CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1420	**Date: JANUARY 25, 2008**
	Change Request 5837

SUBJECT: Clarification Regarding the Coordination of Benefits Agreement (COBA) Medigap Claim-Based Crossover Process

I. SUMMARY OF CHANGES: This instruction provides formal confirmation of a recent CMS decision to not require Medicare Part B contractors as well as 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 prescribed within CR 5662, Transmittal 283.

NEW / REVISED MATERIAL
**EFFECTIVE DATE: ***October 1, 2007
IMPLEMENTATION DATE: February 1, 2008

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	21/50.35/ Supplemental Coverage/Medigap
R	24/40.4/ COB Training Partner and Medigap Plan Crossover Claim Requirements
R	26/10.2/ Items 1-11 - Patient and Insured Information
R	28/40/ MSN Messages
R	28/70.6.4/ Coordination of Benefits Agreement (COBA) Medigap Claim-Based Crossover Process

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. 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.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1420	Date: January 25, 2008	Change Request: 5837

SUBJECT: Clarification Regarding the Coordination of Benefits Agreement (COBA) Medigap Claim-Based Crossover Process

Effective Date: October 1, 2007

Implementation Date: February 1, 2008

I. GENERAL INFORMATION

A. Background: The Centers for Medicare & Medicaid Services (CMS) issued joint signature memorandum/technical direction letter (JSM/TDL)-07535 on September 18, 2007, to communicate its decision to Medicare Part B contractors, including Medicare Administrative Contractors (MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs) that they shall not be required to update their internal insurer files or tables with the Coordination of Benefits Contractor (COBC)-assigned COBA Medigap claim-based identifiers (IDs). This direction represented a departure from the guidance provided in Transmittal 283, CR 5662, which provided for a transitional updating of the contractors' internal insurer files/tables prior to October 1, 2007, once the COBC had assigned COBA Medigap claim-based IDs to the various Medigap insurers and they were deemed "production-ready." Through JSM/TDL-07535, CMS also required its Medicare contractors to post language on their provider websites that stipulated that providers shall not 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. The CMS is formally issuing its requirements from JSM/TDL-07535, in addition to other clarifying language for the benefit of the contractors and their associated providers, through this instruction.

B. Policy: Part B contractors, including A/B MACs, and DME MACs shall **not** be 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 Transmittal 283, CR 5662. The aforementioned 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 abends or for the printing of post-hoc beneficiary-requested Medicare Summary Notices (MSNs). However, in accordance with Transmittal 1242, CR 5601, contractors shall 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 this instruction, all Part B contractors, including A/B MACs and DME MACs, shall discontinue publication of their routine Medigap newsletters. These contractors should, however, publish one last edition of this newsletter 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."*

All Part B contractors, including A/B MACs, and DME MACs shall 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 9D of the CMS-1500 claim form for purposes of triggering a crossing over of the claim to a Medigap insurer. Providers should be informed that the listing on the CMS COB website at http://www.cms.hhs.gov/COBAgreement/Downloads/Medigap%20Claim-based%20COBA%20IDs%20for%20Billing%20Purpose.pdf is complete and up-to-date and is 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. (**NOTE:** The CMS MLN article that will accompany this instruction may be utilized for this purpose.)

All Part B contractors, including A/B MACs, and DME MACs shall provide a link on their provider Web sites (preferably under "Hot Topics") to CMS' recently published special edition MLN article 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. That link is as follows: http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0743.pdf

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	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5837.1	Part B contractors, including A/B MACs, and DME MACs shall **not** be required to update their internal insurer files/tables following a Medigap insurer's readiness to move into production with the COBC. (**NOTE:** This requirement formerly applied to situations where CMS expected that contractors would update their internal insurer files/tables prior to October 1, 2007, in accordance with CR 5662.)	X	X		X						
5837.1.1	The indicated contractors should retain their older Other Carrier Name and Address (OCNA) or N-key identifiers within their internal insurer files/tables for purposes of avoiding system abends or for the printing of post-hoc beneficiary-requested Medicare Summary Notices [MSNs].)	X	X		X						
5837.1.2	Contractors shall 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.	X	X		X						
5837.2	Effective with this instruction, all Part B contractors,	X	X		X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	including A/B MACs and DME MACs, shall discontinue publication of their routine Medigap newsletters.										
5837.2.1	The indicated contractors should, however, publish one last edition of this newsletter if desired to include the provider education language that follows later within this instruction.	X	X		X						
5837.3	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."*	X	X		X						
5837.3.1	The indicated contractors shall ensure that, in accordance with CR 5601, they include the following revised message on all provider remittance advises when they determine that beneficiary claims will not be crossed over via the Medigap claim-based crossover process due to failures in their up-front syntactical editing process or upon their receipt of an alert code 7704: "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						
5837.4	All Part B contractors, including A/B MACs, and DME MACs shall 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 **only** the newly assigned	X	X		X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	5-byte COBA Medigap claim-based ID (range 55000 to 59999) with item 9D of the CMS-1500 claim form for purposes of triggering a crossing over of the claim to a Medigap insurer. Providers should be informed that the listing on the CMS COB website at http://www.cms.hhs.gov/COBAgreement/Downloads/Medigap%20Claim-based%20COBA%20IDs%20for%20Billing%20Purpose.pdf is complete and up-to-date and is 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. (**NOTE:** The CMS MLN article that will accompany this instruction may be utilized for this purpose.)										
5837.4.1	All Part B contractors, including A/B MACs, and DME MACs shall provide a link on their provider Web sites (preferably under "Hot Topics") to CMS' recently published special edition MLN article 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. That link is as follows: <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0743.pdf>.	X	X		X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5837.5	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 one 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 free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X		X						

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 this space:

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 and Carriers*, use the following statement:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

B. ***For Medicare Administrative Contractors (MAC)*****, use the following statement:**
The Medicare Administrative Contractor (MAC) is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as changes to the MAC Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified 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.

50.35 - Supplemental Coverage/Medigap

(Rev. 1420; Issued: 01-25-08; Effective: 10-01-07; Implementation: 02-01-08)

35.1 - This information is being sent to your private insurer(s). Send any questions regarding your benefits to them. (NOTE: Add if possible. "Your private insurer(s) is/are _____.)"

35.2 - We have sent your claim to your Medigap insurer. Send any questions regarding your benefits to them. (NOTE: Add if possible: "Your Medigap insurer is _____.)"

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.

35.4 - A copy of this notice will not be forwarded to your Medigap insurer because your provider does not participate in the Medicare program. Please submit a copy of this notice to your Medigap insurer.

35.5 - We did not send this claim to your private insurer. They have indicated no additional payment can be made. Send any questions regarding your benefits to them.

35.6 - Your supplemental policy is not a Medigap policy under Federal and State law or regulation. It is your responsibility to file a claim directly with your insurer.

35.7 - Please do not submit this notice to them (Add-on to other messages as appropriate.)

40.4 - COB Trading Partner and Medigap Plan Crossover Claim Requirements

(Rev. 1420; Issued: 01-25-08; Effective: 10-01-07; Implementation: 02-01-08)

A. X12 837 COB and Medigap Claims

Outbound 837 Coordination of Benefit (COB) and Medigap claims are sent to COB trading partners and Medigap plans on a post-adjudicative basis. This type of transaction includes incoming claim data, as modified during adjudication if applicable, as well as payment data. *All Medicare contractors* are required to accept all 837 segments and data elements permitted by those implementation guides on an initial 837 professional or institutional claim from a provider, but are not required to use every segment or data element for Medicare adjudication. Those supplemental segments and data elements shall be retained, however, because they could be needed by a Medicare COB trading partner or a Medigap Plan. The shared systems shall maintain a store-and-forward repository (SFR) for retention of such supplemental data. Data shall be subjected to standard syntax and applicable IG edits prior to being deposited in the SFR to assure non-compliant data are not sent to another payer. SFR data shall be re-associated with those data elements used in Medicare claim adjudication as well as with payment data in order to create an 837 IG-compliant outbound COB/Medigap transaction. The shared systems shall retain the data in the SFR for a minimum of 6 months.

The 837 version 4010A1 institutional and professional implementation guides require that claims submitted for secondary payment contain standard claim adjustment reason codes to explain adjudicative decisions made by the primary payer. For a secondary claim to be valid, the amount paid by the primary payer plus the amounts adjusted by the primary payer shall equal the billed amount for the services in the claim. A tertiary payer to which Medicare *may* forward a claim *may well* need all data and adjustment codes Medicare receives on a claim. A tertiary payer could reject a claim forwarded by Medicare if the adjustment and payment data from the primary payer or from Medicare did not balance against the billed amounts for the services and the claim. As a result, shared systems shall reject inbound Medicare Secondary Payer claims if the paid and adjusted amounts do not equal the billed amounts at the line and claim level and if the claim lacks standard claim adjustment reason codes to identify the adjustments performed.

The shared system maintainers shall populate an outbound COB/Medigap file as an 837 flat file with the Tax ID or SSN (for a sole practitioner) present in the provider's file. Once the National Provider Identifier (NPI) is available, qualifier XX shall be reported in NM108 and the NPI in NM109, and the taxpayer identification number *shall be* reported in the REF segment of the billing provider loop. Prior to completion of NPI implementation, when an NPI is reported in NM109 for any of the types of providers for which data *are* included in a claim, Medicare will also send the legacy number (UPIN, PIN, National Supplier Clearinghouse or OSCAR) for each provider enrolled in Medicare in the REF segment of the loop used to supply identifying information for that provider.

The shared systems shall populate outbound claims with the provider's first name, last name, middle initial, address, city, state and zip code as contained in the Medicare provider files, in the event of any discrepancy with the inbound 837.

*Effective with the Coordination of Benefits Agreement (COBA) eligibility file-based crossover process, e*ach *COBA trading partner* specifies the types of claims it wants the COBC to transfer. Examples of claims most frequently excluded from the crossover process are:

- *Fully* denied claims;
- Adjustment claims;
- MSP claims; and
- Claims *that are fully paid without deductible or co-insurance remaining.*

The COBC is the single contractor responsible for COB trading partner agreements and transmission of COB/Medigap claims to *Coordination of Benefits Agreement (COBA) trading partners*. Refer to Chapter 28, § 70.6 and accompanying subsections of this manual for further details about specific *Medicare contractor crossover-related* responsibilities when interacting with the COBC. Each *shared system* will *generate* COB/Medigap flat files *for its Medicare contractors* and will forward those flat file records to the COBC. The COBC's translator will translate those flat files into outbound 837 COB/Medigap transactions.

The HIPAA implementation guides (IGs) state that the ISA08 is an "identification code published by the receiver of the data; when sending, it is used by the sender as *its* sending ID, thus other parties sending to *that entity* will use this as a receiving ID to route data to them." The ISA08 is a 15-position alphanumeric data element. *The Medicare contractors* and their shared systems shall populate 15 positions of ISA08 data (as published by the receiver of the data) on outbound X12N HIPAA transactions, including electronic COB and Medigap claims. *All Medicare contractors* shall also make the necessary changes to be able to ensure that each Medigap plan and COB trading partner sent a claim electronically has a unique ISA08. *All Medicare contractors* and the COBC shall inform their trading partners and Medigap plans that the CMS cannot allow two trading partners to have the same ISA08.

HIPAA required that any payer that conducts electronic COB including in Medicare's case, electronic Medigap transactions, for other than retail pharmacy drug claims use the X12 837 version 4010A1 format for COB by October 16, 2003 (subsequently extended by the ASCA extension request process and the Medicare HIPAA contingency period). HIPAA did not give payers the option to exclude claims received on paper or received in a pre-HIPAA electronic format from compliancy requirements for X12 837 version 4010A1 COB/Medigap transactions. An inbound claim received on paper could lack data elements, or contain data that do not meet the data attribute (alpha-numeric, numeric, minimum or maximum lengths, etc.) requirements needed to prepare a HIPAA-compliant outbound X12 837 COB/Medigap transaction, however. Paper claims do not contain as

many data requirements as the claim versions adopted as the national standards under HIPAA.

In most cases, electronic claims received with invalid data are rejected, but in limited cases such as for a claim received on paper, a claim could be accepted and adjudicated that lacks one or more pieces of data needed for a HIPAA-compliant COB/Medigap transaction. It is also possible to receive invalid data from the Medicare Common Working File (CWF) database. For example, a State abbreviation in an address transferred from the Social Security Administration (SSA) for Medicare enrollment might contain one letter rather than two in the State abbreviation. A one letter State abbreviation violates the X12 requirements that two letters appear in a State abbreviation, but due to the Medicare prohibition against modification of beneficiary addresses supplied by SSA, the shared system is left with a dilemma. Such errors cannot be corrected unless the beneficiary contacts SSA and requests correction, but this is not a priority for many beneficiaries since they receive their SSA payments electronically.

When a paper claim does not contain data necessary to create a HIPAA compliant outbound X12N 837 HIPAA COB/Medigap claim, the shared systems maintainers (other than MCS) and the *contractors* that use MCS shall gap-fill alphanumeric data elements with Xs and numeric data elements with 9s. For example, a 5-character alphanumeric data element would contain "XXXXX" and a 5-character numeric data element would contain "99999."

When paper claims do not contain a required telephone number to create a HIPAA compliant outbound X12 837 HIPAA COB/Medigap transaction, the shared system maintainers (other than MCS) and MCS Carriers shall gap fill the phone number data element with "8009999999."

Data elements with pre-defined IG values such as qualifiers, and data elements that refer to a valid code source shall not be gap filled. Paper claims do not usually contain qualifiers but do contain explicit field names that provide information equivalent to qualifiers or that identify valid code sources. For COB/Medigap purposes, those field names shall be mapped to the appropriate qualifier or code source for reporting to trading partners and Medigap plans in the 837 version 4010A1 format.

B. NCPDP COB/Medigap Transaction*s*

The NCPDP has approved the following use of qualifiers in the Other Payer Paid Amount field for reporting Medicare COB/Medigap amounts:

"07" = Medicare Allowed Amount
"08" = Medicare Paid Amount
"99" = Deductible Amount
"99" = Coinsurance Amount
"99" = Co-Payment Amount

NOTE: The first occurrence of “99” will indicate the Deductible Amount.

The second occurrence of “99” will indicate the Coinsurance Amount.

The third occurrence “99” will indicate the Co-Payment Amount.

10.2 - Items 1-11 - Patient and Insured Information

(Rev. 1420; Issued: 01-25-08; Effective: 10-01-07; Implementation: 02-01-08)

Item 1 - Show the type of health insurance coverage applicable to this claim by checking the appropriate box, e.g., if a Medicare claim is being filed, check the Medicare box.

Item 1a - Enter the patient's Medicare Health Insurance Claim Number (HICN) whether Medicare is the primary or secondary payer. This is a required field.

Item 2 - Enter the patient's last name, first name, and middle initial, if any, as shown on the patient's Medicare card. This is a required field.

Item 3 - Enter the patient's 8-digit birth date (MM | DD | CCYY) and sex.

Item 4 - If there is insurance primary to Medicare, either through the patient's or spouse's employment or any other source, list the name of the insured here. When the insured and the patient are the same, enter the word SAME. If Medicare is primary, leave blank.

Item 5 - Enter the patient's mailing address and telephone number. On the first line enter the street address; the second line, the city and state; the third line, the ZIP code and phone number.

Item 6 - Check the appropriate box for patient's relationship to insured when item 4 is completed.

Item 7 - Enter the insured's address and telephone number. When the address is the same as the patient's, enter the word SAME. Complete this item only when items 4, 6, and 11 are completed.

Item 8 - Check the appropriate box for the patient's marital status and whether employed or a student.

Item 9 - Enter the last name, first name, and middle initial of the enrollee in a Medigap policy if it is different from that shown in item 2. Otherwise, enter the word SAME. If no Medigap benefits are assigned, leave blank. **This field may be used in the future for supplemental insurance plans.**

NOTE: Only *p*articipating *p*hysicians and *s*uppliers are to complete item 9 and its subdivisions and only when the *b*eneficiary wishes to assign his/her benefits under a MEDIGAP policy to the *p*articipating *p*hysician or *s*upplier..

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. (See chapter 28.)

Medigap - Medigap policy meets the statutory definition of a "Medicare supplemental policy" contained in §1882(g)(1) of title XVIII of the Social Security Act (the Act) and the definition contained in the NAIC Model Regulation that is incorporated by reference to the statute. It is a health insurance policy or other health benefit plan offered by a private entity to those persons entitled to Medicare benefits and is specifically designed to supplement Medicare benefits. It fills in some of the "gaps" in Medicare coverage by providing payment for some of the charges for which Medicare does not have responsibility due to the applicability of deductibles, coinsurance amounts, or other limitations imposed by Medicare. It does not include limited benefit coverage available to Medicare beneficiaries such as "specified disease" or "hospital indemnity" coverage. Also, it explicitly excludes a policy or plan offered by an employer to employees or former employees, as well as that offered by a labor organization to members or former members.

Do not list other supplemental coverage in item 9 and its subdivisions at the time a Medicare claim is filed. Other supplemental claims are forwarded automatically to the private insurer if the private insurer contracts with the carrier to send Medicare claim information electronically. If there is no such contract, the beneficiary must file his/her own supplemental claim.

Item 9a - Enter the policy and/or group number of the Medigap insured preceded by MEDIGAP, MG, or MGAP.

NOTE: Item 9d must be completed, *even when* the provider enters a policy and/or group number in item 9a.

Item 9b - Enter the Medigap insured's 8-digit birth date (MM | DD | CCYY) and sex.

Item 9c - Leave blank if a Medigap PayerID is entered in item 9d. Otherwise, enter the claims processing address of the Medigap insurer. Use an abbreviated street address, two-letter postal code, and ZIP code copied from the Medigap insured's Medigap identification card. For example:

1257 Anywhere Street
Baltimore, MD 21204

is shown as "1257 Anywhere St. MD 21204."

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

If the beneficiary wants Medicare payment data forwarded to a Medigap insurer *through the Medigap claim-based crossover process*, the participating provider of service or supplier must accurately complete all of the information in items 9, 9a, 9b, and 9d. *A Medicare participating provider or supplier shall **only** enter the COBA Medigap claim-based ID within item 9d when seeking to have the beneficiary's claim crossed over to a Medigap insurer. If a participating provider or supplier enters the PAYERID or the Medigap insurer program or its plan name within item 9d,* the Medicare *Part B contractor or Durable Medical Equipment Medicare Administrative Contractor (DMAC) will be unable to* forward the claim information to the Medigap insurer *prior to October 1, 2007, or to the Coordination of Benefits Contractor (COBC) for transfer to the Medicare insurer on or after October 1, 2007. (See chapter 28 §70.6.4 for more information concerning the COBA Medigap claim-based crossover process.)*
Items 10a through 10c - Check "YES" or "NO" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in item 24. Enter the State postal code. Any item checked "YES" indicates there may be other insurance primary to Medicare. Identify primary insurance information in item 11.

Item 10d - Use this item exclusively for Medicaid (MCD) information. If the patient is entitled to Medicaid, enter the patient's Medicaid number preceded by MCD.

Item 11 - THIS ITEM MUST BE COMPLETED, IT IS A REQUIRED FIELD. BY COMPLETING THIS ITEM, THE PHYSICIAN/SUPPLIER ACKNOWLEDGES HAVING MADE A GOOD FAITH EFFORT TO DETERMINE WHETHER MEDICARE IS THE PRIMARY OR SECONDARY PAYER.

If there is insurance primary to Medicare, enter the insured's policy or group number and proceed to items 11a - 11c. Items 4, 6, and 7 must also be completed.

NOTE: Enter the appropriate information in item 11c if insurance primary to Medicare is indicated in item 11.

If there is no insurance primary to Medicare, enter the word "NONE" and proceed to item 12.

If the insured reports a terminating event with regard to insurance which had been primary to Medicare (e.g., insured retired), enter the word "NONE" and proceed to item 11b.

If a lab has collected previously and retained MSP information for a beneficiary, the lab may use that information for billing purposes of the non-face-to-face lab service. If the lab has no MSP information for the beneficiary, the lab will enter the word “None” in Block 11 of Form CMS-1500, when submitting a claim for payment of a reference lab service. Where there has been no face-to-face encounter with the beneficiary, the claim will then follow the normal claims process. When a lab has a face-to-face encounter with a beneficiary, the lab is expected to collect the MSP information and bill accordingly.

Insurance Primary to Medicare - Circumstances under which Medicare payment may be secondary to other insurance include:

- Group Health Plan Coverage
    - Working Aged;
    - Disability (Large Group Health Plan); and
    - End Stage Renal Disease;
- No Fault and/or Other Liability; and
- Work-Related Illness/Injury:
    - Workers' Compensation;
    - Black Lung; and
    - Veterans Benefits.

NOTE: For a paper claim to be considered for Medicare secondary payer benefits, a copy of the primary payer's explanation of benefits (EOB) notice must be forwarded along with the claim form. (See Pub. 100-05, Medicare Secondary Payer Manual, chapter 3.)

40 - MSN Messages

(Rev. 1420; Issued: 01-25-08; Effective: 10-01-07; Implementation: 02-01-08)

FI/Carriers should use the following messages, as appropriate, on the beneficiary's MSN for each approved claim for which they have sent or will send a transaction to a Medigap insurer:

MSN # 35.1 - "This information is being sent to your private insurer(s). Send any questions regarding your benefits to them." (**Note:** add if possible: Your private insurer(s) is/are).

MSN # 35.2 - "We have sent your claim to your Medigap insurer. Send any questions regarding your Medigap benefits to them." (**Note:** add if possible: Your Medigap insurer is.).

FIs/carriers use the following messages, as appropriate, to explain why a transaction was not or will not be sent to the Medigap insurer:

Effective with October 1, 2007, contractors shall ensure that MSN #35.3 reads as follows:

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."

Spanish translation of MSN # 35.3:

"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."

MSN #35.4 - " A copy of this notice will not be forwarded to your Medigap insurer because your provider does not participate in the Medicare program. Please submit a copy of this notice to your Medigap insurer.

MSN #35.5 - "We did not send this claim to your private insurer. They have indicated no additional payment can be made. Send any questions regarding your benefits to them." (This would be expressed on a RA by the absence of transfer information.)

MSN #35.6 - "Your supplemental policy is not a Medigap policy under Federal and State law/regulation. It is your responsibility to file a claim directly with your insurer."

MSN #35.7 - "Please do not submit this notice to them." (Add-on to other messages as appropriate).

MSN's must be sent in all instances except for the following claim types: laboratory, demonstrations, exact duplicates, and statistical adjustments. These four types require the suppression of notices.

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

(Rev. 1420; Issued: 01-25-08; Effective: 10-01-07; Implementation: 02-01-08)

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. 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. *For this purpose, CMS will be making a "Medigap Claim-based Billing Identifier" spreadsheet available on the Coordination of Benefits Contractor (COBC) website. The COBC will* ***not*** *populate the spreadsheet until after 1) it has signed a national crossover agreement with a Medigap insurer, and 2) that insurer has tested the Medigap claim-based crossover process with the COBC.*

*Per a CMS directive issued on September 18, 2007, all Part B co*ntractors*, including MACs, and DMACs* shall ***not*** *be required to* perform file maintenance to include the newly assigned COBA Medigap claim-based ID within their insurer tables *in advance of October 1, 2007. The indicated 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 abends or for the printing of post-hoc beneficiary-requested Medicare Summary Notices (MSNs). However, contractors shall 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 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 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 *included* within the appropriate designated fields, as indicated above.

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.