



News Flash - Physician Quality Reporting Initiative (PQRI) Measures and Specifications

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that the 2007 Physician Quality Reporting Initiative (PQRI) Quality Measures and Specifications are now available. To access both the measures and measure specifications documents, visit the PQRI web page at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html> on the CMS website. Once there, go to the Measures/Codes section of the page and scroll down to the Downloads section. **Please note that many of the quality codes are new and will be rejected by Medicare claims processing systems prior to the July 1, 2007 HCPCS update.**

MLN Matters Number: MM5662 **Revised**

Related Change Request (CR) #: 5662

Related CR Release Date: June 15, 2007

Effective Date: June 15, 2007

Related CR Transmittal #: R2830TN

Implementation Date: July 16, 2007

Note: This article was updated on April 10, 2014, to show that the Coordination of Benefits Contractor (COBC) is now known as the Benefits Coordination and Recovery Center (BCRC). All other information remains unchanged.

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

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, DME Medicare Administrative Contractors (DMACs and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries.

What Providers Need to Know

CR 5662, from which this article is taken, outlines the processes that Part B carriers, MACs responsible for Part B claims processing, and Durable Medical Equipment Medicare Administrative Contractors (DMACs) shall follow in notifying affected parties that the mandatory Medigap (claim-based) crossover process is transitioned to the

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Benefits Recovery and Coordination Center(BCRC), formerly known as the Coordination of Benefits contractor, effective October 1, 2007.

Background

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 BCRC. Further, CMS has decided that, in accordance with Public Law 104-191 and 45 Code of Federal Regulations (CFR) 160, it will only – transmit claims to Medigap claim-based crossover 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 change request (CR) 5601, as reflected in MLN Matters article MM5601 at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM5601.pdf> on the CMS website.)

Starting with June 2007, CMS’ BCRC 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. CMS anticipates that the BCRC will complete the execution of crossover agreements with Medigap claim-based insurers and assign new COBA Medigap claim-based identifiers to these entities by August 31, 2007. As the BCRC 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 contractor-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 will also maintain a link to the COB website (<http://www.cms.gov/Medicare/Coordination-of-Benefits/COBAgreement/index.html>) for purposes of receiving updates to the COBA Medigap claim-based ID listing.

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 and shall also notify their paper claim recipients through information included with their next scheduled claim mailings.

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Providers should note the following: Effective October 1, 2007, the BCRC will assume responsibility for the Medigap claim-based crossover, which is driven by information that participating providers enter on the incoming claim. The primary change for providers resulting from this transition will be that they will need to include a new Medigap identifier, even in advance of October 1, 2007, on their incoming Medicare claims to trigger crossovers to Medigap insurers. During June through August 2007, CMS will assign each Medigap insurer that does not provide an eligibility file to the BCRC to identify all of its covered policy or certificate holders for crossover purposes a new 5-digit COBA Medigap claim-based identifier (ID). Providers may reference a weekly updated listing of the newly assigned COBA Medigap claim-based IDs for Medicare billing purposes at <http://www.cms.gov/Medicare/Coordination-of-Benefits/COBAgreement/index.html> on the CMS website.

Once the BCRC 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 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.

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Additional Information

You can find the official instruction, CR5662, issued to your carrier, MAC, or DMAC by visiting <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R283OTN.pdf> on the CMS website.

You may also want to review the following related articles:

- MM5601 (Transitioning the Mandatory Medigap ("Claim-Based") Crossover Process to the Coordination of Benefits Contractor (COBC) at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM5601.pdf>;
- SE0743 (Clarification Concerning Provider Billing Procedures Related to the Transition of the Medigap claim-based Crossover Process to the Coordination of Benefits Contractor on October 1, 2007) at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0743.pdf>; and
- MM5837 (Clarification Regarding the Coordination of Benefits Agreement (COBA) Medigap Claim-based Crossover Process) at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM5837.pdf> on the CMS website.

If you have any questions, please contact your contractor at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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