

**Message to Medigap Carriers and Other Supplemental Insurers - Excerpts from an August 2 letter released by Timothy M. Westmoreland, Director, Center for Medicaid and State Operations**

The purpose of this letter is to provide your organization with important information on systems changes that Medigap carriers will need to make in order to receive crossover claims from Medicare Fiscal Intermediaries (FIs) under Medicare's Hospital Outpatient Prospective Payment System (OPPS). This letter also contains information applicable to Medigap carriers that use paper claims in their claims processing functions. The Final Rule on OPPS was published in the *Federal Register* on April 7, 2000 (65 FR 18434). The effective date for OPPS is August 1, 2000.

It was critical that the August 1, 2000 effective date be met so that beneficiaries will have the full benefit of the OPPS as quickly as possible. Over time, the OPPS will reduce beneficiary coinsurance to the 20 percent level generally provided for under the Medicare law for other Part B services, rather than the much higher rates that beneficiaries have been paying. The Administration proposed the OPPS to achieve this goal, and we were glad that Congress agreed to our proposal.

While information on OPPS-related changes has been available through the *Federal Register*, various Health Care Financing Administration (HCFA) Program Memoranda, and the HCFA website, we wanted to provide certain information directly to you. HCFA strongly encourages you to share the information contained in this letter with your member organizations that will be affected by Medicare's new payment system for hospital outpatient services. We believe that this information will assist Medigap carriers in making the systems changes necessary to assure that Medicare beneficiaries are protected and to facilitate a smooth transition to OPPS.

**Background**

Section 4523 of the Balanced Budget Act of 1997 (BBA) mandated that a prospective payment system be implemented for hospital outpatient services and Part B services for inpatients who have no Part A coverage. The new prospective payment system will also be used to pay for partial hospitalization services furnished by community mental health centers (CMHCs). The BBA created the new payment system to ensure that beneficiaries pay lower copayments and hospitals receive more predictable payments than under the current payment system. The provisions of this section of the BBA were modified by Sections 201 and 202 of the Balanced Budget Refinement Act of 1999 (BBRA). All services paid under OPPS are classified into groups called Ambulatory Payment Classifications (APCs). Services in each APC group are similar clinically and in terms of resource utilization. Each APC group has a payment rate and hospitals may be paid for more than one APC group for an encounter.

Of particular interest to Medigap carriers and other supplemental insurers is the way beneficiary coinsurance is determined for services under OPPS. Under the current cost-based payment methodology for hospital outpatient services, a beneficiary's coinsurance obligation is 20 percent of the hospital's billed charges. Under OPPS, a national unadjusted copayment amount

has been calculated for each APC group, based on 20 percent of the national median charges for services in the APC group. Both the APC rate and the copayment amount will be adjusted to reflect geographic wage variations using the hospital wage index. The copayment for each APC group will not change until such time as the copayment amount becomes 20 percent of the APC rate. The copayment for an APC group cannot be greater than the inpatient hospital deductible in a given year. In addition, providers may elect to reduce the copayment for any or all APC groups. Please refer to the Final Rule for a complete explanation of copayments under OPSS.

### **Changes to the Coordination of Benefits (COB) Record Format**

A significant systems change that affects OPSS is the requirement that each service furnished by a provider be reported on an individual line on a bill. This requirement is commonly referred to as Claims Expansion Line Item Processing (CELIP) and has necessitated an increase in record fields on the UB-92 flat file. CELIP affects hospital outpatient departments, CMHCs, skilled nursing facilities, and home health agencies.

In April 2000 HCFA issued Transmittal 1796 (Change Request 1151) which contained instructions on revisions to the UB-92 flat file for the Coordination of Benefits Records (COB) between Medicare and supplementary/complementary insurers. The revisions to the COB UB-92 records were necessary to accommodate line item expansion. As noted in Transmittal 1796, all supplemental insurers that receive crossover claims from Medicare fiscal intermediaries (FIs) must be on Version 6.0 by no later than

December 31, 2000. HCFA WILL STOP SUPPORTING EARLIER VERSIONS OF THE UB-92 FLAT FILE FOR BOTH REGULAR INCOMING AND COB CLAIMS AFTER DECEMBER 31, 2000. ALL COB CLAIMS SHOULD BE IN VERSION 6.0 AS OF DECEMBER 31, 2000, INCLUDING THOSE THAT HAD TRADING PARTNER AGREEMENTS BEFORE JUNE 1996.

Medigap carriers must implement Version 6.0 of the UB-92 flat file by December 31, 2000. However, Medigap carriers that wish to receive line item detail on crossover claims once OPSS is implemented must implement Version 6.0 for their COB records by August 1, 2000. After OPSS is implemented, but prior to December 31, 2000, earlier versions of the UB-92 flat file (e.g., Version 5.0) will be functional, but Medigap carriers will receive claim level summary data only. If a Medigap carrier wants to continue receiving claim level summary data, instead of line item detail, then an earlier version of the UB-92 may be used until December 31, 2000.

In order to ensure that Medigap carriers are able to receive line item detail on crossover claims, it is imperative that Medigap carriers implement Version 6.0 of the electronic COB formats. No changes will be made to earlier versions of the COB formats to accommodate line item expansion. Medigap carriers should refer to Transmittal 1796 (CR 1151) and Transmittal 1800 (CR 1258) for the specifications for Version 6.0 of the COB UB-92 flat file. Program Memoranda can be found on the HCFA website at:  
<http://www.hcfa.gov/pubforms/transmit/memos>.

### **Medigap Carriers Receiving Paper Claims**

Medigap carriers that do not have trading partner agreements with the FIs usually receive paper claims consisting of UB-92 forms and Provider Remittance Advices (PRAs). It is our understanding that Medigap carriers that receive paper claims generally use claim level summary data to process and pay claims. While Version 4A.01 of the electronic remittance advice will carry line-by-line payment and adjustment information that corresponds to each service line submitted on a claim, earlier versions of the electronic remittance advice and corresponding PC print versions will continue to report summary, claim level data only. The standard paper remittance advice will also continue to report summary, claim level payment data.

### **Calculation of Copayments**

While the copayment amount due for each line item will be shown on the crossover claims that are in Version 6.0 of the UB-92, it is our understanding that some Medigap carriers may wish to verify the copayment amounts that appear on the crossover claims. In the event a Medigap carrier wishes to perform an independent calculation for a given line item, calculation of copayments for APC groups can be performed by using the payment rates, unadjusted copayment amounts, and wage indices in the Final Rule.

Software products are available to assist in determining Medicare payment amounts and copayments. A PC version of the Outpatient Code Editor (OCE) software has been developed by 3M and is available through the National Technical Information Service (NTIS). Please contact NTIS at (800) 553-6847 for more information. In addition, a PC based version of the PRICER software has been developed by HCFA and is available for downloading from the HCFA website.

### **Communications with Trading Partners**

In June 2000, HCFA released a Program Memorandum (CR 1200) instructing the FIs to engage in education and outreach efforts with COB trading partners, including Medigap carriers. We strongly recommend that Medigap carriers contact the Medicare FI(s) with whom they have trading partner agreements for more details on systems changes and opportunities to test crossover claims processes.

### **Additional Information/Resources**

Finally, attached to this letter is a question and answer (Q & A) document based on questions HCFA has received about how OPSS will impact Medigap carriers. This Q & A, along with other Frequently Asked Questions and training materials, is posted on <http://www.hcfa.gov/medlearn/refopps.htm>.

For additional information on OPSS, we recommend that you visit the HCFA website on OPSS at <http://www.hcfa.gov/medicare/hopsmain.htm>.