Important Information Regarding the Centers for Medicare & Medicaid Services (CMS) National Claims Crossover Process – JA0909

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Contractors Affected	All Medicare contractors
Provider Types Affected	All Medicare physicians, providers, and suppliers

CMS requests that all Medicare physicians, providers, and suppliers allow sufficient time for the Medicare crossover process before attempting to balance bill their patients' supplemental insurers and payers for amounts remaining after Medicare's payment determination on their submitted claims.

Provider Needs to Know...

Situations Where Balance Billing of Supplemental Insurers Is Justified

- Situation 1: Claim Data Errors Encountered
  - Approximately 98 percent of all claims that Medicare indicates crossed-over, as annotated on its generated 835 electronic remittance advice (ERA) and standard paper remittance advice (SPR), actually were successfully transmitted to supplemental insurers.
  - For the remaining two (2) percent of cases, the physician, provider, or supplier's claims fail Health Insurance Portability and Accountability Act (HIPAA) compliance within the Coordination of Benefits Contractor's (COBC's) code validation routine.

- Due to Medicare's shared claims processing systems problems, Medicare contractors occasionally transmit structurally unusable claims to the COBC. Such claims are rejected back to the Medicare contractor within 24 hours of receipt.
- The COBC may, in some instances, successfully transmit claims to various supplemental insurers only to have them rejected due to issues such as national provider identifier (NPI) mismatch (dispute error code 200), claims selection criteria problems (dispute error code 600), and less frequently HIPAA compliance matters (dispute error code 700).
- When the COBC rejects claims back to the Medicare contractors, they issue special correspondence letters (sent to the provider's Medicare on-file "correspondence" address) to the provider's organization within five (5) business days from COBC's rejection action.
- The special letters indicate the affected claims, including Health Insurance Claim Number and associated internal control number document control number, along with an error code and error description specifying why the COBC could not cross-over the affected claims.
- This same procedure occurs when insurers reject claims, typically several days later through a dispute process with the COBC, with the exception that standard verbiage is carried on the special letter indicating that the affected claim(s) was/were rejected by the supplemental insurer and an associated dispute error code appears (e.g., 200, 600, 700).
- When providers receive such notifications, they should then attempt to bill the supplemental insurer or benefit program, given that Medicare was unable to cross-over the affected claim(s) successfully.

- Situation 2: Patient's Insurer Not Part of Crossover Process
  - If the provider can clearly determine that the patient's insurer cannot or will not voluntarily participate in the CMS national crossover process, s/he is within her/his rights to balance bill the patient's supplemental insurer.

Special Note Regarding Claim Repair Processes

- When a Medicare contractor's volume of HIPAA compliance rejections equals or exceeds four (4) percent of all claims that the affected Medicare contractor transmitted to the COBC for a given day, or if entire envelopes of claims fail structural editing at the COBC, that Medicare contractor is instructed by CMS to go into "claim repair mode".
- That is, the Medicare contractor is to do the following:
  - Determine how long it will take working through its shared claims processing system maintainer to effectuate a correction of the errored claims; and
  - Subject to concurrence from CMS, initiate a claim repair for all claims with a given error condition. Typically, most repairs are accomplished within 10 to 15 business days from the date when the COBC rejected the claims.

IMPORTANT: At CMS direction, most Medicare contractors, including Medicare Administrative Contractors will alert providers to such situations in the interests of ensuring that they do not balance bill their affected patients' supplemental insurers or benefit programs. In the majority of instances, Medicare contractors will issue the special correspondence letters, which have been held within the system, if they have determined through consultation with CMS, that a claims repair cannot be accomplished. Providers may also receive additional information about the abandonment of a claims repair process via the affected Medicare contractors' provider website.

Requested Physician, Provider, and Supplier Action

- Recently, CMS has received a growing number of complaints from supplemental insurers about their receipt of paper SPRs or printed 835 ERAs that physicians, providers, and suppliers billing vendors are generating well in advance of their receipt of the CMS "official" Medicare crossover claims.
- Consequently, these supplemental insurers are in receipt of duplicate claim pairings—one generated on paper by the provider and another, the "official" crossover claim, generated from the COBC.
- Since payment from supplemental insurers should (as a rule) occur only after the Medicare payment has been issued, CMS requests that providers do not bill their patients' supplemental insurers for a minimum of 15 workdays after receiving the Medicare payment.
- This should allow sufficient time for any potential CMS-approved Medicare claims recovery situations (should they need to occur), and for the supplemental insurer to take actions necessary to issue payment determination following its receipt of a Medicare crossover claim.
- Additionally, CMS requests that physicians, providers, and suppliers take the following actions before balance billing their patients' supplemental insurers:
    - Check the following CMS website for verification that the patient's supplemental insurer is participating in the automatic crossover process nationally with the CMS COBC: *http://www.cms.hhs.gov/COBAgreement/Downloads/Contacts.pdf* on the CMS website. As verified by the spreadsheet's header, this document is a listing of all participants in the Medicare automatic crossover process. It is not just a listing of beneficiary and provider contact information for each insurer indicated.
    - Prior to submitting a claim to a supplemental payer/insurer, providers should utilize available self-service tools to research the status of their supplemental payment (e.g., the supplemental insurer's website, or claims automated "hot line," as applicable).
- In addition, as a reminder, only the "official" Medicare remittance advice or HIPAA 835 ERA should be used for supplemental billing purposes. CMS requests that copies of screen prints from any system that is used to access Medicare claim status not be submitted to a supplemental payer/insurer for billing purposes even if:
    - The supplemental payer/insurer is being billed after the 15 work days from the

Medicare-issued payment have expired; and

- The available self-service tools have been used to confirm the status of the supplemental payment.

Background

Eligibility File-based Crossover Process

- CMS consolidated the "automatic" or eligibility file-based crossover process under the COBC as of September 2006.
- Under the "automatic" crossover process, other supplemental insurers, including Medicaid agencies, sign a standard national COB Agreement with the COBC.
- They then submit enrollment information via a standard eligibility file feed through a secure connection with the COBC.
- Within this eligibility feed, the supplemental insurers identify their covered members or policy/ certificate holders for Medicare claim matching purposes.
- The COBC, in turn, transmits this information to the CMS Common Working File (CWF).
- After the CMS CWF system tags individual claims for crossover to a designated insurer, it then prompts the Medicare contractor to send the adjudicated claims to the COBC for crossover purposes once the claims have met their payment floor requirements, as prescribed by CMS.

Claim-based Crossover Process

- CMS consolidated the Medigap claim-based crossover process under the COBC in October 2007.
- Under this process, the COBC assigns to a Medigap plan a 5-digit Medigap claim-based COBA ID (range 55000 through 59999) to ensure that if participating Part B physicians or suppliers enter that value on incoming paper CMS-1500 claim forms or 837 professional claims, the Medicare contractor will be able to transfer the claims to the COBC for crossover to that specific Medigap plan.

Note: Virtually all Medigap insurers participate in the automatic or eligibility file-based crossover process. Approximately ten or eleven Medigap plans avail themselves of the less commonly used Medigap claim-based crossover process, which cannot be used in association with Part A 837 institutional claims (including inpatient, outpatient, home health, and hospice related types of bills) or with claims for which the physician or supplier is non-participating with Medicare. These insurers, some of whom also participate in part in the automatic crossover process, may be referenced at *http://www.cms.hhs.gov/COBAgreement/Downloads/Medigap%20Claim-based%20COBA%20IDs%20for%20Billing%20Purpose.pdf* on the CMS website.

Operational Impact	N/A
Reference Materials	The related MLN Matters® article can be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0909.pdf* on the CMS website. Providers may also want to review MLN Matters® article MM5601 ("Transitioning the Mandatory Medigap ("Claim-Based") Crossover Process to the Coordination of Benefits Contractor (COBC)") at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5601.pdf* on the CMS website.