CMS Manual System

Pub. 100-06 Medicare Financial Management

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 62 **Date: JANUARY 21, 2005**

CHANGE REQUEST 3658

SUBJECT: Timeframe for Continued Execution of Crossover Agreements and Updated on the Transition to the National Coordination of Benefits Agreement (COBA) Program

I. SUMMARY OF CHANGES: Through this Change Request, CMS is modifying language from Transmittal 138 in the manual sections indicated below to update timeframes for execution of new crossover Trading Partner Agreements (TPAs) and transition of trading partners from their existing crossover process to the national COBA program. Language regarding the COBC contractor role in the collection of COBA crossover fees was also modified through this manual change.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: February 22, 2005
IMPLEMENTATION DATE: February 22, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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 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: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

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

Attachment - Business Requirements

Pub. 100-06	Transmittal: 62	Date: January 21, 2005	Change Request 3658

SUBJECT: Timeframe for Continued Execution of Crossover Agreements and Update on the Transition to the National Coordination of Benefits Agreement (COBA) Program

I. GENERAL INFORMATION

A. Background: Through the publication of Transmittal 138 (Change Request 3218), contractors received guidance regarding the crossover fee collection and distribution process once the crossover function is consolidated under the Coordination of Benefits Contractor (COBC). This instruction updates that guidance.

B. Policy: Contractors shall utilize the updated information in Medicare Financial Management manual as guidance regarding the Coordination of Benefits Agreement (COBA) consolidated crossover process fee distribution process.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3658.1	Contractors shall refer to the language in § 450 of chapter 1 of the Medicare Financial Management (MFM) for purposes of understanding how the crossover fee collection and distribution process will be implemented under CMS' COBA consolidated crossover process.	X	X	X	X					

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)					
		FI	RHH	Car	DME	Shared System Maintainers	Other

						FISS	MCS	VMS	CWF	
	.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: 30 days after issuance. **Implementation Date:** 30 days after issuance. **Pre-Implementation Contact(s):** Brian Pabst (410) 786-2487 **Post-Implementation Contact(s):** Brian Pabst (410) 786-2487	**No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2005 operating budgets.**

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

450 - Coordination of Medicare and Complementary Insurance Programs -

(Rev. 62, Issued: 01-21-05, Effective: 02-22-05, Implementation: 02-22-05)

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.

A contractor may release Medicare claims information for complementary insurance purposes to a complementary insurer, including its own complementary insurance operation, to beneficiaries, their authorized representatives, and to Social Security offices (SSOs).

A complementary insurer 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).) If a contractor has a written agreement with a complementary insurer to provide Medicare claims information, it may not charge a fee to anyone, other than the complementary insurer, for this effort.

The CMS will begin efforts to consolidate the claims crossover process under the Coordination of Benefits Contractor (COBC) starting on July 6, 2004. The effort to consolidate the claims crossover process, known as the Coordination of Benefits Agreement (COBA) initiative, will be implemented initially on a small-scale *beginning* July 6, 2004. By July 6, 2004, the COBC will have started the process of marketing and entering into Agreements, known as Coordination of Benefits Agreements (COBAs), with trading partners that will initially participate as beta-site testers during a parallel production crossover period. *Under the smaller-scale COBA process, ten trading partners will participate in a parallel production crossover process, whereby they continue to receive crossover claims from intermediaries and carriers while also receiving claims from the COBC. This parallel production process will continue until CMS, the COBC, and the trading partners conclude the testing results demonstrate a high level of confidence. The larger-scale COBA process, where additional trading partners are first identified as testing participants with the COBC and then are moved to crossover production with the COBC following the successful completion of testing, may be activated at any time during the COBA parallel production process. Activation of the larger-scale COBA process will most likely not occur before the early months of calendar year 2005. Refer to Pub.100-04, Medicare Claims Processing Manual, §70.6 for more details.*

In addition to executing national COBAs, the COBC will also invoice, collect, and reconcile fees arising from the claims that it crosses over to trading partners. *The COBC will also be tasked with distributing collected crossover fees to Medicare intermediaries and carriers.*

B - Cost Accounting

Charges to the complementary insurer are based on a standard rate, established by CMS, in an effort to distribute the costs to Medicare and the complementary insurer in a manner that reflects the benefits each receives. Where mutual benefit is derived, full cost sharing is required.

CMS has established a standard rate to charge Part A complementary insurers. The rate is computed based on the following criteria from the Final Administrative Cost Proposal (FACP) - Administrative Budget and Cost Report, Activity Form:

Intermediaries	**Carriers**
Form CMS 1523	Form CMS 1524
Lines 1-2 (less 8.5 percent of line 1)*	Lines 1-3 (less 50 percent of line 3)**
Schedule D, Line 1	Schedule D, Line 1
Schedule E, Line 1	Schedule E, Line 1
Schedule E, Line 3	Schedule E, Line 3
Form CMS-2580	Form CMS-2580
Postage	Postage

*17 percent of line 1 is attributable to inquiries.

**Only 50 percent of inquiries are attributable to the adjudication of Medicare claims.

The sum of these costs will be divided by the claims payment workload to determine a unit cost. (Postage is a subtraction to the formula.)

The complementary insurance rate will be the determined shared cost (50 percent) of the national average cost per claim of all contractors, computed in accordance with the criteria contained in this section. The rate will be reviewed and updated bi-annually and will be included in the initial BPR package each fiscal year. CMS has determined that the above criteria are necessary to fulfill normal claims processing requirements and are of mutual benefit to Medicare and the complementary insurer.

The contractor shall include the credit for Medicare claims information transferred on the appropriate line of the face-sheet and Schedule A of Form CMS 1523 or 1524 for each reporting use of the form (Budget Request (BR), Interim Expenditure Report (IER), and

FACP). On an annual basis, the contractor shall report the detail of these credits on the credit schedule report of Form CMS 1523 or 1524 (FACP).

The interim amount to credit to the Medicare program for each fiscal year is based on the initial BR for that fiscal year.

Once CMS has fully consolidated the claims crossover process under the COBC, the COBC will have exclusive responsibility for collection of crossover claim fees for those Medigap and non-Medigap claims sent to it by intermediaries and carriers to be crossed over to COBA trading partners. *As aforementioned, the COBC will also have responsibility for distribution of collected crossover fees to Medicare intermediaries and carriers.* (See *also* Pub.100-04, Chapter 28, §70.6.)