



News Flash - The *Hospice Payment System Fact Sheet*, which offers providers information about the Medicare hospice benefit, is now available from the Centers for Medicare & Medicaid Services Medicare Learning Network in downloadable format at http://www.cms.hhs.gov/MLNProducts/downloads/hospice_pay_sys_fs.pdf on the CMS website.

MLN Matters Number: MM5837 **Revised**

Related Change Request (CR) #: 5837

Related CR Release Date: January 25, 2008

Effective Date: October 1, 2007

Related CR Transmittal #: R1420CP and R135FM

Implementation Date: February 1, 2008

Clarification Regarding the Coordination of Benefits Agreement (COBA) Medigap Claim-based Crossover Process

Note: This article was revised on January 30, 2008, to show the correct implementation date (see above), which is February 1, 2008. All other information remains the same.

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MACs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for Medicare Part B services provided to Medicare beneficiaries.

Provider Action Needed



STOP - Impact to You

This article is based on Change Request (CR) 5837 which clarifies instructions regarding the Coordination of Benefits Agreement (COBA) Medigap claim-based crossover process.

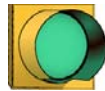
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CAUTION – What You Need to Know

CR 5837 provides formal confirmation of a recent Centers for Medicare & Medicaid Services (CMS) decision to **not require** Medicare Part B contractors (including Durable Medical Equipment Medicare Administrative Contractors (DME MACs) to update their internal insurer tables or files with each Medigap insurer's newly assigned Coordination of Benefits Agreement (COBA) Medigap claim-based ID, as was previously prescribed in CR 5662. In addition, CR 5837 conveys clarifying provider billing requirements in relation to Medigap claim-based crossovers.



GO – What You Need to Do

See the Background and Additional Information Sections of this article for further details regarding these changes.

Background

Effective October 1, 2007, the CMS transferred responsibility for the mandatory Medigap crossover process (also known as the "Medicare claim-based crossover process") to its Coordination of Benefits Contractor. With this change, Part B contractors, including A/B MACs and DME MACs:

- No longer maintain crossover relationships with Medigap insurers, and
- No longer bill such entities for crossover claims effective with the last claims file that they transmit to these entities no later than October 31, 2007.

In a directive issued on September 18, 2007, CMS communicated to Medicare Part B contractors (carriers, DME MACs, and A/B MACs) its decision that they are not required to update their internal insurer files or tables with the Coordination of Benefits Contractor (COBC)-assigned COBA Medigap claim-based identifiers (IDs). This is because, as discussed in Change Request (CR) 5601, the contractors' front-end system now simply verifies that a Medigap claim-based crossover identifier on an incoming claim is syntactically correct (5 digits, beginning with a "5"). CMS' Common Working File (CWF) system is now tasked with validation of the actual ID submitted on incoming claims.

The September 18, 2007, directive represented a departure from previous guidance communicated in CR5662 (see MLN Matters article, MM5662, at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5662.pdf> on the CMS website), in which CMS provided for transitional updating of the contractors' internal insurer files/tables prior to October 1, 2007, once the COBC had:

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- Assigned COBA Medigap claim-based IDs to the various Medigap insurers, and
- Deemed Medigap insurers “production-ready.”

CMS also required Medicare contractors to post language on their provider websites stipulating that:

- Providers are not to begin including the new COBA Medigap claim-based IDs on incoming Part B claims or claims for durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) before October 1, 2007.

CR 5837 instructs Part B contractors (including A/B MACs and DME MACs) that they **are not required to update their internal insurer files/tables** following a Medigap insurer’s readiness to move into production with the COBC. This requirement formerly applied to situations where CMS expected that contractors update their internal insurer files/tables prior to October 1, 2007, in accordance with CR 5662 (Transmittal 283). These Part B contractors may retain their older Other Carrier Name and Address (OCNA) or N-key identifiers within their internal insurer files/tables for purposes of avoiding system issues or for the printing of post-hoc beneficiary-requested Medicare Summary Notices (MSNs). However, in accordance with CR 5601, at <http://www.cms.hhs.gov/transmittals/downloads/R1242CP.pdf> on the CMS website, contractors will have disabled the logic that they formerly used to tag claims for crossover to Medigap insurers effective prior to claims they received for processing on October 1, 2007.

Effective with CR 5837, all Part B contractors (including A/B MACs and DME MACs) will discontinue publication of their routine Medigap newsletters. These contractors may, however, at their discretion, publish one last edition of this newsletter if desired to include the provider education language that follows:

In accordance with the language modification to MSN message 35.3

—“A copy of this notice will not be forwarded to your Medigap insurer because the information submitted on the claim was incomplete or invalid. Please submit a copy of this notice to your Medigap insurer.”— which contractors made as part of Transmittal 1242, CR 5601, all Part B contractors, including A/B MACs, and DME MACs shall make available a Spanish translation of the modified MSN message, which shall read as follows: “No se enviará copia de esta notificación a su asegurador de Medigap debido a que la información estaba incompleta o era inválida. Favor de someter una copia de esta notificación a su asegurador Medigap.”

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All Part B contractors (including A/B MACs, and DME MACs) are to inform their associated billing providers that are exempted from billing their claims electronically under the Administrative Simplification Compliance Act (ASCA) that they should only be entering the newly assigned 5-byte COBA Medigap claim-based ID (range 55000 to 59999) with item 9-D of the CMS-1500 claim form for purposes of triggering a crossing over of the claim to a Medigap insurer.

All Part B contractors (including A/B MACs, and DME MACs) are also to provide a link on their provider Web sites (preferably under "Hot Topics") to the recently published special edition MLN article (SE0743 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0743.pdf> on the CMS website) that clarifies for providers the differences between:

- Medigap crossover that is accomplished via the automatic, eligibility file-based crossover process, and
- The Medigap claim-based crossover process, which is triggered by information that they include on incoming claim.

Providers should note that the listing at <http://www.cms.hhs.gov/COBAgreement/Downloads/Medigap%20Claim-based%20COBA%20IDs%20for%20Billing%20Purpose.pdf> on the CMS COB website is:

- Complete and up-to-date, and
- The only source for the identifiers to be included on incoming claims for purposes of triggering crossovers to those Medigap insurers that **do not** participate fully in the automatic crossover process.

Additional Information

The official instruction, CR 5837, was issued in two transmittals issued to your Medicare carrier, DME MAC, or A/B MAC. Those transmittals may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1420CP.pdf> and <http://www.cms.hhs.gov/Transmittals/downloads/R135FM.pdf> on the CMS website. These transmittals make revisions to the Medicare Claims Processing and Medicare Financial Management Manuals, respectively

If you have any questions, please contact your Medicare carrier, DME MAC, or A/B MAC at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

News Flash - It's Not Too Late to Get the Flu Shot. We are in the midst of flu season and a flu vaccine is still the best way to prevent infection and the complications associated with the flu. But re-vaccination is necessary each year because flu viruses change each year. Please encourage your Medicare patients who

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haven't already done so to get their annual flu shot. – And don't forget to immunize yourself and your staff. Protect yourself, your patients, and your family and friends. Get Your Flu Shot – Not the Flu! Remember - Influenza vaccination is a covered Part B benefit. Note that influenza vaccine is NOT a Part D covered drug. Health care professionals and their staff can learn more about Medicare's coverage of adult immunizations and related provider education resources, by reviewing Special Edition MLN Matters article SE0748 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0748.pdf> on the CMS website.

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