CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-06 Medicare Financial Management	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 135	**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: Through this instruction, the Centers for Medicare and Medicaid Services (CMS) is updating its financial management requirements to correspond with the transition of the Medigap claim-based crossover process from the Medicare contractors to its Coordination of Benefits Contractor (COBC).

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	1/450/ Coordination of Medicare and Complementary Insurance Programs

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. 100-06	Transmittal: 135	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: Effective October 1, 2007, the Centers for Medicare & Medicaid Services (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 Medicare Administrative Contractors (MACs) and Durable Medical Equipment Medicare Administrative Contractors (DME MACs) will no longer maintain crossover relationships with Medigap insurers.

B. Policy: As stipulated in Transmittal 1332, CR 5601, all Part B contractors, including MACs, and DME MACs shall invoice their associated Medigap insurers for the last claims files that they transmit to them. In addition, these affected contractors shall pursue unpaid balances with the Medigap insurers following the conclusion of the Medigap claim-based crossover transition, which included clearing all residual Medigap claim-based crossover claims from their payment floors no later than October 31, 2007.

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	As stipulated in Transmittal 1332, CR 5601, all Part B contractors, including MACs, and DME MACs shall invoice their associated Medigap insurers for the last claims files that they transmit to them.	X	X		X						
5837.1.1	The indicated contractors shall, in addition, pursue unpaid balances with the Medigap insurers following the conclusion of the Medigap claim-based crossover transition, which included clearing all residual Medigap claim-based crossover claims from their claims payment floors no later than October 31, 2007.	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	
	None										

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.

450 - Coordination of Medicare and Complementary Insurance Programs

(Rev. 135; Issued: 01-25-08; Effective: 10-01-07; Implementation: 02-01-08)

The release of title XVIII claims information for complementary health insurance purposes is permitted (under specified conditions) by Regulation No. 1 (Disclosure of Official Records and Information). This section establishes financial policies concerning identification of costs related to the release of this information by the contractor.

Under the national Coordination of Benefits Agreement (COBA) crossover process, a COBA trading partner must pay the required charges for the release of Medicare claims information. The Medicare program absorbs charges for supplying duplicate Medicare Summary Notice (MSN) or billing forms to beneficiaries, their authorized representatives, and to SSOs. (See Medicare Bill Processing, Chapter 21, Medicare Summary Notice).

On behalf of CMS, the Coordination of Benefits Contractor now signs national crossover agreements, known as COBAs, and also invoices, collects, and reconciles fees arising from the claims that it crosses over to trading partners. The COBC *is also* tasked with distributing collected crossover fees to those Medicare contractors *whose claims were successfully transmitted and accepted by the COBA trading partner.*

Effective with October 1, 2007, the COBC assumes responsibility for the Medigap claim-based crossover process. At that time, it also assumes the foregoing responsibilities associated with invoicing the affected Medigap insurers, collecting the crossover fees from these entities, and distributing these fees to the affected Medicare contractors.

All Part B contractors, including Medicare Administrative Contractors (MACs), and Durable Medical Equipment Medicare Administrative Contractors (DMACs) shall invoice for the last claims files that they transmit to their associated Medigap insurers. In addition, these affected contractors shall pursue unpaid balances with the Medigap insurers following the conclusion of the Medigap claim-based crossover transition, which included clearing all residual Medigap claim-based crossover claims from their payment floors no later than October 31, 2007.

COBA Financial Management Processes

Contractors were instructed through Transmittal 130 (Change Request [CR] 3614), dated December 17, 2004, to populate the 837 flat file with a 21-digit unique identifier in the Beginning of Hierarchical Transaction (BHT03) segment. Transmittal 586 (CR 3906), dated June 17, 2005, will add an additional digit to that BHT03 segment identifying the file as Test (T) or Production (P). Contractors shall report only these “production” claims sent to the COBC to their financial staff along with the unique value populated in the BHT03 segment, to facilitate reconciliation of reimbursements due to the contractor and related workload reporting. System reports shall include, at a minimum, formatted data similar to those developed for the receipt of the COBC Detailed Error Report, created in

Transmittal 474 (CR 3709), dated February 11, 2005. It is possible for a claim to be crossed over to more than one trading partner. System reports shall reflect those situations when more than one Coordination of Benefits Agreement Identification Number (COBA ID) is included in a Common Working File (CWF) response trailer (29).

Contractors shall decrease the number of claims from the reported amount on a particular BHT03 segment (when the last digit of the segment is a "P") to their financial staff based on the receipt of a COBC Detailed Error Report. Contractor financial staff shall not expect reimbursement for any claims that appear on the error report and shall adjust financial records (accrued credits) accordingly. If a trading partner receives a paper claim from a provider before it processes the electronic claim from the COBC, the trading partner will still have payment responsibility for the claim crossed over by the COBC. Therefore, the contractor financial staff shall expect payment for such claims. For COBA IDs that fall in the range for Medicaid claims (70000-77999), contractors shall not expect payment on these claims, and shall subtract that number of claims from the amount reported to their contractor financial staff for a particular BHT03 segment that contains a "P". There are certain situations in which contractors will not be reimbursed for production claims that did cross over and did not appear on a COBC Detailed Error Report. These non-error report adjustments include (1) claims that may be crossed by both the contractor and the COBC within the first thirty (30) days of production; (2) write-offs that are approved by CMS; (3) claims that can't be read by the trading partner and, therefore, cannot be disputed at the Internal Control Number (ICN) level; and (4) other as defined by CMS. The non-error report adjustments may or may not identify the BHT03 number or the ICN, but will include a total count for the situations listed above. The contractor's financial contacts will be notified of these adjustments monthly, no later than the same business day that reimbursements are received. Contractors shall not expect reimbursement and adjust financial records (accrued credits) accordingly.

Each contractor's financial staff shall use the remittance advice accompanying a monthly deposit, which links a specific BHT03 segment with how many claims were actually crossed over on that file (and not rejected due to flat file errors, HIPAA validation errors, trading partner accepted disputes, or non-error report adjustments), to reconcile the reimbursement received against reimbursement expected for a particular BHT03 value. Contractors shall not expect any claims that contain a Julian date in the BHT03 segment that is within two (2) business days of the end of the month to be billed on that month's invoice to the trading partner. Those claims will be billed on the following month's invoice.

Contractors shall provide CMS with appropriate banking information to facilitate payment via automatic funds transfer. (NOTE: The remittance advice for reimbursement will be sent electronically to the contractor's bank. If the contractor would prefer a hard copy of the advice, they must request one by sending an e-mail to COBAProcess@cms.hhs.gov). Contractors shall be responsible for notifying CMS of any updates to their current banking information by sending an e-mail to COBAProcess@cms.hhs.gov for the purpose of requesting a telephone call from CMS to

discuss the changes. Contractors will receive reimbursement into one bank account associated to the contractor number used for Contractor Administrative-Budget and Financial System (CAFM II) reporting. The contractor shall provide CMS with a list of all contractor numbers that are combined for reporting purposes to the CAFM II contractor number. A comparison and variance report is available in CAFM II for reconciliation purposes. The contractor shall reconcile total credits received and total accrued credits on the comparison and variance reports monthly.

Contractors shall send initial notification of financial contact information to COBAProcess@cms.hhs.gov as well as updates to that contact information, as they occur.