

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



News Flash – Effective January 1, 2012, Diversified Service Options, Inc, a wholly-owned subsidiary of Blue Cross and Blue Shield of Florida Inc, acquired Highmark Medicare Services from its parent company, Highmark Inc. As a result, Highmark Medicare Services changed its name to Novitas Solutions, Inc. Novitas will continue to be the Medicare Administrative Contractor (MAC) for the J12 jurisdiction and will also continue as the Section 1011 Administrative Contractor. In the near future, the Highmark website will be changing to <http://www.Novitas-Solutions.com> on the Internet.

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Important Information Concerning Medicare Outreach Efforts to Supplemental Payers Directing Their Payments to Incorrect Addresses

Provider Types Affected

This MLN Matters® Special Edition Article is intended for physicians and other practitioners who bill Medicare contractors (carriers or Medicare Administrative Contractors (A/B MACs)) for providing services to Medicare beneficiaries.

What You Need to Know

Over the past several weeks, many physician/practitioner billing offices have notified their servicing A/B Medicare Administrative Contractor or Part B Carrier and the Centers for Medicare & Medicaid Services (CMS) that various supplemental payers have directed payment, arising from Medicare crossover claims, to incorrect payment addresses. The problem appears to have escalated as the supplemental payers have transitioned from receipt of crossover claims in the Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X12-N version 4010A1 837 professional claims format to the version 5010A1 837 professional claims format. CMS believes it understands the full dimension of the problem and wishes to pass along those details to affected physician/practitioner billing offices through this article.

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CMS Directive Governing Addresses Reflected on Outbound Crossover Claims

Medicare makes direct electronic funds transfer (EFT) payments to physicians/ practitioners, suppliers, and providers in connection with adjudicated Medicare claims. There is also a long-standing CMS directive to its Medicare fee-for-service contractors that governs the reporting of provider address information that must appear on outbound crossover claims:

- Medicare contractors are to populate both the 2010AA (Bill-to Provider) and 2010AB (Pay-to Provider) N3 and N4 segments with information retained within the Provider Enrollment Chain of Ownership System (PECOS) and within the internal Medicare claims processing systems' physician/practitioner, supplier, and provider files.

This means that the Bill-to and Pay-to Address information reported on incoming claims to Medicare will **not** be what will be included on outbound Medicare crossover claims.

Physicians/practitioners, suppliers, and providers need to ensure that Medicare has the most up-to-date address information—most particularly, check and remittance advice (or Pay-To) address information—correctly on file for their various offices. This will ensure that correct address information is reflected on outbound crossover claims.

Most Likely Reasons Why Supplemental Payments Are Being Directed To Incorrect Addresses

CMS has learned that many physician/practitioner billing offices have to return checks to supplemental payers to have them reissue checks to corrected addresses. There are at least three (3) possible causes for this problem:

Possible Cause #1:

For HIPAA ANSI X12-N 837 version 4010A1 professional claims, Medicare's Part B claims processing system (Multi-Carrier System or MCS) usually only created the 2010AA loop, including the N3 and N4 segments. Since the HIPAA 4010A1 837 Professional Claims Implementation Guide had no prohibition against reporting Pay-to Address-related information—such as Lock-Box or P. O. Box address information, as retained within PECOS and the internal physician/practitioner files as the physician/practitioner's "check or remittance address"—in the 2010AA N3 and N4 segments, the Part B claims system created 4010A1 837 professional outbound crossovers that only contained 2010AA loop address information.

Under HIPAA 5010 requirements, Medicare must now create a 2010AB loop, with N3 and N4 segments, if the Pay-to Provider Address differs from the Bill-to Provider Address. This means that the address that most often used to be reflected in the 2010AA loop N3 and N4 address segments (which in reality was the Pay-to Address) now has to be reflected in the 2010AB N3 and N4 segments. Now, under HIPAA 5010, the address that Medicare reflects in the 2010AA N3 and N4 loops is truly the Bill-to Provider Address (or "master" and/or "physical address," as captured within PECOS and the internal Medicare files).

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Conclusion Tied to Possible Cause #1: Supplemental payers with Coordination of Benefits Agreements (COBA) may systematically still be reading the 2010AA N3 and N4 loops as the basis for determining where to direct their supplemental payments.

Remedy to Possible Cause #1: To try to mitigate this possibility, CMS has conducted outreach to the supplemental payer community, either directly or indirectly; i.e.:

- On August 19, 2011 and December 28, 2011, CMS issued broadcasts to all Coordination of Benefits Agreement (COBA) supplemental payers concerning these changes between HIPAA 837 professional claim versions 4010A1 and 5010A1 for the benefit of all crossover trading partners.
- On February 2, 2012, CMS enlisted the help of America's Health Insurance Plans (AHIP) and the Blue Cross/Blue Shield Association (BCBSA) in reminding their membership of these important changes during early February 2012. AHIP and BCBSA communicated the information that CMS shared with supplemental payers on December 28 as a means of reminding their membership of this important issue. This information is repeated here as follows:

December 28, 2011

To All COBA Trading Partners:

COBVA Alert--Reminder Concerning Reporting of Pay-To Information on Version 5010 Coordination of Benefits (COB)/Crossover Claims

The Centers for Medicare & Medicaid Services (CMS) and Coordination of Benefits Contractor (COBC) Coordination of Benefits Agreement (COBA) teams wish to remind all COBA trading partners of the following important information:

As documented within pages 28-29 (top) of the CMS "Coordination of Benefits Agreement (COBA) Companion Guide for Health Insurance Portability and Accountability Act (HIPAA) 837 Institutional and Professional Medicare Coordination of Benefits Version 5010 (COB)/Crossover Claim Transactions," there are differences between version 4010A1 and version 5010 837 professional claims with respect to reporting of provider address. Here are direct citations taken from the aforementioned source for direct reference by our COBA trading partners:

- Typically, the Part B shared system now reflects a physician/practitioner's Pay-to Address in the N3 and N4 segments of loop 2010AA on current 4010A1 production claims and does **not** create a 2010AB (Pay-to Provider) loop. There are times, however, when the Part B system does create a separate 2010AB loop for version 4010A1 837 professional COB claims.
- Contrastingly, in creating test 5010A1 837 professional claims, the Medicare Part B shared system will always populate the N3 and N4 segments in 2010AA with the physician or practitioner's practice or "master" address, which is on file with Medicare. And, for test 5010A1 COB claims, the Medicare Part

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B shared system will only create the 2010AB (“Pay-to Provider”) loop if the physician/practitioner has supplied Medicare with a differing address for remittance or check payment purposes. **(NOTE:** The same results may be expected if Medicare created the 837 professional COB claims for trading partners in 5010A1 **production** mode.)

Several billing vendors for various physician/practitioner and supplier offices have recently contacted CMS to advise that COBA trading partners are directing their supplemental payments to incorrect addresses. **[NOTE:** Fortunately, CMS is **not** receiving similar complaints from institutional providers as tied to Pay-to Address information reported on HIPAA 5010 837 institutional production COB/crossover claims.] Therefore, relative to production version 5010A1 837 professional COB/crossover claims, COBA trading partners should be taking the following steps:

- Modify existing routines to use the 2010AB N3 and N4 segment information as the basis for directing COB payments in association with production HIPAA 5010 COB/crossover claims (as applicable); or
- Make corrections to your internal provider files when used for direction of COB payments for situations in which billing vendors for providers, physicians/practitioners, or suppliers notify your organization that you are directing COB payments to an incorrect address.

Both the CMS and the COBC COBA teams hope that this reminder COBVA will lessen the incidences in which COBA trading partners direct payment to a physician/practitioner or supplier at an incorrect, no longer valid address.

IMPORTANT NOTE APPLICABLE TO ENTITIES THAT DIRECT PAYMENT BASED UPON INFORMATION RECEIVED ON THE CROSSOVER CLAIMS:

If it ever turns out that the address reported in 2010AB on outbound 837 institutional or professional COB/crossover claims is incorrect, as verified through conversations with a provider, physician/practitioner, or supplier’s billing vendor, the COBA trading partner should direct the billing vendor to contact the local Medicare contractor to request the needed forms to have the provider, physician/practitioner, or supplier’s remittance check address (which becomes the 2010AB Pay-to Address on outbound HIPAA 5010 Medicare COB/crossover claims) modified.

Possible Cause #2:

The physician/practitioner’s “check or remittance address,” as maintained by Medicare is no longer valid. As previously mentioned, the “check or remittance address” becomes the 2010AB N3 and N4 segments on outbound version 5010A1 837 professional crossover claims.

Remedy for Possible Cause#2:

If the address reflected in the 2010AB N3 and N4 segments is incorrect, the physician or practitioner will need to contact its servicing A/B MAC or carrier to have this information updated through appropriately established procedures.

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Possible Cause #3:

There may be instances where the supplemental payer uses the address information that it maintains within its internal files as the basis for directing supplemental payments to a given physician or practitioner, and that information is out of date.

Remedy for Possible Cause#3:

The physician/practitioner's billing office will need to address this matter with the supplemental payer directly for resolution.

Additional Information

If you have questions, please contact your Medicare carrier or MAC at their toll-free number which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

News Flash - It's Not too Late to Give and Get the Flu Vaccine. Take advantage of each office visit and protect your patients against the seasonal flu. Medicare will continue to pay for the seasonal flu vaccine and its administration for all Medicare beneficiaries through the entire flu season. The Centers for Disease Control and Prevention (CDC) also recommends that patients, healthcare workers and caregivers be vaccinated against the seasonal flu. **Protect your patients. Protect your family. Protect yourself. Get the Flu Vaccine—Not the Flu. Remember: The flu vaccine plus its administration are covered Part B benefits. The flu vaccine is NOT a Part D-covered drug.** For more information on coverage and billing of the flu vaccine and its administration, and related provider resources, visit [2011-2012 Provider Seasonal Flu Resources](#) and [Immunizations](#). For the 2011-2012 seasonal flu vaccine payment limits, visit http://www.CMS.gov/McrPartBDrugAvgSalesPrice/10_VaccinesPricing.asp on the Centers for Medicare & Medicaid Services (CMS) website.

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