare claims payment floor.

Thus, physician, provider, and supplier offices should receive payment and/or processing information from a patient's supplemental payer/insurer after the Medicare payment has been received (once the supplemental payer/insurer has transitioned to the COBA crossover process).

Physicians, providers, and suppliers will be able to reference additional information on COBA at *http://www.cms.hhs.gov/COBAgreement/* on the CMS website.

Physicians, providers, and suppliers should note that the following important information will require your attention when a supplemental payer/insurer 1) has transitioned to the COBA eligibility-file-based crossover process and 2) is listed on the website noted in the previous paragraph.

- Although the claim may cross to multiple supplemental payers/insurers, only one will print on your remittance advice. In this situation, if one of the supplemental payers/insurers is Medigap, the Medigap insurer will always print.
- Since payment from the supplemental payer/insurer should occur only after the Medicare payment has been issued, it is advised that you do not bill the supplemental payer/insurer for a minimum of 15 work days after receiving the Medicare payment. This will allow sufficient time for the claim to cross to the supplemental payer/insurer and the subsequent actions necessary to issue payment from the supplemental payer/insurer.

- In addition, prior to submitting a claim to the supplemental payer/insurer, it is advised that you use available self-service tools to research the status of your supplemental payment, e.g., the supplemental payer/insurer's website, claims automated "hot line," etc.
- There may be situations (such as claim errors related to HIPAA) that prevent the automatic crossover from occurring after you have received a Medicare remittance advice (electronic or supplemental paper) notifying you that the claim has crossed to the supplemental payer/insurer.
- Again, it is advised that you allow a minimum of 15 work days after Medicare payment has been issued before billing the supplemental payer/insurer to ensure that an automatic supplemental payment will not be issued. In addition, it is advised that you use the self-service tools of the supplemental payer/insurer to research the status of your supplemental claim prior to submitting it for supplemental payment.
- As a reminder, only the "official" Medicare remittance advice or HIPAA 835 Electronic Remittance Advice should be used for supplemental billing purposes. CMS requests that copies of screen prints from any system that is used to access Medicare claim status not be submitted to a supplemental payer/insurer for billing purposes even if:
  - You are billing the supplemental payer/insurer after the 15 work days from the Medicare- issued payment have expired; and
  - You have used the available self-service tools to research the status of your supplemental payment.

Special Note for Physicians and Suppliers

Currently, Part B carriers and DMERCs assign identification numbers (known as In-key or OCNA numbers) to Medigap insurers that do not participate in the automatic, or eligibility-file-based, crossover process.

There are no current changes to this process and no current action is required of physicians, providers, and suppliers to change internal procedures related to Medigap claim-based crossovers.

Participating physicians and suppliers that bill Part B carriers and DMERCs for claim-based crossover will be informed approximately 90 days prior to implementing any changes to the claim-based crossover process. CMS expects this method of crossover to decrease sharply under the consolidated COBA crossover process, since most Medigap insurers will now have a single entity to which they can submit eligibility files to identify their covered members.

Related Instructions

On April 9, 2004, CMS issued CR 3218 (Transmittal 138) to communicate the new implementation strategy for the COBA initiative. CR 3218 (Transmittal 138), may be viewed at *http://www.cms.hhs.gov/transmittals/Downloads/R138CP.pdf* on the CMS website.

Additional Information

If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at *http://www.cms.hhs.gov/apps/contacts/* on the CMS website.