CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 283	**Date: JUNE 15, 2007**
	Change Request 5662

This transmittal is being re-communicated to correct a broken URL. All other information remains the same.

Subject: Notifying Affected Parties Regarding Changes to the Mandatory Medigap ("Claim-Based") Crossover Process

I. SUMMARY OF CHANGES: This instruction outlines the processes that Part B carriers, Medicare Administrative Contractors (MACs) responsible for Part B claims processing, as well as Durable Medical Equipment Regional Carriers (DMERCs/DME Medicare Administrative Contractors (DMACs) shall follow with respect to notifying affected parties that the mandatory Medigap (claim-based) crossover process is being transitioned to the Coordination of Benefits Contractor (COBC) effective October 1, 2007. Systematic requirements for this transitional process were communicated via change request 5601.

New / Revised Material
Effective Date: June 15, 2007
Implementation Date: July 16, 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
N/A	

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:

One-Time Notification

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

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 283	Date: June 15, 2007	Change Request: 5662

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SUBJECT: Notifying Affected Parties Regarding Changes to the Mandatory Medigap ("Claim-Based") Crossover Process

Effective Date: June 15, 2007

Implementation Date: July 16, 2007.

I. GENERAL INFORMATION

A. Background: Currently, in accordance with §1842(h)(3)(B) of the Social Security Act [§4081(a)(B) of Public Law 100-203, Omnibus Budget Reconciliation Act of 1987], Part B carriers, including Medicare Administrative Contractors (MACs), and Durable Medical Equipment Regional Carriers (DMERCs)/DME Medicare Administrative Contractors (DMACs) send their adjudicated participating provider claims to issuers of Medigap policies on an at least monthly basis. This form of claims transfer is termed "Medigap claim-based crossover," since the trigger for this type of crossover is the information reported on the incoming claim by the provider of service rather than an eligibility file supplied by the insurer. Currently, CMS' Part B contractors, including MACs, and DMACs support a variety of claim formats and transmission methodologies in fulfillment of their legal requirement to cross over participating physician or supplier claims to Medigap insurers that typically have entered into crossover agreements with them.

B. Policy: The Centers for Medicare & Medicaid Services (CMS) has decided that, effective October 1, 2007, all mandatory Medigap ("claim-based") crossovers will now be accomplished through its Coordination of Benefits Contractor (COBC). Further, CMS has decided that, in accordance with Public Law 104-191 and 45 *Code of Federal Regulations* (CFR) 160, it will **only** cross claims over to claim-based Medigap recipients in the Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X12-N 837 professional (version 4010A1) coordination of benefits (COB) claim format or in the National Council for Prescription Drug Programs (NCPDP) version 5.1 batch standard 1.1 format. (**NOTE:** The systematic requirements relating to this transition were communicated via Transmittal 1242, change request (CR) 5601.)

Starting with June 2007, CMS' COBC will gradually begin to assign new Medigap claim-based COBA identifiers (range 55000 to 59999) to Medigap insurers that have not voluntarily moved to the COBA eligibility file-based crossover process following their execution of a national crossover agreement. CMS anticipates that the COBC will complete this process by August 31, 2007. As the COBC assigns a new COBA Medigap claim-based ID to a Medigap claim-based crossover recipient, CMS will alert all Part B contractors, including MACs, and DMACs via e-mail of this action on a weekly basis. The CMS alert will include the following information: affected entity's name; the entity's multiple formerly assigned Other Carrier Name and Address (OCNA) or N-key identifiers; and its newly assigned COBA Medigap claim-based ID. Upon receipt of the CMS alert, the affected contractors shall manually add the newly assigned COBA Medigap claim-based ID to their existing insurer screens or tables to replace the formerly assigned OCNA or N-key identifier. Contractors shall also maintain a link to the COB website

(www.cms.hhs.gov/COBAgreement) for purposes of receiving updates to the COBA Medigap claim-based ID listing. During the interim period (June through September 2007), contractors are not expected to add COBA Medigap COBA IDs to their internal insurer screens/tables for Medigap insurers for which they previously did not establish an OCNA or N-key identifier. As appropriate, the CMS will issue a future instruction that addresses the contractors' requirement to add the balance of the COBA Medigap claim-based IDs, with accompanying insurer names, to their internal insurer screens/tables, with this action being accomplished following the implementation of the new COBA Medigap claim-based crossover process on October 1, 2007.

The affected contractors shall post CMS' Medigap claim-based crossover transition announcement in its entirety on their websites that are accessed by the public and insurers. These contractors shall also mail the CMS announcement on a one-time basis to their electronic Medigap claim-based crossover recipients. Those contractors that send paper claims, known as "Notices of Medigap Claims Information" (NOMCIs), to their Medigap insurers shall, at the next scheduled claims delivery date, include with those claims a separate notification (an envelope stuffer would be acceptable) that includes the following informational blurb: "NOTICE: Please see the following website to learn about changes that you will be required to make to ensure your continued receipt of Medicare crossover claims: (contractor inserts its appropriate URL address here)."

Part B contractors, including MACs, and DMACs shall inform their providers and suppliers of the changes to the Medigap claim-based crossover process via their next regularly scheduled provider bulletins. The affected contractors shall include the following language within their next regularly scheduled provider bulletin: "CMS' Coordination of Benefits Contractor (COBC) will assume responsibility for the Medigap claim-based crossover, which is driven by information that participating providers enter on the incoming claim, effective October 1, 2007. During June through August 2007, CMS will assign each Medigap insurer that does not provide an eligibility file to the COBC to identify all of its covered policy or certificate holders for crossover purposes a new 5-digit Medigap identifier (ID). Providers may reference a weekly updated listing of the newly assigned COBA Medigap claim-based IDs on CMS' Coordination of Benefits website at: http://www.cms.hhs.gov/COBAgreement/Downloads/Medigap Claim-based COBA IDs for Billing Purpose.pdf. Once the COBC has assigned a new COBA Medigap claim-based ID to a Medigap insurer, participating providers that wish to trigger crossovers to Medigap insurers will be required to include that new identifier, as found on the CMS COB website, on their incoming Medicare claims. Failure to do so will result in their claims not being successfully crossed over to the Medigap insurer. If the older contractor-assigned number is included on the claim, Medicare will include the standard MA19 message—'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.'—on the provider's electronic remittance advice (ERA) or other production remittance advice for the associated claim(s). Participating providers that are permitted under Administrative Simplification Compliance Act (ASCA) to bill Medicare on paper should include the newly assigned 5-digit COBA Medigap claim-based ID within block 9-D of the CMS-1500 claim form. Providers that are required to bill Medicare electronically using the Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X12-N 837 professional claim shall include the newly assigned 5-byte only COBA Medigap claim-based ID (range=55000 to 59999) left-justified in field NM109 of the NM1 segment within the 2330B loop and followed by spaces. **(See important note that follows regarding the submission of claims to Durable Medical Equipment Medicare Administrative Contractors [DMACs].)** Retail pharmacies that bill National Council for Prescription Drug Programs (NCPDP) batch claims to Medicare shall include the newly assigned Medigap identifier left-justified within field 301-C1 of the T04 segment of their incoming NCPDP claims and followed by spaces. **IMPORTANT:** For all of the claim submission situations discussed above, suppliers

(including retail pharmacies) that bill DMACs must include an accompanying 4-byte "Z001" identifier with the newly assigned COBA Medigap claim-based crossover ID (for example, 55000Z001) when seeking to trigger Medigap claim-based crossovers during the interim transitional period, which runs from June through September 30, 2007. Providers should notify their clearinghouses and billing vendors of the impending changes to the existing Medigap claim-based crossover process as soon as possible." In addition, contractors shall include the link to the URL where they post the Medigap transitional announcement (see Attachment A) along with the foregoing language within their next regularly scheduled provider bulletin.

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	
5662.1	CMS will send weekly e-mail alerts, with subject line "Medigap Claim-based ID Updates," to the affected Medicare contractors' designated crossover contacts after the COBC has assigned a Medigap insurer a new 5-digit COBA Medigap claim-based ID.											X CMS
5662.1.1	If the COBC did **not** sign a new crossover agreement or assign a COBA Medigap claim-based ID during a particular week, CMS will not generate an e-mail alert to the Medicare contractors.											X CMS
5662.1.2	Upon receipt of the CMS e-mail alert, which informs the Medicare contractors of the Medigap insurer's name, its multiple formerly assigned OCNA or N-key identifiers, and its newly assigned single COBA Medigap claim-based ID, the affected contractors shall manually add the newly assigned COBA Medigap claim-based ID to their existing insurer screens or tables if they have previously established an OCNA or N-key for the insurer(s) indicated.	X	X		X	X						
5662.1.3	The affected contractors shall replace their formerly assigned OCNA or N-key identifiers with the newly assigned COBA Medigap claim-based ID within their internal insurer screens or tables. **NOTE:** As appropriate, the CMS will issue	X	X		X	X						

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	a future instruction that addresses the contractors' requirement to add the balance of the COBA Medigap claim-based IDs, with accompanying insurer names, to their internal insurer screens/tables, with this action being accomplished following the implementation of the new COBA Medigap claim-based crossover process on October 1, 2007.											
5662.1.4	Contractors shall also maintain a link to the COB website at http://www.cms.hhs.gov/COBAgreement/Downloads/Medigap Claim-based COBA IDs for Billing Purpose.pdf for purposes of receiving updates to the COBA Medigap claim-based ID listing.	X	X		X	X						
5662.2	Prior to October 1, 2007, the affected contractors shall continue to follow their current screening procedures for Medigap claim-based crossovers, including validation that the incoming Medigap identifier is valid; confirmation that the provider participates with Medicare; and verification that the beneficiary has assigned payment rights to the provider.	X	X		X	X						
5662.2.1	If the provider includes the previously assigned OCNA or N-key ID on the incoming claim after the Medicare contractors have inputted the newly assigned COBA Medigap claim-based ID within their insurer screens or tables, the affected contractors shall **not** cross the claim over to the Medigap insurer via their current Medigap claim-based crossover process.	X	X		X	X						
5662.2.2	In addition, the affected contractors shall apply remittance advice remark code MA-19—"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."—on the provider's ERA or other production remittance advice for the associated claim(s).	X	X		X	X						

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5662.3	The affected contractors shall post CMS' Medigap claim-based crossover transition announcement (Attachment A) in its entirety on their websites that are accessed by the public and insurers.	X	X		X	X						
5662.3.1	The affected contractors shall also mail the CMS announcement on a one-time basis to their electronic Medigap claim-based crossover recipients.	X	X		X	X						
5662.3.2	Those contractors that mail paper claims, known as "Notices of Medigap Claims Information" (NOMCIs), to their Medigap insurers shall, at the next scheduled claims delivery date, include with those claims a separate notification (an envelope stuffer would be acceptable) that includes the following informational blurb: "**NOTICE:** Please see the following website to learn about changes that you will be required to make to ensure your continued receipt of Medicare crossover claims: (contractor inserts its URL address here)."	X	X		X	X						
5662.4	Part B contractors, including MACs, and DMACs shall inform their providers and suppliers of the changes to the Medigap claim-based crossover process via their next regularly scheduled provider bulletins.	X	X		X	X						
5662.4.1	The affected contractors shall include the precise provider-oriented language, as found in the "Policy" section above, within their next regularly scheduled provider bulletins.	X	X		X	X						
5662.4.2	In addition, the affected contractors shall include the link to the URL where they post the Medigap transitional announcement (see Attachment A) along with the foregoing language within their next regularly scheduled provider bulletin.	X	X		X	X						
5662.4.3	The affected contractors shall also post the standard language from the "Policy" section above relating to the Medigap claim-based crossover changes to all of the provider web sites they maintain.	X	X		X	X						

III. PROVIDER EDUCATION TABLE

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Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5662.5	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 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 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	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:
	None.

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, Carriers, and the Durable Medical Equipment Regional Carrier (DMERC)*:

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 A

Dear Medigap Insurer:

MEDIGAP CLAIM-BASED CROSSOVER MOVES TO A CONSOLIDATED, STANDARDIZED PROCESS.

This announcement is to inform you that, effective October 1, 2007, the Centers for Medicare & Medicaid Services (CMS) will transfer the mandatory Medicare supplemental (Medigap) insurance claim-based crossover process from its Medicare contractors to the national Coordination of Benefits Contractor (COBC). The definition of a "Medicare supplemental (Medigap) policy" is found at §1882(g)(1) of the Social Security Act, the text of which is being attached for your reference. The Medigap crossover process is mandated by §1842(h)(3)(B) of Title XVIII of the Social Security Act and is activated when 1) a participating Medicare provider includes a specific identifier on the beneficiary's claim and 2) the beneficiary assigns payment rights to that provider.

WHAT DOES THIS MEAN TO YOU?

The CMS is expecting your organization to contact the COBC during June 2007 regarding your need to sign a national Coordination of Benefits Agreement (COBA) that will enable you to continue receiving Medigap claim-based crossover claims. You may reach the COBC for this purpose by dialing 1-646-458-6740. The executed COBA will address claim transfer protocols, the frequency of the claim transfers (available options include daily, weekly, bi-weekly, or monthly), and the standard crossover fee. After your organization has signed the COBA, you will be assigned a new 5-byte COBA Medigap claim-based identifier. All participating providers will then have access to the Medigap insurer's new COBA Medigap claim-based identifier prior to October 1, 2007, and will be required to include this new identifier on your policy or certificate holders' incoming Medicare claims to successfully trigger mandatory Medigap claim-based crossovers.

With the transition of the Medigap claim-based crossover process to the COBC, Medigap insurers will enjoy the benefit of only needing to interact with one entity when they have questions or concerns. In addition, the Medigap insurers will now receive their claims and invoices from a single entity rather than individually from numerous Medicare contractors across the nation.

Effective October 1, 2007, CMS will discontinue the use of all non-standard claim formats, including National Standard Format (NSF) and paper claims. As "covered entities" under the final Health Insurance Portability and Accountability Act (HIPAA) transactions and code sets rule, Medigap insurers must be able to accept the standard HIPAA American National Standards Institute (ANSI) X12-N 837 professional coordination of benefits (COB) version 4010-A1 claim. In addition, your organization should be able to accept National Council for Prescription Drug Programs (NCPDP) version 5.1 batch

standard 1.1 Part B drug claims. However, CMS is **not** mandating receipt of NCPDP batch standard claims at this time. CMS will advise your organization when acceptance of these claims is required. Therefore, effective October 1, 2007, your organization will receive Part B physician and supplier claims in the HIPAA ANSI X12-N 837 professional claim (with receipt of NCPDP batch standard claims to follow in the future). In accordance with volume 55, number 225 of the November 21, 1990, *Federal Register Notice*, CMS will exclude non-assigned, fully paid original and fully paid adjustment claims, fully denied original and fully denied adjustment claims, and non-monetary adjustment claims from its national COBA Medigap claim-based crossover process with your organization..

Medigap insurers will continue to receive their crossover claims from their associated Medicare contractors at their currently designated frequency and in their currently designated claims format during the interim period from June 1 to September 30, 2007. Until October 1, 2007, the only change to the current Medigap claim-based process is that the Medigap insurer will be replacing its current identifier that initiates claim-based crossover to the 5-byte COBA Medigap claim-based identifier for processing purposes. This change will occur shortly after execution of the COBA.

WHAT CAN MY ORGANIZATION DO TO BE PREPARED FOR THE OCTOBER 1, 2007, CHANGE?

Since your organization will no longer receive Medigap claim-based crossovers from CMS' Medicare contractors effective October 1, 2007, CMS strongly encourages all Medigap insurers that are currently receiving their crossovers via this methodology to act now and contact the COBC at 1-646-458-6740 to obtain more information about signing the national Coordination of Benefits Agreement (COBA). Your COBA will need to be signed during the months from June to August 2007, to allow your organization sufficient time for testing with the COBC in advance of the October 1, 2007, implementation. In addition, since Medicare will exclusively be crossing claims over to your organization in the standard HIPAA ANSI X12-N 837 professional claim format effective October 1, 2007, your organization may need to consider planning now to contract with an outside vendor that is able to accept the standard HIPAA claims format on your behalf.

Upon receipt of your COBA Medigap claim-based identifier, your organization should initiate provider and member education on the use of the new identifier. CMS recommends that, in accordance with §1882(c)(3)(C) of the Social Security Act, you consider issuing new cards to your Medigap policy and certificate holders that inform them of the new COBA Medigap claim-based ID for your organization. This will assist your policy or certificate holders with ensuring that their providers include the correct number on their incoming claims to Medicare. In addition, Medicare will be conducting extensive provider education concerning the new COBA Medigap crossover process through its Medicare contractor provider communication channels and websites.

If your organization currently provides an eligibility file to initiate COBA Medigap crossovers, you may simply add all policy or certificate holders to your COBA eligibility file and maintain your current COBA identifier. In addition, please contact your COBC EDI or CMS representative for information on discontinuing your current Medigap claim-based crossover contract(s) with the Medicare contractor(s) if applicable.

WHAT OTHER DETAILS SHOULD MY ORGANIZATION KNOW?

Effective with claims received after your COBA has been executed, your previously assigned Other Carrier Name and Address (OCNA) or N-key Medigap identifier will no longer be accepted on participating provider claims as a basis for triggering the crossing over of adjudicated claims to your organization. Also, unless your organization has executed a COBA with the COBC prior to October 1, 2007, your organization will be unprepared to test the new process with the COBC and, consequently, will be unable to receive production claim-based crossover claims following the implementation of the new process on October 1, 2007.

Starting October 1, 2007, claims will exclusively be selected for crossover to your organization through the new COBA Medigap claim-based crossover process. CMS' Medicare contractors will cease crossing claims directly to your organization. In addition, all current Medigap claim-based crossover recipients are advised that CMS' Medicare contractors will automatically terminate any existing crossover agreements with your organization no later than October 31, 2007, following your receipt of the final or residual claims that were tagged for crossover directly from the Medicare contractors prior to October 1, 2007.

If your organization has already signed a COBA with the COBC to participate in the eligibility file-based crossover process but you wish to continue receipt of claim-based crossovers for a portion of your policy or certificate holders, your organization will need to sign a new COBA (base agreement and attachment) to address your receipt of claims via the COBA Medigap claim-based crossover process.

The CMS and its COBC look forward to working with your organization to ensure a smooth transition from your current Medigap claim-based crossover process to the consolidated COBA Medigap claim-based crossover process.

ATTACHMENT A—Additional Information

Definition of a Medicare Supplemental (Medigap) Policy

In accordance with §1882 (g)(1) of Title XVIII of the Social Security Act, a ***Medicare supplemental policy*** is a health insurance policy or other health benefit plan offered by a private entity to individuals who are entitled to have payment made under this title, which provides reimbursement for expenses incurred for services and items for which payment may be made under this title but which are not reimbursable by reason of the applicability of deductibles, coinsurance amounts, or other limitations imposed pursuant to this title; but does not include a Medicare+Choice plan or any such policy or plan of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations (or combination thereof), for employees or former employees (or combination thereof) or for members or former members (or combination thereof) of the labor organizations and does not include a policy or plan of an eligible organization (as defined in section 1876(b)) if the policy or plan provides benefits pursuant to a contract under section 1876 or an approved demonstration project described in section 603(c) of the Social Security Amendments of 1983, section 2355 of the Deficit Reduction Act of 1984, or section 9412(b) of the Omnibus Budget Reconciliation Act of 1986, or, during the period beginning on the date specified in subsection (p)(1)(C) and ending on December 31, 1995, a policy or plan of an organization if the policy or plan provides benefits pursuant to an agreement under section 1833(a)(1)(A). For purposes of this section, the term "policy" includes a certificate issued under such policy.