CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1242	**Date: MAY 18, 2007**
	Change Request 5601

Subject: Transitioning the Mandatory Medigap ("Claim-Based") Crossover Process to the Coordination of Benefits Contractor (COBC)

I. SUMMARY OF CHANGES: Through this change request, CMS outlines its systematic requirements for the transitioning of its mandatory Medigap ("claim-based") crossover process from its Part B contractors, including carriers and Medicare Administrative Contractors (MACs), and Durable Medical Equipment Regional Carriers (DMERCs)/DME MACs to the Coordination of Benefits Contractor. Another instruction will address the non-systematic instructions associated with this transition process.

New / Revised Material
Effective Date: October 1, 2007
Implementation Date: October 1, 2007

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	27/ Table of Contents
R	27/80.15/ Claims Crossover Disposition Indicators
N	27/80.17/ Coordination of Benefits Agreement (COBA) Medigap Claim-Based Crossover Process
R	28/ Table of Contents
R	28/30/ Completion of the Claim Form
R	28/30.1/ Form CMS-1500 (ANSI X12N 837 COB (version 4010))
R	28/30.2/ UB-92 (Form CMS-1450)
R	28/70/ Coordination of Medicare With Medigap and Other Complementary Health Insurance Policies
N	28/70.6.4/ Coordination of Benefits Agreement (COBA) Medigap Claim-Based Crossover Process

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1242	Date: May 18, 2007	Change Request: 5601

SUBJECT: Transitioning the Mandatory Medigap ("Claim-Based") Crossover Process to the Coordination of Benefits Contractor (COBC)

Effective Date: October 1, 2007

Implementation Date: October 1, 2007

I. GENERAL INFORMATION

A. Background: Currently, in accordance with §1842(h)(3)(B) of the Social Security Act and §4081(a)(B) of Public Law 100-203 (the Omnibus Budget Reconciliation Act of 1987), Part B contractors, including carriers and Medicare Administrative Contractors (MACs), and Durable Medical Equipment Regional Carriers (DMERCs)/DME Medicare Administrative Contractors (DMACs) transfer participating provider claims to Medigap insurers if the beneficiary has assigned rights to payment to the provider and if other claims filing requirements are met. This form of claims transfer is commonly termed "Medigap claims-based crossover." One of the "other" claims filing requirements for Medigap claim-based crossover is that the participating provider must include an Other Carrier Name and Address (OCNA) or N-key identification number on the incoming electronic claim to trigger the crossing over of the claim.

At present, Part B contractors and DMACs maintain a variety of claim formats and connectivity options in support of the Medigap claim-based crossover process. Effective with the transitioning of the Medigap claim-based crossover process to the Coordination of Benefits Contractor (COBC) on October 1, 2007, the Centers for Medicare & Medicaid Services (CMS) will only support the Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X-12N 837 professional COB (version 4010-A1) claim format and National Council for Prescription Drug Programs (NCPDP) version 5.1 batch standard 1.1 claim format for such crossovers. This ensures that CMS fulfills the requirements within Public Law 104-191 and 45 *Code of Federal Regulations* (CFR) 160 relating to all "covered entities," as defined at 45 CFR160.103, being able to accept the HIPAA ANSI X12-N 837 COB claim transaction.

B. Policy: The CMS envisions that, during the period from June through September 2007, its COBC will have signed national crossover agreements with all the Medigap claim-based crossover recipients, assigned new Medigap claim-based COBA IDs to these entities, and successfully tested the new process with these insurers in anticipation of the new COBA Medigap claim-based crossover process being inaugurated on October 1, 2007. The COBC will assign the new claim-based COBA IDs to the Medigap insurers on a graduated basis throughout the three month period. Through a separate, non-systems instruction that CMS plans to issue during May 2007, CMS will apprise the affected Medicare contractors that, during the three (3) month transitional period, they shall accept the old OCNA or N-key identifier and the newly assigned COBA Medigap claim-based ID on incoming participating provider claims. During this time, the affected contractors shall also continue to cross claims over as normal to their Medigap claim-based crossover recipients. CMS will regularly apprise the affected Medicare contractors when they have assigned new COBA Medigap claim-based IDs to the Medigap insurers and will post this information on its COB website so that contractors may direct providers to that link for purposes of obtaining regular updates. As will be specified in the future instruction, contractors shall perform file maintenance to include the newly assigned COBA Medigap claim-based ID within their insurer tables throughout the transitional period. Greater substantive detail concerning these matters will be included in the future non-systems change.

Effective with claims filed to Medicare on October 1, 2007, all participating providers that have been granted a billing exception under the Administrative Simplification Compliance Act (ASCA) shall be required to enter CMS' newly assigned Coordination of Benefits Agreement (COBA) Medigap claim-based identifier (ID) within block 9-D of the incoming CMS-1500 claim for purposes of triggering Medigap claim-based crossovers. All other participating providers shall enter the newly assigned COBA Medigap claim-based ID, left-justified and followed by spaces within the NM109 portion of the 2330B loop of the incoming HIPAA ANSI X12-N 837 professional claim **and** within field 301-C1 of the T04 segment on incoming National Council for Prescription Drug Programs (NCPDP) claims for purposes of triggering Medigap claim-based crossovers. These provider requirements will be addressed at greater length in the future non-systems instruction.

Beginning with October 1, 2007, the Part B contractors, including MACs, and DMACs' internal processes for screening claims for Medigap claim-based crossovers shall feature a syntactic editing of the incoming COBA claim-based Medigap ID to ensure that the identifier begins with a "5," contains 5 numeric digits, and is left-justified within the field, followed by blanks. If the claim fails this syntactic verification, the contractor shall not copy the identifier from the incoming claim and populate it within field 34 ("Crossover ID") of the HUBC or HUDC transaction. Instead, the contractor shall continue to follow its pre-existing processes for notifying the provider or beneficiary that the information reported on the claim did **not** result in the claim being crossed over. The affected contractors' screening processes for Medigap claim-based crossovers shall also continue to include verification that the provider participates with Medicare and that the beneficiary has assigned benefits to the provider.

Following successful completion of the contractors' internal screening processes, including the up-front syntactic check, the affected contractors' systems shall copy the COBA Medigap claim-based ID from the incoming Medicare claim and populate the 5-digit COBA Medigap claim-based ID within field 34 (header portion) of the HUBC and HUDC claims transactions that the contractors send to CWF for verification and validation purposes. The affected contractors' systems shall populate the ID within field 34, right-justified and prefixed with 5 zeroes. (**NOTE:** Through this instruction, the CWF maintainer is deleting the remaining two (2) 10-byte segments within field 34.)

Upon receipt of HUBC and HUDC claims that contain a value in field 34, the CWF shall read the value that is present within the field for purposes of conducting a validity check. The CWF shall accept the following values as valid in field 34: a value within the range of 0000055000 to 0000059999, **or** spaces. If the contractor has sent an inappropriate value in field 34 of the HUBC and HUDC claims transaction, CWF shall return an alert code 7704 on the "01" disposition response via the claim-based alert trailer 21. After CWF returns an the alert code 7704 to the contractor, it shall 1) mark the claim with crossover disposition indicator "Z," and 2) display this indicator, together with the invalid field 34 value, in association with the claim on the appropriate Heath Insurance Master Record (HIMR) detailed history screen in the "claim-based crossover" segment. Upon receipt of an alert code 7704, the affected contractor shall include the following standard message on the provider's Electronic Remittance Advice (ERA) or other production remittance advice in association with the claim: (MA19)- "Information was **not** sent to the Medigap insurer due to incorrect/invalid information you submitted concerning the insurer. Please verify your information and submit your secondary claim directly to that insurer." In addition, the affected contractor shall include the following **revised** standard message on the beneficiary's Medicare Summary Notice in association with the claim: (MSN #35.3) - "A copy of this notice will **not** be forwarded to your Medigap insurer because the Medigap information submitted on the claim was incomplete or invalid. Please submit a copy of this notice to your Medigap insurer."

If the affected contractor receives an alert code 7704 for an invalid Medigap claim-based COBA ID (outside the range 0000055000 to 0000059999 or space) and also receives a Beneficiary Other Insurance (BOI) reply trailer (29) that contains a "production" eligibility file-based Medigap COBA ID (30000-54999), the contractor shall print the MSN and ERA messages that are tied to receipt of the "production" eligibility file-based Medigap COBA ID (30000-54999).

Following receipt of an HUBC and HUDC claims transaction that contains a valid value within the first 10-byte iteration of field 34 (a 5-digit number within the range 0000055000 to 0000059999 **or** spaces), CWF shall check for the presence of a Beneficiary Other Insurance (BOI) auxiliary record for the purpose of triggering crossovers for all other eligibility file-based COBA IDs. The CWF shall then read the COBA Insurance File (COIF) to determine the claims selection criteria for any eligibility file-based trading partners as well as for the claim-based Medigap insurer. For informational purposes, contractors shall note that CWF shall display the Medigap claim-based COBA ID (0000055000 to 0000059999) on the HIMR detailed history screen within the "claim-based crossover" segment **without a crossover disposition indicator** under two (2) circumstances: 1) when CWF does not find a corresponding COIF for the valid ID; and 2) when the Medigap claim-based insurer is in "test" mode with the COBC.

The CWF shall then perform a duplicate check to determine if the beneficiary is identified for crossover to a Medigap eligibility file-based insurer (COBA ID 30000-54999) as well as to a Medigap claim-based insurer (COBA ID range=0000055000 to 0000059999). If CWF determines that the beneficiary is identified for crossover to both a Medigap eligibility file-based insurer (COBA ID range=30000 to 54999) and a claim-based Medigap insurer, both of which are in production mode, it shall suppress the BOI reply trailer (29) for the claim-based Medigap insurer (COBA ID range=0000055000 to 0000059999). After CWF has determined that the beneficiary has already been identified for Medigap eligibility file-based crossover, it shall 1) mark the associated claim with indicator "AA" and, 2) display this indicator, together with the affected claim-based Medigap COBA ID, in association with the claim on the appropriate HIMR detailed history screen in the "claim-based crossover" segment.

If CWF determines that the claim meets the trading partner's claims selection criteria, it shall select the claim and return a BOI reply trailer 29 for the claim to the affected Medicare contractor. The CWF shall display the "A" crossover disposition indicator for the claim-based crossover claim within the "claim-based crossover" segment of the HIMR detailed history claim screens. As with the COBA eligibility file-based crossover process, CWF shall display the COBA ID and accompanying crossover disposition indicator on claim detailed history screens.

In light of the new COBA Medigap claim-based crossover process, the CWF sort routine for COBA IDs to be returned via the BOI reply 29 trailer shall be modified as follows: Medigap eligibility file-based (30000-54999), Medigap claim-based (55000-59999), supplemental (00001-29999), TRICARE for Life (60000-69999), Other insurer (80000-89999), and Medicaid (70000-79999). Upon receipt of a BOI reply trailer (29), the affected contractors shall continue to utilize information from this source to populate the beneficiary's MSN and provider ERA or other remittance advice in production. The affected contractors shall continue to list **only** the name of the first entity listed on the BOI reply trailer (29) on the provider 835 ERA or provider remittance advice in production, in accordance with the guidance previously provided via Transmittal 158, change request (CR) 3273.

Part B contractors, including MACs, and DMACs shall ensure that claims that are cabled to CWF for verification and validation prior to October 1, 2007 (and prior to the installation of the October 2007 release), are tagged and crossed over via their own mandatory Medigap (claim-based) crossover process. Unless the affected contractors have already transitioned to the healthcare integrated general ledger accounting system (HIGLAS), they shall modify their systems control facility (SCF) logic, or, as applicable, "MM" or other insurer screen/table logic, to cross the final claims to the Medigap claim-based crossover recipients at the point that CWF approves the claims for payment and before they finalize on their payment floor. During this transition period, the affected contractors shall maintain their pre-existing dupe logic created as part of Transmittal 158, CR 3273. The affected contractors may alternatively set a crossover time indicator date of October 1, 2007, to effectuate the crossing over of their "final" claims at the point the claims are "approved to pay." If contractors shall be unable to cross the final claims over the claim-based Medigap recipients at

"approved to pay," they shall provide their rationale for not doing so in writing or via phone to a member of the COBA crossover team. Following transmission of their last claims files or notices to the Medigap claim-based insurers (including those claims that the contractor had already sent to CWF for verification and validation prior to October 1, 2007, but remained in suspense status until after October 1, 2007), all Part B contractors, including MACs, and DMACs shall 1) cancel all contracts with Medigap claim-based insurers immediately, and 2) discontinue their outbound crossover transactions to Medigap claim-based recipients. These actions shall occur no later than October 31, 2007.

Following their receipt of a BOI reply trailer (29) that contains a Medigap claim-based COBA ID (range 0000055000-0000059999), Part B contractors, including MACs, and DMACs shall populate a "Y" within the REF02 segment of the 2300 ("Mandatory Medicare Section 4081 Crossover Indicator") loop of the affected adjudicated Health Insurance Portability and Accountability (HIPAA) 837 claims. The affected contractors shall include a 4081 value of "N" within loop 2300 REF02 of their adjudicated HIPAA 837 claims for all other COBA IDs included as part of the BOI reply trailer (29).

The affected contractors shall invoice the Medigap claim-based crossover recipients for the final claims file that they transmitted (or the final paper Notices of Medigap Claims Information (NOMCIs) mailed) to these entities. Contractors shall ensure that they do **not** invoice for claims that CWF tags for Medigap claim-based crossover effective with October 1, 2007. The COBC will invoice the Medigap insurers for these claims. Contractors will be reimbursed directly by the COBC for these claims.

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	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5601.1	Effective with claims that are cabled to CWF for verification and validation prior to October 1, 2007 (before installation of the release), the Part B contractors, including MACs, and DMACs' internal processes for screening claims for Medigap claim-based crossovers shall be modified to accommodate the new COBA claim-based Medigap crossover process.	X	X		X	X			X	X		
5601.1.1	The affected contractors' processes for screening incoming claims for Medigap claim-based crossovers shall feature a syntactic editing of the incoming COBA claim-based Medigap ID to ensure that the identifier begins with a "5" and contains 5 numeric digits. Additionally for incoming	X	X		X	X			X	X		

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	837 or NCPDP claims, the Medigap claim-based COBA ID must be left-justified within the designated field, as indicated within the "Policy" section above, and followed by spaces.											
5601.1.2	If the claim fails the syntactic verification, the contractor shall not copy the identifier from the incoming claim and populate it within field 34 ("Crossover ID") of the HUBC or HUDC claim transaction.	X	X		X	X			X	X		
5601.1.3	Instead, the contractor shall follow its pre-existing processes for notifying the provider via the ERA or other remittance advice and the beneficiary via the MSN that the information reported did not result in the claim being crossed over.	X	X		X	X			X	X		
5601.1.4	The affected contractors' screening processes for claim-based Medigap crossovers shall also continue to include verification that the provider participates with Medicare and that the beneficiary has assigned benefits to the provider.	X	X		X	X			X	X		
5601.1.5	If the provider-populated value for the claim-based Medigap ID passes the contractor's syntactic editing process, the affected contractors' systems shall copy the claim-based Medigap COBA ID value from the incoming claim to field 34 of the HUBC or HUDC claims (header) transaction that the contractors send to CWF for verification and validation.								X	X		
5601.1.5.1	The contractors' systems shall populate the value right-justified and prefixed with 5 zeroes (e.g., 0000056000) within field 34 of the HUBC or HUDC claims transaction (claim header).								X	X		
5601.2	Upon receipt of HUBC and HUDC claims that contain a value within field 34, the CWF shall read the value that is present within the field for purposes of conducting a validity										X	

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	check.											
5601.2.1	The CWF shall accept the following values as valid within field 34: a value within the Medigap claim-based range of 0000055000 to 0000059999, **or** spaces.										X	
5601.2.2	If the affected contractor has sent an inappropriate value in field 34 (value other than 0000055000 to 0000059999 **or** spaces) of the HUBC and HUDC claims transaction, CWF shall return an alert code 7704 on the "01" disposition response via the claim-based alert trailer 21.										X	
5601.2.3	The CWF maintainer shall create a new crossover disposition indicator "Z" to accommodate the scenario of the contractor sending an incorrect value within field 34 of the HUBC and HUDC claim transaction.										X	
5601.2.4	After CWF returns an alert code 7704 to the contractor, it shall take the following actions with respect to the claim: 1) Mark the claim with crossover disposition indicator "Z" ("invalid Medigap claim-based crossover ID included on the claim"); and Display the indicator, together with the invalid value from field 34 of the HUBC or HUDC transaction, in association with the claim on the appropriate HIMR detailed history screen in the "claim-based crossover" segment.										X	
5601.3	Upon receipt of an alert code 7704, the affected contractor shall include the following standard message on the provider's ERA or other production remittance advice in association with the claim: (MA19)- "Information was not sent to the Medigap insurer due to incorrect/invalid information you submitted concerning the insurer. Please verify your information and submit your secondary claim directly to that insurer."	X	X		X	X			X	X		

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5601.3.1	In addition, the affected contractor shall include the following **revised** standard message on the beneficiary's MSN in association with the claim: (MSN #35.3) - "A copy of this notice will not be forwarded to your Medigap insurer because the Medigap information submitted on the claim was incomplete or invalid. Please submit a copy of this notice to your Medigap insurer."	X	X		X	X			X	X		
5601.3.2	If the affected contractor receives an alert code 7704 for an invalid Medigap claim-based COBA ID (outside the range 0000055000 to 0000059999 or space), and also receives a BOI reply trailer (29) that contains a "production" eligibility file-based Medigap COBA ID (30000-54999), the contractor shall print the MSN 35.2 and ERA MA18 messages that are tied to receipt of the "production" eligibility file-based Medigap COBA ID.											
5601.3.3	Following receipt of an HUBC and HUDC claims transaction that contains a valid value within field 34 (a 5-digit number within the range 0000055000 to 0000059999 **or** spaces), CWF shall check for the presence of a Beneficiary Other Insurance (BOI) auxiliary record for the purpose of triggering eligibility file-based crossovers.										X	
5601.3.4	CWF shall then read the COBA Insurance File (COIF) to determine the claims selection criteria for any eligibility file-based trading partners (all other COBA IDs) as well as for the Medigap claim-based insurer (range 0000055000 to 0000059999).										X	
5601.3.5	For informational purposes, contractors shall note that CWF shall display the Medigap claim-based COBA ID (0000055000 to 0000059999) on the HIMR detailed history screen within the "claim-based crossover" segment **without a crossover disposition indicator** under two (2) circumstances:	X	X		X	X						

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A / B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	1) when CWF does **not** find a corresponding COIF for the valid ID; and when the Medigap claim-based insurer is in "test" mode with the COBC.											
5601.4	The CWF shall then perform a duplicate check to determine if the beneficiary is identified for crossover to a "production" Medigap eligibility file-based insurer (COBA ID range=30000 to 54999) and to a Medigap claim-based insurer (COBA ID range=0000055000 to 0000059999).										X	
5601.4.1	If CWF determines that the beneficiary is identified for crossover to both a "production" Medigap eligibility file-based insurer (COBA ID range=30000 to 54999) and a Medigap claim-based Medigap insurer (COBA ID range=0000055000 to 0000059999), it shall suppress the BOI reply trailer (29) for the claim-based Medigap insurer (COBA ID range 0000055000 to 0000059999).										X	
5601.4.2	The CWF maintainer shall create a new crossover disposition indicator "AA" to accommodate the CWF duplicate check, where it has determined that the beneficiary's claim is eligible for crossover via both the Medigap eligibility file-based crossover and the claim-based Medigap crossover.										X	
5601.4.3	After CWF has determined that beneficiary has already been identified for Medigap eligibility file-based crossover, it shall take the following actions with respect to the claim: 1) Mark the associated claim with indicator "AA" ("beneficiary identified on Medigap insurer eligibility file; duplicate Medigap claim-based crossover voided); Display this indicator, together with the affected claim-based Medigap COBA ID, in association with the claim on the appropriate										X	

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	HIMR detailed history screen in the "claim-based crossover" segment.											
5601.4.4	The CWF shall update its documentation to include the newly developed crossover disposition indicators "Z" and "AA," together with their accompanying descriptions as found above in requirements 2.4 and 4.3 and in Attachment A.										X	
5601.4.5	The Next Generation Desktop (NGD) and MCS-DT applications shall display the new crossover disposition indicators "Z" and "AA," together with their accompanying descriptions, for customer service purposes.								X			X NGD MCSDT
5601.5	If CWF determines that the claim does **not** warrant exclusion on the basis of the foregoing scenarios, and otherwise meets the Medigap claim-based insurer's claims selection criteria, it shall select the claim and return a BOI reply trailer (29) for the claim to the affected Medicare contractor.										X	
5601.5.1	The CWF shall display the "A" crossover disposition indicator for the Medigap claim-based crossover claim within the "claim-based crossover" segment of the HIMR claim detailed history screens.										X	
5601.5.2	As with the COBA eligibility file-based crossover process, CWF shall display the COBA ID and accompanying crossover disposition indicator on claim detailed history screens.										X	
5601.6	In light of the new COBA Medigap claim-based crossover process, the CWF sort routine for COBA IDs to be returned via the BOI reply 29 trailer shall be modified as follows: 1) Medigap eligibility file-based (30000-54999); 2) Medigap claim-based (55000-59999); 3) Supplemental (00000-29999); 4) TRICARE for Life (60000-69999); 5) Other insurer (80000-89999); and										X	

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	6) Medicaid (70000-79999).											
5601.6.1	Upon receipt of a BOI reply trailer (29), the affected contractors shall continue to utilize information from this source to populate the beneficiary's MSN and 835 ERA (or other provider remittance advice in production).	X	X		X	X			X	X		
5601.6.2	The affected contractors shall continue to print **only** the name of the first listed entity returned via the BOI reply trailer on the 835 ERA or other provider remittance advice in production.	X	X		X	X						
5601.6.3	If the affected contractor receives an alert code 7704 for an invalid Medigap claim-based COBA ID (outside the range 0000055000 to 0000059999 **or** spaces) and also receives a BOI reply trailer (29) that contains a "production" eligibility file-based Medigap COBA ID (30000-54999), the contractor shall print the MSN message 35.2 and ERA message MA18, which are tied to receipt of the "production" eligibility file-based Medigap COBA ID, on those communications.	X	X		X	X			X	X		
5601.7	Part B contractors, including MACs, and DMACs shall ensure that the final claims that are cabled to CWF prior to October 1, 2007 (prior to the installation of the October 2007 release), are tagged and crossed over via their own mandatory Medigap ("claim-based") crossover process.	X	X		X	X			X	X		
5601.7.1	Unless the affected contractors have already transitioned to the healthcare integrated general ledger accounting system (HIGLAS), they shall modify their systems control facility (SCF) logic, or, as applicable, "MM" or insurer screen/table logic, to cross these final claims to the Medigap claim-based crossover recipients at the point that CWF approves the claims for payment and before they finalize on their payment floor.	X	X		X	X						
5601.7.1.1	The affected contractors may alternatively	X	X		X	X						

Number	Requirement	Responsibility (place an “X” in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers FISS	MCS	VMS	CWF	OTHER
	set a crossover time indicator date of October 1, 2007, to effectuate the crossing over of their “final” claims at the point the claims are “approved to pay.”											
5601.7.2	If contractors shall be unable to cross these final claims over to the claim-based Medigap recipients at “approved to pay,” they shall provide their rationale for not doing so in writing or via phone to a member of the COBA crossover team.	X	X		X	X						
5601.7.3	Following transmission of their last claims file or notices to the Medigap claim-based insurers (including those claims that the contractor had already sent to CWF for verification and validation prior to October 1, 2007, but remained in suspense status until after October 1, 2007), all Part B contractors, including MACs, and DMACs shall cancel all contracts with Medigap claim-based insurers no later than October 31, 2007.	X	X		X	X						
5601.7.3.1	The affected contractors shall also discontinue their outbound crossover transactions or notices to Medigap claim-based crossover recipients following the sending of their last tagged claims to these entities no later than October 31, 2007.	X	X		X	X			X	X		
5601.7.4	Following their receipt of a BOI reply trailer (29) that contains a Medigap claim-based COBA ID (range 0000055000-0000059999), Part B contractors, including MACs, and DMACs shall populate a “Y” within the REF02 segment of the 2300 (“Mandatory Medicare Section 4081 Crossover Indicator”) loop of the affected adjudicated HIPAA 837 claims.								X	X		
5601.7.5	The affected contractors shall include a 4081 value of “N” within loop 2300 REF02 of their adjudicated HIPAA 837 claims if all other COBA IDs (00001-29999; 30000-54999; 60000-69999; 70000-77999; 80000-89999) are included as part of the BOI reply trailer								X	X		

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	(29).											
5601.7.6	The designated contractors and their associated systems shall ensure that all other flat file creation processes relating to the COBA process remain unchanged.	X	X		X	X			X	X		
5601.7.7	The affected contractors shall invoice the Medigap claim-based crossover recipients for the final claims file that they transmitted (or the final paper NOMCIs mailed) to these entities.	X	X		X	X						
5601.7.8	Contractors shall ensure that they do **not** invoice for claims that CWF tags for Medigap claim-based crossover effective with October 1, 2007. (**NOTE:** The COBC will invoice the Medigap insurers directly for these claims.)	X	X		X	X			X	X		

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5601.8	Option 2: A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are	X	X		X	X						

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.											

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:
"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

B. For all other recommendations and supporting information, use the space below:

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

A. ***For Fiscal Intermediaries, Carriers, and the Durable Medical Equipment Regional Carrier (DMAC)*****:**
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

B. ***For Medicare Administrative Contractors (MAC)*****:**

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). 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

ATTACHMENT A

CROSSOVER CLAIM DISPOSITION INDICATORS

Claims Crossover Disposition Indicator	Definition/Description
A	This claim was selected to be crossed over.
B	This Type of Bill (TOB) excluded.
C	Non-assigned claim excluded.
D	Original Medicare claims fully paid without deductible or co-insurance remaining excluded.
E	Original Medicare claims paid at greater than 100% of the submitted charges without deductible or co-insurance remaining excluded. **Also covers the exclusion of Original Medicare claims paid at greater than 100% of the submitted charges for Part B ambulatory surgical center (ASC) claims, even if deductible or co-insurance applies.
F	100% denied claims, with no additional beneficiary liability excluded.
G	100% denied claims, with additional beneficiary liability excluded.
H	Adjustment claims, monetary, excluded (represents non-mass adjustment claims)
I	Adjustment claims, non-monetary/statistical, excluded (represents non-mass adjustment claims)
J	MSP claims excluded
K	This Claim contains a provider identification number (ID) or provider state that is excluded by the COBA trading partner.
L	Claims from this Contractor ID excluded
M	The beneficiary has other insurance (such as Medigap, supplemental, TRICARE, or other) that pays before Medicaid. Claim excluded by Medicaid.
N	NCPDP claims excluded.
O	All Part A claims excluded.
P	All Part B claims excluded.
Q	All DMERC claims excluded.
R	Adjustment claim excluded because original claim was not crossed over.
S	Adjustment Claims Fully Paid without deductible and co-insurance remaining excluded.
T	Adjustments Claims, 100% Denied, with no additional beneficiary liability excluded.
U	Adjustment Claims, 100% Denied, with additional

	beneficiary liability excluded.
V	MSP cost-avoided claims excluded.
W	Mass Adjustment Claims-Medicare Physician Fee Schedule (MPFS) update excluded.
X	Mass Adjustment Claims-Other excluded.
Y	Archived adjustment claim excluded
Z	*Invalid Claim-based Medigap crossover ID included on the claim.*
AA	*Beneficiary identified on Medigap insurer eligibility file; duplicate Medigap claim-based crossover voided*

Medicare Claims Processing Manual

Chapter 27 - Contractor Instructions for CWF

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(Rev.1242, 05-18-07)

80.17—Coordination of Benefits Agreement (COBA) Medigap Claim-Based Crossover Process

80.15 - Claims Crossover Disposition Indicators

(Rev.1242, Issued: 05-18-07, Effective: 10-01-07, Implementation: 10-01-07)

Effective with the October 2004 systems release, when a COBA trading partner is in production mode (Test/Production Indicator sent via the COIF submission=P), CWF shall annotate each processed claim on detailed history in the Health Insurance Master Record (HIMR) with a claims crossover disposition indicator after it has applied the COBA trading partner's claims selection criteria. (See the table below for a listing of the indicators.) In addition, when a COBA trading partner is in production mode, CWF shall annotate each processed claim with a 10-position COBA ID (5-digit COBA ID preceded by 5 zeroes) to identify the entity to which the claim was crossed or not crossed, in accordance with the terms of the COBA.

CWF shall not annotate processed Medicare claims on the detailed history screens in HIMR when a COBA trading partner is in test mode (Test/Production Indicator sent via the COIF submission=T).

Once the claims crossover process is fully consolidated under the Coordination of Benefits Contractor (COBC), Medicare contractor customer service staff will have access to a CWF auxiliary file that will display the crossover disposition of each beneficiary claim. The crossover disposition indicators that will appear on the HIMR detailed history screens (INPH, OUTH, HOSH, PTBH, DMEH, and HHAH) are summarized below.

Effective with October 2006, the CWF maintainer shall update its data elements/documentation to capture the revised descriptor for crossover disposition indicators "E," as reflected below. In addition, the CWF maintainer shall update its data elements/documentation to capture the newly added "R," "S," "T," "U," and "V" crossover disposition indicators, as reflected in the Claims Crossover Disposition Indicators table below.

Effective with July 2007, the CWF maintainer shall update its data elements/ documentation to capture the newly added "W," "X," and "Y" crossover disposition indicators, as well as all other changes, reflected in the table directly below.

As reflected in the table below, the CWF maintainer is creating crossover disposition indicators "Z" and "AA" to be effective October 1, 2007.

Claims Crossover Disposition Indicator	Definition/Description
A	This claim was selected to be crossed over.
B	This Type of Bill (TOB) excluded.
C	Non-assigned claim excluded.

D	Original Fully Paid Medicare claims without deductible and co-insurance remaining excluded.
E	Original Medicare claims paid at greater than 100% of the submitted charges without deductible or co-insurance remaining excluded (Part A). **Also covers the exclusion of Original Medicare claims paid at greater than 100% of the submitted charges excluded for Part B ambulatory surgical center (ASC) claims, even if deductible or co-insurance applies.
F	100% denied claims, with no additional beneficiary liability excluded.
G	100% denied claims, with additional beneficiary liability excluded.
H	Adjustment claims, monetary, excluded (not representative of mass adjustments).
I	Adjustment claims, non-monetary/statistical, excluded (not representative of mass adjustments).
J	MSP claims excluded.
K	This claim contains a provider identification number (ID) or provider state that is excluded by the COBA trading partner.
L	Claims from this Contractor ID excluded.
M	The beneficiary has other insurance (such as Medigap, supplemental, TRICARE, or other) that pays before Medicaid. Claim excluded by Medicaid.
N	NCPDP claims excluded.
O	All Part A claims excluded.
P	All Part B claims excluded.
Q	All DMERC claims excluded.
R	Adjustment claim excluded because original claim

	was not crossed over.
S	Adjustment fully paid claims with no deductible or co-Insurance remaining excluded.
T	Adjustment Claims, 100% Denied, with no additional beneficiary liability excluded.
U	Adjustment Claims, 100% Denied, with additional beneficiary liability excluded.
V	MSP cost-avoided claims excluded.
W	Mass Adjustment Claims—Medicare Physician Fee Schedule (MPFS) excluded.
X	Mass Adjustment Claims—Other excluded.
Y	Archived adjustment claim excluded.
Z	*Invalid Claim-based Medigap crossover ID included on the claim.*
AA	*Beneficiary identified on Medigap insurer eligibility file; duplicate Medigap claim-based crossover voided*

80.17 Coordination of Benefits Agreement Medigap Claim-Based Crossover Process

(Rev.1242, Issued: 05-18-07, Effective: 10-01-07, Implementation: 10-01-07)

In advance of October 1, 2007, CMS will issue for its participating Medicare providers' use a listing of claim-based Medigap crossover recipients along with their pre-existing Other Carrier Name and Address (OCNA) or N-key identifiers versus their current COBA Medigap claim-based crossover ID. During a transition period running from June through September 2007, providers will be permitted to include the older OCNA or N-key identifier and the newly assigned COBA Medigap claim-based identifier on incoming claims. The affected contractors will continue to cross claims over to their Medigap claim-based crossover recipients as normal during this timeframe. However, effective with claims submitted to Medicare on October 1, 2007, and after, participating providers will be expected to include this identifier on these incoming crossover claims for purposes of triggering claim-based Medigap crossovers. Additionally, effective with October 1, 2007, claim-based Medigap crossovers will occur exclusively through the Coordination of Benefits Contractor (COBC) in the Health Insurance Portability and Accountability Act

(HIPAA) American National Standards Institute (ANSI) X12-N 837 professional claim format (version 4010A1 or more current standard) and National Council for Prescription Drug Programs (NCPDP) claim format.

A. Changes to Contractor Up-Front Screening Processes for COBA Claim-based Medigap Crossovers

Effective with claims that the Part B contractors, including MACs, and DMACs cable to CWF on October 1, 2007, their internal processes for screening claims for Medigap claim-based crossovers shall be modified to accommodate the new Medigap claim-based COBA crossover process. The affected contractors' processes for screening claims for Medigap claim-based crossovers shall now feature a syntactic editing of the incoming COBA claim-based Medigap ID to ensure that the identifier begins with a "5" and contains 5 numeric digits. In addition, for incoming 837 professional and NCPDP claims, contractors shall ensure that the Medigap claim-based COBA ID is left-justified within the field and followed by blanks.

If the claim fails the syntactic verification, the contractor shall ***not*** *copy the identifier from the incoming claim and populate it within field 34 ("Crossover ID") of the HUBC or HUDC claim transaction that is sent to the Common Working File (CWF) for verification and validation. Instead, the contractor shall continue to follow its pre-existing processes for notifying the provider via the ERA or other remittance advice and the beneficiary via the MSN that the information reported did* ***not*** *result in the claim being crossed over. The affected contractors' screening processes for Medigap claim-based crossovers shall also continue to include verification that the provider participates with Medicare and that the beneficiary has assigned benefits to the provider.*

If the provider-populated value for the Medigap claim-based ID passes the contractor's syntactic editing process, the affected contractors' systems shall copy the Medigap claim-based COBA ID value from the incoming claim to field 34 of the HUBC or HUDC claims transactions that are sent to CWF for verification and validation. The contractors shall populate the identifier in field 34 right-justified and prefixed with five zeroes.

B. CWF Validation of Values within Field 34 of the HUBC and HUDC Transactions

Upon receipt of HUBC and HUDC claims that contain a value within field 34 ("Crossover ID"), the CWF shall read the value that is present within the field for purposes of conducting a validity check. The CWF shall accept the following values as valid within field 34: a value within the range of 0000055000 to 0000059999, ***or*** *spaces.*

If the contractor has sent an inappropriate value in field 34 of the HUBC and HUDC claims transaction, CWF shall return an alert code 7704 on the "01" disposition response via the claim-based alert trailer 21. For customer service purposes, the CWF maintainer shall create a new crossover disposition indicator "Z" to accommodate the scenario of the contractor sending an incorrect value within field 34 of the HUBC and HUDC transaction. (See §80.15 of this chapter for more information regarding this

crossover disposition indicator.) At the point that CWF returns an alert code 7704 to the affected contractor, it shall take the following actions with respect to the claim:

1. Mark the claim with crossover disposition indicator "Z" ("invalid Medigap claim-based crossover ID included on the claim"); and

2. Display the indicator, together with the invalid COBA ID value from field 34, in association with the claim on the appropriate Health Insurance Master Record (HIMR) detailed history screen in the "claim-based crossover" segment.

See Pub.100-04 chapter 28, §70.6.4 for an explanation of contractor processes following receipt of a CWF alert code 7704 via a 21 trailer.

C. CWF Processing for COBA Claim-based Medigap Crossovers

Following receipt of an HUBC and HUDC claims transaction that contains a valid value within field 34 (a value within the range of 0000055000 to 0000059999 ***or*** *spaces), CWF shall check for the presence of a Beneficiary Other Insurance (BOI) auxiliary record for the purpose of triggering eligibility file-based crossovers. CWF shall then read the COBA Insurance File (COIF) to determine the claims selection criteria for any eligibility file-based trading partners (all other COBA IDs) as well as for the Medigap claim-based insurer (range 0000055000 to 0000059999). If the HUBC or HUDC claim contains a valid COBA Medigap claim-based ID within field 34 but the valid ID cannot be found on the COIF, the CWF shall post the valid COBA Medigap claim-based ID* ***without an accompanying crossover disposition indicator*** *in association with the claim within the "claim-based crossover" segment of the appropriate HIMR claim detailed history screen.*

If the claim meets the COBA trading partner's selection criteria, as per the COIF, and none of the other scenarios presented below applies, CWF shall return a Beneficiary Other Insurance (BOI) reply trailer (29) to the contractor for purposes of having the contractor trigger a crossover to the COBC

<u>Duplicate Check</u>

The CWF shall perform a duplicate check to determine if the beneficiary is identified for crossover to a Medigap eligibility file-based insurer (COBA ID 30000-54999) and to a Medigap claim-based insurer (COBA ID 0000055000-0000059999). If CWF determines that the beneficiary is identified for crossover to both a ***"production"*** *Medigap eligibility file-based insurer (COBA ID range=30000 to 54999) and a Medigap claim-based Medigap insurer (COBA ID range=0000055000 to 0000059999), it shall suppress the BOI reply trailer (29) for the claim-based Medigap insurer (COBA ID range= 0000055000 to 0000059999).*

<u>Crossover Disposition Indicator "AA"</u>

Effective with October 1, 2007, the CWF maintainer shall create a new crossover disposition indicator "AA" to accommodate the CWF duplicate check, where it has determined that the beneficiary's claim is eligible for crossover to both a "production" Medigap eligibility file-based insurer ***<u>and</u>*** *a Medigap claim-based crossover insurer. After CWF has determined that beneficiary has already been identified for Medigap*

eligibility file-based crossover, it shall take the following actions with respect to the claim:

1. Mark the associated claim with indicator “AA” (“beneficiary identified on Medigap insurer eligibility file; duplicate Medigap claim-based crossover voided);

2. Display this indicator, together with the affected claim-based Medigap COBA ID, in association with the claim on the appropriate HIMR detailed history screen in the “claim-based crossover” segment.

D. BOI Reply Trailer (29) Process

If CWF determines that the claim meets the trading partner’s claims selection criteria, it shall select the claim and return a BOI reply trailer 29 for the claim to the affected Medicare contractor. The CWF shall display the appropriate crossover disposition indicator for the claim-based crossover claim within the “claim-based crossover” segment of the HIMR claim detailed history screens. As with the COBA eligibility file-based crossover process (see §80.14 of this chapter for more details regarding this process), CWF shall display the COBA ID and accompanying crossover disposition indicator on claim detailed history screens, with the exception of circumstances where the valid ID cannot be located on the COIF, as discussed above, or the Medigap claim-based insurer is in “test” mode with the COBC. In these situations, only the COBA Medigap claim-based ID shall be displayed.

Modification of the CWF Sort Routine For Multiple COBA IDs and Accompanying Contractor Actions Following Receipt of the BOI Reply Trailer (29)

*In light of the new COBA Medigap claim-based crossover process, the CWF sort routine for COBA IDs to be returned via the BOI reply 29 trailer shall be modified as follows: Medigap eligibility file-based (30000-54999), Medigap claim-based (55000-59999), supplemental (00001-29999), TRICARE for Life (60000-69999), Other insurer (80000-89999), and Medicaid (70000-79999). (**NOTE:** This information is also being updated in Pub.100-04, chapter 27 §80.14.)*

Upon receipt of the BOI reply trailer (29), the affected contractors shall continue to utilize information from this source to populate the beneficiary’s MSN and provider ERA or other remittance advice in production in accordance with the existing guidance that appears in §80.14 of this chapter.

Medicare Claims Processing Manual
Chapter 28 - Coordination With Medigap, Medicaid, and Other Complementary Insurers

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(Rev. 1242, 05-18-07)

70.6.4 - Coordination of Benefits Agreement (COBA) Medigap Claim-Based Crossover Process

30 - Completion of the Claim Form

(Rev.1242, Issued: 05-18-07, Effective: 10-01-07, Implementation: 10-01-07)

*As part of the national Coordination of Benefits Agreement (COBA) claim-based Medigap crossover process, p*articipating physicians and providers/suppliers *that are attempting to trigger mandatory Medigap ("claim-based") crossovers* must include *the CMS-assigned 5-digit Medigap COBA claim-based ID within* designated areas on the appropriate claims forms *as follows*:

- *Block 9-D of the incoming paper CMS-1500 claim form; and*
- *Left-justified and followed by spaces within field NM109 of the NM1 segment within the 2330B loop of the incoming Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X12-N 837 professional claim (version 4010-A1 or more current format).*

In addition, retail chain pharmacies that are attempting to trigger crossovers to their clients' Medigap insurers should enter the Medigap COBA claim-based ID left-justified and followed by spaces within field 301-C1 of the T04 segment on the incoming National Council for Prescription Drug Programs (NCPDP) batch claims (version 5.1 batch standard 1.1 or more current format).

For more information regarding the COBA Medigap claim-based crossover process, refer to §70.6.4 of this chapter.

30.1 - Form CMS-1500 (ANSI X12N 837 COB (Version 4010))

(Rev.1242, Issued: 05-18-07, Effective: 10-01-07, Implementation: 10-01-07)

Participating physicians and suppliers must enter information required in item 9 and its subdivisions if requested by the beneficiary. Participating physicians/suppliers sign an agreement with Medicare to accept assignment of Medicare benefits for all Medicare patients. A claim for which a beneficiary elects to assign his/her benefits under a Medigap policy to a participating physician/supplier is called a *"*mandated Medigap transfer.*"* Medigap information is entered on the *CMS Form* 1500 as follows:

Item 9a - The policy and/or group number of the Medigap insured preceded by MEDIGAP, MG, or MGAP. Note - item 9d must be completed if a policy and/or group number is entered in item 9a.

Item 9b - The Medigap insured's 8-digit date of birth (MMDDYYYY) and sex.

Item 9c - Blank if a Medigap Payer ID is entered in item 9d. Otherwise, the claims processing address of the Medigap insurer. An abbreviated street address, two-letter postal code, and ZIP code copied from the Medigap insured's Medigap identification card is entered. For example:

1257 Anywhere Street
Baltimore, Md. 21204
Is shown as
1257 Anywhere St. MD 21204

Item 9d - 9-digit PAYERID number of the Medigap insurer - If no PAYERID number exists, the Medigap insurance program or plan name.

All the information in items 9, 9a, 9 b, and 9d must be complete and accurate. Otherwise, the Medicare contractor cannot forward the claim information.

Under CMS' national COBA claim-based Medigap process, participating Part B and DME providers and suppliers *that are exempted under the Administrative Simplification Compliance Act (ASCA) from having to bill electronically* will be required to enter the CMS-assigned *5-digit* claim-based *Medigap* COBA ID in block 9-D of Form CMS-1500. *Those participating providers and suppliers that must bill electronically shall enter the 5-digit claim-based Medigap COBA ID left-justified and followed by spaces* in field NM109 of the NM1 segment in loop 2330B of the *Health Insurance Portability and Accountability Act (*HIPAA*) American National Standards Institute (ANSI) X12-N* 837 *p*rofessional claim *for purposes of triggering Medigap claim-based crossovers.* If a participating Part B provider or supplier *of durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS)* fails to include this identifier in the field just described, the claim will not be transferred to the Medigap insurer *via the COBA claim-based Medigap crossover process.*

Retail pharmacies that wish to trigger claim-based crossovers to Medigap insurers shall enter the Medigap claim-based COBA ID left-justified and followed by spaces within field 301-C1 of the T04 segment of the NCPDP claim.

30.2 - UB-92 (Form CMS-1450)

(Rev.1242, Issued: 05-18-07, Effective: 10-01-07, Implementation: 10-01-07)

Under CMS direction, claim-based Medigap crossovers have been limited to claims processing situations involving Part B contractors, including carriers and Medicare Administrative Contractors (MACs), and to Durable Medical Equipment Regional Carriers (DMERCs)/DME Medicare Administrative Contractors (DMACs) since 1994. In accordance with the language provided within §1842(h)(3)(B) of the Social Security Act, no information entered on an incoming UB-92 claim (or UB-04 or successor claim form) or incoming Health Insurance Portability Act (HIPAA) American National Standards Institute (ANSI) X12-N 837 institutional claim (4010-A1 or more current format) shall result in a process whereby CMS transfers the claim to a Medigap insurer.

70 - Coordination of Medicare With Medigap and Other Complementary Health Insurance Policies

(Rev.1242, Issued: 05-18-07, Effective: 10-01-07, Implementation: 10-01-07)

For applicable policy on information sharing, see Pub 100-1, the Medicare General Information, Eligibility and Entitlement Manual, Chapter 6.

For applicable cost sharing policy, see Pub 100-06, the Medicare Financial Management Manual, Chapter 1.

Cost Calculation Process Leading Up to the Coordination of Benefit Contractor's (COBC's) Assumption of Claim-Based Medigap Crossovers

Up to and including the final claims transferred under their pre-existing mandatory Medigap (claim-based) crossover processes (note: the "final" claims should be those processed by the contractor just before the October 2007 release is installed), Part B contractors, including Medicare Administrative Contractors *(MACs)*, as well as DME Medicare Administrative Contractors (*DMACs*) should determine the frequency at which they routinely transmit notices to all Medigap insurers but must transmit not less often than monthly. (See §70.4)

During fiscal year 2006, the CMS consolidated the eligibility file-based claims crossover process, as it relates to Medigap insurers and other commercial payers, under the Coordination of Benefits Contractor (COBC). Refer to §70.6 and succeeding sub-sections for Medicare contractor requirements and responsibilities relating to the national Coordination of Benefits Agreement (COBA) consolidated crossover process. *Refer to §70.6.3 for all contractor requirements relating to the COBA Medigap claim-based crossover process, which shall be inaugurated on October 1, 2007. (See also Pub.100-04 chapter 27 §80.17.)*

All contractors shall continue to pursue collection of unpaid debts from Medigap insurers and other existing trading partners, even if such entities have been transitioned to the COBA process. *Those contractors that maintained claim-based crossover arrangements with Medigap insurers shall pursue collection of their invoices up through and including their invoices for the final claims transfer to the Medigap entities. These invoices should have been issued no later than one (1) month following the last claims transfer to the Medigap insurers.*

Suppression of Sanctioned Provider Claims from Claim-Based Medigap Crossovers

Effective with April 2, 2007, all Part B contractors, including MACs, and DMERCs/*DMACs* shall suppress fully denied provider sanctioned claims for their mandatory Medigap crossover process with Medigap insurers, as authorized by §1842(h)(3)(B) of the Social Security Act and §4081(a)(B) of the Omnibus Budget Reconciliation Act of 1987 [Public Law 100-230].

NOTE: All such contractors shall continue to suppress 100 percent paid and 100 percent denied claims from their mandatory Medigap crossovers, per previous CMS guidance.

70.6.4 Coordination of Benefits Agreement (COBA) Medigap Claim-Based Crossover Process

(Rev.1242, Issued: 05-18-07, Effective: 10-01-07, Implementation: 10-01-07)

The Centers for Medicare & Medicaid Services (CMS) plans to transfer the mandatory Medigap ("claim-based") crossover function from its Medicare Part B contractors, including Medicare Administrative Contractors (MACs), and Durable Medical Equipment Medicare Administrative Contractors (DMACs) effective October 1, 2007. During the period from June through September 2007, CMS envisions that its COBC will have signed national crossover agreements with all the Medigap claim-based crossover recipients, assigned new Medigap claim-based COBA IDs to these entities, and successfully tested the new process with these insurers in anticipation of the new COBA Medigap claim-based crossover process being inaugurated on October 1, 2007. The COBC will assign the new claim-based COBA IDs to the Medigap insurers on a graduated basis throughout the three month period. Through a separate, non-systems instruction that CMS plans to issue during May 2007, CMS will apprise the affected Medicare contractors that, during the three (3) month transitional period, they shall accept the old OCNA or N-key identifier and the newly assigned COBA Medigap claim-based ID on incoming participating provider claims and continue to cross claims over as normal to their Medigap claim-based crossover recipients. CMS will regularly apprise the affected Medicare contractors when they have assigned new COBA Medigap claim-based IDs to the Medigap insurers and will post this information on its COB Web site so that contractors may direct providers to that link for purposes of obtaining regular updates. As will be specified in the future instruction, contractors shall perform file maintenance to include the newly assigned COBA Medigap claim-based ID within their insurer tables throughout the transitional period.

Effective with claims filed to Medicare on October 1, 2007, all participating providers that have been granted a billing exception under the Administrative Simplification Compliance Act (ASCA) shall be required to enter CMS' newly assigned Coordination of Benefits Agreement (COBA) Medigap claim-based identifier (ID) within block 9-D of the incoming CMS-1500 claim for purposes of triggering Medigap claim-based crossovers. All other participating providers shall enter the newly assigned COBA Medigap claim-based ID, left-justified and followed by spaces within the NM109 portion of the 2330B loop of the incoming HIPAA ANSI X12-N 837 professional claim and within field 301-C1 of the T04 segment on incoming National Council for Prescription Drug Programs (NCPDP) claims for purposes of triggering Medigap claim-based crossovers. These provider requirements will be addressed at greater length via a separate future non-systems instruction.

Effective with October 1, 2007, Medigap claim-based crossovers will occur exclusively through the Coordination of Benefits Contractor (COBC) in the Health Insurance

Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X12-N 837 professional claim format (version 4010A1 or more current standard).

A. Changes to Contractor Up-Front Screening Processes for COBA Claim-based Medigap Crossovers

The affected contractors' processes for screening incoming claims for Medigap claim-based crossovers shall feature a syntactic editing of the incoming COBA claim-based Medigap ID to ensure that the identifier begins with a "5" and contains 5 numeric digits. Additionally, for incoming 837 or NCPDP claims, the Medigap claim-based COBA ID must be left-justified within the appropriate designated fields, as indicated above, and followed by spaces.

NOTE: *These provider requirements will be addressed at greater length in the future non-systems instruction.*

If the claim fails the syntactic verification, the contractor shall ***not*** *copy the identifier from the incoming claim and populate it within field 34 ("Crossover ID") of the HUBC or HUDC claim transaction that is sent to the Common Working File (CWF) for verification and validation. Instead, the contractor shall continue to follow its pre-existing processes for notifying the provider via the ERA or other remittance advice and the beneficiary via the MSN that the information reported did* ***not*** *result in the claim being crossed over. The affected contractors' screening processes for Medigap claim-based crossovers shall also continue to include verification that the provider participates with Medicare and that the beneficiary has assigned benefits to the provider.*
If the provider-populated value for the claim-based Medigap ID passes the contractor's syntactic editing process, the affected contractors' systems shall copy the claim-based Medigap COBA ID value from the incoming claim to the first 10-byte iteration of field 34 of the HUBC or HUDC claims transactions that are sent to CWF for verification and validation.

B. Use of Field 34 Within the HUBC and HUDC Claims Transactions and CWF Validity Check

Following successful completion of the contractors' internal screening processes, including the up-front syntactical check, the contractors' system shall copy the COBA Medigap claim-based ID from the incoming Medicare claim and populate it within the field 34 (header portion, defined as "Crossover ID") of the HUBC and HUDC claims transactions that the contractors send to CWF for verification and validation purposes. The contractors' systems shall populate the value right-justified ***and*** *prefixed with 5 zeroes (e.g., 0000056000) within field 34 of the HUBC or HUDC claims transaction.*

NOTE: *Effective with October 1, 2007, the CWF maintainer will be deactivating the second and third 10-byte iterations that have heretofore been included as part of field 34 of the HUBC or HUDC claim (header) transaction.*

*Upon receipt of HUBC and HUDC claims that contain a value within field 34, the CWF shall read the value that is present within the field for purposes of conducting a validity check. The CWF shall accept the following values as valid for field 34: a value within the range 0000055000 to 0000059999, **or** spaces. If the contractor has sent an inappropriate value within field 34 of the HUBC and HUDC claims transaction, CWF shall return an alert code 7704 on the "01" disposition response via the claim-based alert trailer 21.*

Use of Standard Medicare Summary Notice (MSN) and Electronic Remittance Advice (ERA) Messages When the Identifier in Field 34 Is Invalid

*Upon receipt of the alert code 7704, the affected contractor shall include the following standard message on the provider's ERA or other production remittance advice in association with the claim: (MA19)- "Information was not sent to the Medigap insurer due to incorrect/invalid information you submitted concerning the insurer. Please verify your information and submit your secondary claim directly to that insurer." In addition, the affected contractor shall include **a revised** message on the beneficiary's MSN in association with the claim: (MSN #35.3) - "A copy of this notice will not be forwarded to your Medigap insurer because the Medigap information **submitted on the claim** was incomplete or invalid. Please submit a copy of this notice to your Medigap insurer." (See §§40 and 50 of chapter 28 for more information regarding MSN and ERA messages.)*

Special Note Regarding Information to Print on the MSN and ERA

*If the affected contractor receives an alert code 7704 for an invalid Medigap claim-based COBA ID (outside the range 0000055000 to 0000059999 **or** space), and also receives a BOI reply trailer (29) that contains a "production" eligibility file-based Medigap COBA ID (30000-54999), the contractor shall print the MSN 35.2 and ERA MA18 messages that are tied to receipt of the "production" eligibility file-based Medigap COBA ID.*

C. CWF Processing for COBA Claim-based Medigap Crossovers

*Following receipt of an HUBC and HUDC claims transaction that contains a valid value within field 34 (a value within range of 0000055000 to 0000059999 **or** spaces), CWF shall check for the presence of a Beneficiary Other Insurance (BOI) auxiliary record for the purpose of triggering crossovers for all other eligibility file-based COBA IDs. Then CWF shall read the COBA Insurance File (COIF) to determine the claims selection criteria for any eligibility file-based trading partners as well as for the claim-based Medigap insurer. If CWF does not locate a corresponding COIF for the valid COBA Medigap claim-based ID, it shall **not** return a BOI reply 29. In addition, since the valid value was part of the incoming HUBC or HUDC claim, the CWF shall post the valid COBA Medigap claim-based ID **without an accompanying crossover disposition indicator** in association with the claim within the "claim-based crossover" segment of the appropriate HIMR claim detailed history screen.*
*The CWF shall then perform a duplicate check to determine if the beneficiary is identified for crossover to a **"production"** Medigap eligibility file-based insurer (COBA ID 30000-54999) and to a claim-based Medigap insurer (COBA ID 0000055000 to 0000059999). If CWF determines that the beneficiary is identified for crossover to both a **"production"** Medigap eligibility file-based insurer and a claim-based Medigap insurer, it shall*

suppress the BOI reply trailer (29) for the claim-based Medigap insurer (COBA ID range 0000055000 to 0000059999). After CWF has determined that beneficiary has already been identified for Medigap eligibility file-based crossover, it shall 1) mark the associated claim with indicator "AA" and, 2) display this indicator, together with the affected claim-based Medigap COBA ID, in association with the claim on the appropriate HIMR detailed history screen in the "claim-based crossover" segment. (See Pub. 100-04, chapter 27 §80.17 for more information regarding this process.) If CWF determines that the claim meets the trading partner's claims selection criteria, it shall select the claim and return a BOI reply trailer (29) for the claim to the affected Medicare contractor. The CWF shall display the "A" crossover disposition indicator for the claim-based crossover claim within the "claim-based crossover" segment of the Health Insurance Master Record (HIMR) claim detailed history screens. As with the COBA eligibility file-based crossover process, CWF shall display the COBA ID and accompanying crossover disposition indicator on claim detailed history screens, with the exception of circumstances where there the valid ID cannot be located on the COIF, as discussed above, or the Medigap claim-based insurer is in "test" mode with the COBC. In these situations, only the COBA Medigap claim-based ID shall be displayed.

D. Modification of the CWF Sort Routine For Multiple COBA IDs and Accompanying Contractor Actions Following Receipt of the BOI Reply Trailer (29)

In light of the new COBA Medigap claim-based crossover process, the CWF sort routine for COBA IDs to be returned via the BOI reply (29) trailer shall be modified as follows:

1) *Medigap eligibility file-based (30000-54999);*
2) *Medigap claim-based (55000-59999);*
3) *Supplemental (00000-29999);*
4) *TRICARE for Life (60000-69999);*
5) *Other insurer (80000-89999); and*
6) *Medicaid (70000-77999).*

*Upon receipt of the BOI reply trailer (29), the affected contractors shall continue to utilize information from this source to populate the beneficiary's MSN and provider ERA (or other provider remittance advice in production). The affected contractors shall continue to report the name of **only** the first listed entity returned via the BOI reply trailer 29 on the provider ERA or remittance advice if they receive multiple COBA IDs and accompanying insurer names via the BOI reply trailer 29. (Refer to chapter 27 §80.14 for additional details.)*

E. Impact Upon Flat File Creation Processes

Following their receipt of a BOI reply trailer (29) that contains a Medigap claim-based COBA ID (range 55000-59999), Part B contractors, including MACs, and DMACs shall populate a "Y" within the REF02 segment of the 2300 ("Mandatory Medicare Section 4081 Crossover Indicator") loop of the affected HIPAA 837 adjudicated claims for transmission to the COBC. The affected contractors shall include a 4081 indicator value of "N" in the 2300 loop REF02 of their adjudicated HIPAA 837 claims for transmission to the COBC for all other COBA IDs included as part of the BOI reply trailer (29).

F. The Contractor Shut-Down Processes Pertaining to Claim-based Medigap Crossovers

All Part B contractors, including MACs, and DMACs shall ensure that the claims they sent to CWF for verification and validation ***prior to*** *October 1, 2007 (before the installation of the October 2007 release), are tagged and crossed over via their own mandatory Medigap ("claim-based") crossover process.*

The affected contractors shall modify their systems control facility (SCF) logic, or, as applicable, "MM" or other insurer screen/table logic, to cross the final claims to the Medigap claim-based crossover recipients at the point that CWF approves the claims for payment and before they finalize on their payment floor. If contractors are unable to cross the final claims over to their claim-based Medigap recipients at "approved to pay," they shall provide their rationale for not doing so in writing or via phone to a member of the COBA crossover team. The affected contractors may alternatively set a crossover time indicator date of October 1, 2007, to effectuate the crossing over of their "final" claims at the point the claims are "approved to pay."

Following transmission of their last claims files or notices to the Medigap claim-based insurers (including those claims that the contractor had already sent to CWF for verification and validation prior to October 1, 2007, but remained in suspense status until after October 1, 2007), all Part B contractors, including MACs, and DMACs shall 1) cancel all contracts with Medigap claim-based insurers immediately, and 2) discontinue their outbound crossover transactions to Medigap claim-based recipients. These actions shall occur no later than October 31, 2007.

The affected contractors shall invoice the Medigap claim-based crossover recipients for the final claims file that they transmitted (or the final paper Notices of Medigap Claims Information [NOMCIs] mailed) to these entities. Contractors shall ensure that they do ***not*** *invoice for claims that CWF tags for Medigap claim-based crossover effective with October 1, 2007. The COBC will invoice the Medigap insurers directly for these claims.*