Medicare Claims Processing Manual

Chapter 28 - Coordination With Medigap, Medicaid, and Other Complementary Insurers

---

Table of Contents

(Rev. 158, 04-30-04)

70.6 Consolidation of the Claims Crossover Process

80 - Electronic Transmission - General Requirements

80.1 - HIPPA Provisions Affecting Medigap Transactions

80.2 - ANSI X12N 837 COB (Version 4010) Transaction Fee Collection

80.3 - Medigap Electronic Claims Transfer Agreements

80.3.1 - Intermediary Crossover Claim Requirements

80.3.2 - Carrier/DMERC Crossover Claim Requirements

90 - Paper Submission

100 - Medigap Insurers Fraud Referral

110 - Medigap Criminal Penalties/Types of Complaints Under Section 1882(d)

110.1 - Outline of Complaint Referral Process

110.2 - Preliminary Screening and Referral to Regional Office of the Inspector General

110.3 - CMS Regional Office Quarterly Report on Medicare Supplemental Health Insurance Penalty Provision Activity

110.3.1 - Statistics

110.3.2 - Narrative

10 - Medigap - Definition and Scope

(Rev. 1, 10-01-03)

B3-4700

The Omnibus Budget Reconciliation Act of 1990 (OBRA 1990, Public Law 101-508) requires all Medicare supplemental (Medigap) insurance policies to conform to minimum standards including loss ratio requirements, standardized benefit packages and consumer protection requirements.

The procedures described in §§20 through 110 apply to all policies meeting the definition of Medicare supplemental insurance policies ("Medigap") in §1882(g)(1) of the Social Security Act (the Act.)

A Medigap policy is: A group or individual policy of accident and sickness insurance, or a subscriber contract of hospital and medical service associations or health maintenance organizations, other than a policy issued pursuant to a contract under §1876 or §1833 of the Act, or a policy issued under a demonstration project.

A Medigap policy is offered by a private company to those entitled to Medicare benefits and provides payment for Medicare charges not payable because of the applicability of deductibles, coinsurance amounts or other Medicare imposed limitations. Typically, a Medigap policy does not include limited benefit coverage areas available to Medicare beneficiaries, such as "specified disease" or "hospital indemnity" coverage. By law, the definition explicitly excludes a policy or plan offered by an employer to employees, or former employees, as well as policies offered by a labor organization to members or former members.

The National Association of Insurance Commissioners has developed model regulatory language for State insurance commissions to apply to Medigap insurance offerings. This model regulatory language is located at: http://www.carfra.com/products/medsupappendixb.pdf. It recommends the requirements that states should consider for approving proposed Medigap insurance plans.

The following procedures for furnishing information are mandatory for Medigap plans. Contractors may enter similar arrangements with other insurers or State Medicaid plans for furnishing claims information. Medicaid agencies are furnished information in the standard format free of charge. Other payers must pay the Medicare costs for providing information.

20 - Assignment of Claims and Transfer Policy

(Rev. 1, 10-01-03)

B3-4702, B3-3047

A Medicare beneficiary who has a Medigap policy may authorize the participating physician, provider, or supplier of services to file a claim on his or her behalf and to receive payment directly from the insurer instead of through the beneficiary. In such cases, the intermediary or carrier must transfer Medicare claims information to the Medigap insurer. The Medigap insurer pays the physician/provider/supplier, and must pay the intermediary or carrier for their costs in supplying the information subject to limitations.

Paid claims from participating physicians or providers/suppliers for beneficiaries who have assigned their right to payment under a Medigap policy, regardless of whether or not it is in or from a State with an approved Medigap program, are to result in the transfer of claim information to the specified insurers.

The carrier systems must have the capability to distinguish between claims of participating and nonparticipating physicians and suppliers. This is because Medigap assignment of claims and transfer policy does not apply to nonparticipating physicians or non-participating suppliers.

20.1 - Beneficiary Insurance Assignment Selection

(Rev. 1, 10-01-03)

B3-4702.1, B3-3047, B4-2110.1

Beneficiaries indicate that they have assigned their Medigap benefits to a participating physician or supplier by signing block #13 on the Form CMS-1500. This authorization is in addition to their assignment of Medicare benefits as indicated by their signature in block #12.

The UB-92 makes no provision for the provider to indicate that the beneficiary has assigned benefits because the UB-92 is used only for institutional claims, for which payment is generally assigned to the provider of services. For claims the institutional provider submits to carriers for physician payments for physician employees; hospitals, SNFs, HHAs, OPTs, CORFs, or ESRD facilities may maintain a beneficiary statement in file instead of submitting a separate statement with each claim. This authorization must be insurer specific.

If the beneficiary has a Medigap policy, the following statement should be signed:

HICN

NAME OF BENEFICIARY MEDIGAP POLICY NUMBER

I request that payment of authorized Medigap benefits be made either to me or on my behalf to _____ for any services furnished me by that physician/provider/supplier. I authorize any holder of medical information about me to release to (name of Medigap insurer) any information needed to determine these benefits or the benefits payable for related services.

Since the beneficiary may selectively authorize Medigap assignments, caution providers about routinely stamping block #13 of the Form CMS-1500 "signature on file." The Medigap assignment on file in the participating doctor/supplier's office must be insurer specific. However, it may state that the authorization applies to all occasions of services until it is revoked.

30 - Completion of the Claim Form

(Rev. 1, 10-01-03)

B3-2010 - 2010.3, B3-4702, PM-A-01-20, PM-A-01-63

Participating physicians and providers/suppliers must include Medigap policy information in the designated areas on the appropriate claims forms:

Form CMS-1500 (12/90) transmitted in ANSI X12N 837 COB (Version 4010) Transaction form or the National Standard Format (NSF). The NSF format is scheduled to be discontinued in October 2003.

Form CMS-1450 transmitted in the UB-92 format or the ANSI X12N 837 COB (Version 4010).

30.1 - Form CMS-1500 (ANSI X12N 837 COB (Version 4010))

(Rev. 1, 10-01-03)

B1-2010 - 2010.3, B3-4702, PM-A-01-20, PM-A-01-63

Participating physicians and suppliers must enter information required in item 9 and its subdivisions if requested by the beneficiary. Participating physicians/suppliers sign an agreement with Medicare to accept assignment of Medicare benefits for **all** Medicare patients. A claim for which a beneficiary elects to assign his/her benefits under a Medigap policy to a participating physician/supplier is called a mandated Medigap transfer. Medigap information is entered on the 1500 as follows:

Item 9a - The policy and/or group number of the Medigap insured preceded by **MEDIGAP, MG, or MGAP.** Note - item 9d must be completed if a policy and/or group number is entered in item 9a.

9b - The Medigap insured's 8-digit date of birth (MMDDYYYY) and sex.

Item 9c - Blank if a Medigap Payer ID is entered in item 9d. Otherwise, the claims processing address of the Medigap insurer. An abbreviated street address, two-letter postal code, and ZIP code copied from the Medigap insured's Medigap identification card is entered. For example:

1257 Anywhere Street
Baltimore, Md. 21204

Is shown as

1257 Anywhere St. MD 21204

Item 9d - 9-digit PAYERID number of the Medigap insurer - If no PAYERID number exists, the Medigap insurance program or plan name.

All the information in items 9, 9a, 9 b, and 9d must be complete and accurate. Otherwise, the Medicare contractor cannot forward the claim information. If prior arrangements have been made, the intermediary or carrier forwards the Medicare information electronically to the private insurer. Otherwise, the intermediary or carrier forwards a hardcopy of the claim to the private insurer.

A participating physician/supplier lists other supplemental coverage in item 9 and its subdivisions at the time each Medicare claim is filed.

30.2 - UB-92 (Form CMS-1450)

(Rev. 1, 10-01-03)

HO-460, A3-3604

The intermediary sends the full incoming claim records and the outbound COB records. See the CMS HIPAA Web page for the records, at http://www.cms.hhs.gov/providers/edi/hipaadoc.asp. The outbound records contain information about adjudication and payment of the claims, while the incoming records show the claim as received from the provider.

The provider must be sure that FL50 contains the identity of the Medigap insurer in sufficient detail for the intermediary to process the record to the Medigap payer. The intermediary is to inform providers of the identity and provider claims processing requirements of the Medigap payers with which it has a transfer agreement.

In the case of Medigap insurance, since Medicare is the primary payer, the provider would enter "Medicare" in FL 50 on line A and enter the Medigap insurer's name in FLs

50 B. If Medicare is not primary, then the provider would enter the primary insurance payer(s) name in line A ahead of "Medicare" in FLs 50 Line B. The provider would enter the Medigap insurer's name in order after "Medicare."

FLs 52 - Indicates whether the provider has a signed release of information from the beneficiary on file (see §20.1).

FLs 60 - Shows the patient's number under the Medigap insurance.

FLs 61 - Contains the insurance group or plan of the Medigap insurer if needed.

FLs 62 - Identification number, of code assigned by Medigap insurer if needed.

Note: For coordination of benefits between Medicare and payers other than Medigap that the intermediary has trading partner agreements with the same rules apply.

40 - MSN Messages

(Rev. 1, 10-01-03)

B3-4703, AB-99-3, AB-01-155

FI/Carriers should use the following messages, as appropriate, on the beneficiary's MSN for each approved claim for which they have sent or will send a transaction to a Medigap insurer:

MSN # 35.1 - "This information is being sent to your private insurer(s). Send any questions regarding your benefits to them." (**Note:** add if possible: Your private insurer(s) is/are).

MSN # 35.2 - "We have sent your claim to your Medigap insurer. Send any questions regarding your Medigap benefits to them." (**Note:** add if possible: Your Medigap insurer is.).

FIs/carriers use the following messages, as appropriate, to explain why a transaction was not or will not be sent to the Medigap insurer:

MSN #35.3 - "A copy of this notice will not be forwarded to your Medigap insurer because the Medigap information was incomplete or invalid. Please submit a copy of this notice to your Medigap insurer."

MSN #35.4 - " A copy of this notice will not be forwarded to your Medigap insurer because your provider does not participate in the Medicare program. Please submit a copy of this notice to your Medigap insurer.

MSN #35.5 - "We did not send this claim to your private insurer. They have indicated no additional payment can be made. Send any questions regarding your benefits to them." (This would be expressed on a RA by the absence of transfer information.)

MSN #35.6 - “Your supplemental policy is not a Medigap policy under Federal and State law/regulation. It is your responsibility to file a claim directly with your insurer.”

MSN #35.7 - “Please do not submit this notice to them.” (Add-on to other messages as appropriate).

MSN’s must be sent in all instances except for the following claim types: laboratory, demonstrations, exact duplicates, and statistical adjustments. These four types require the suppression of notices.

50 - Remittance Notice Messages

(Rev. 1, 10-01-03)

B3-4704, PM-AB-99-3, PM-B-01-35, PM-A-01-57

Carriers/FIs should include the following message on remittance notices sent to participating physicians and suppliers when Medigap benefits are assigned and the information in block #9 of the Form CMS-1500 (or FL50 of the UB-92, as appropriate) is completed:

MA 18 - “A copy of this claim determination will be forwarded to the beneficiary’s supplemental insurer within the next 30 days. Questions regarding payment of supplemental benefits should be directed to that insurer.”

At their option, Carriers/FIs may modify this message to reflect their actual Medigap transmission practices or to reflect the name of the insurer.

If the information in block #9 of the Form CMS-1500 or FL50 of the 1450 is incomplete, or more than one Medigap insurer was entered, FIs/carriers do not transmit a transaction record to the Medigap insurer. In such casers the following message is included on the on remittance notices

MA19 - “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.”

60 - Returned Medigap Notices

(Rev. 1, 10-01-03)

B3-4705, AB-99-3

Notices sent to Medigap insurers may be returned to the intermediary or carrier by the post office or other mail carrier as undeliverable. FIs and carriers consider returned notices as a source of information for detecting processing problems that merit additional analysis or investigation. They use findings to improve the transmittal process with respect to proper identification of the insurer or to update their Medigap insurer files. The

intermediary or carrier should develop procedures to advise beneficiaries, physicians and suppliers of their responsibility for filing Medigap claims when a notice is returned but not re-transmitted. They should re-transmit notices that are returned due to their error.

If an insurer refuses to accept valid notices, FIs and carriers follow the procedures detailed in §70.4.

70 - Coordination of Medicare With Medigap and Other Complementary Health Insurance Policies

(Rev. 1, 10-01-03)

B1-4607, B3-4701, B3-4706, A1-1601; A3-3768 - 3769

For applicable policy on information sharing, see Pub 100-1, the Medicare General Information, Eligibility and Entitlement Manual, Chapter 6.

For applicable cost sharing policy, see Pub 100-6, the Medicare Financial Management Manual, Chapter 1.

A formal agreement is a prerequisite for the electronic transfer of such data. (See §80.3, "Medigap Electronic Claims Transfer Agreement").

The intermediary or carrier should determine the frequency at which they routinely transmit notices to all Medigap insurers but must transmit not less often than monthly. (See §70.4)

Data elements and the formats to be used are described on the CMS EDI Web site, at http://www.cms.hhs.gov/providers/edi/hipaadoc.asp under formats/coordination of benefits. As changes are made that site will be updated.

70.1 - Authorization for Release of Information

(Rev. 1, 10-01-03)

B1-4600-4602.5, B3-10010, A1-1600 - 1602.5, A3-3768, A3-3769

See Pub 100-1, the Medicare General Information, Eligibility, and Entitlement Manual, Chapter 6.

70.1.1 - Requests for Additional Information

(Rev. 1, 10-01-03)

Normally the standard EDI Coordination of Benefits formats are used to convey Medigap or other complementary insurance information. Where the Medigap or other complementary insurer requests title XVIII information for certain claims only, FIs and

carriers treat the situation as a special request and determine the cost for providing it as described in Chapter 1 of Pub. 100-6, the Medicare Financial Management Manual.

If the request is for duplicate MSNs, the FI or carrier first informs the requestor that remittance remarks are included in the COB outbound claim records, and that there is a crosswalk from remittance remarks to MSN messages on the CMS Web site.

In the absence of a standing arrangement, the mere presence of an "authorization" to release and the identification of a complementary insurer on a title XVIII billing form does not constitute a request for the "release" of information. The request for the information must be specific.

70.1.2 - Release of Title XVIII Claims Information for Medigap Insurance Purposes by Providers

(Rev. 1, 10-01-03)

HO-91.3

Subject to specific written beneficiary authorization, providers are permitted to furnish certain limited information about Medicare eligibility status and related claims information to third part payers for complementary insurance purposes. (See Chapter 6 of Pub 100-1, the Medicare General Information, Eligibility, and Entitlement Manual.)

70.2 - Integration of Title XVIII Claims Processing With Complementary Insurance Claims Processing

(Rev. 1, 10-01-03)

A3-3769

General

See Chapter 6 of Pub 100-1, the Medicare General Information, Eligibility, and Entitlement Manual for instructions about disclosure of information.

See Chapter 1 of Pub. 100-6, the Medicare Financial Management Manual, for requirements for determining costs.

70.2.1 - Program Recognition

(Rev. 1, 10-01-03)

Since title XVIII program identity must be maintained, notices and forms for title XVIII purposes must clearly identify their title XVIII origin. The complementary insurance notices and forms must be free of implication that the coordination of benefits constitutes an official endorsement by CMS of the complementary insurance plan. Also, they must

not imply that title XVIII entitlement or enrollment is dependent upon the individual's retention of his/her complementary insurance policy.

70.2.2 - Records and Information

(Rev. 1, 10-01-03)

A3-3769.C

See Chapter 6 of Pub 100-1, the Medicare General Information, Eligibility, and Entitlement Manual.

70.2.3 - Matching Files Against Medicare Claims Files

(Rev. 1, 10-01-03)

A3-3769.D

See Chapter 6 of Pub 100-1, the Medicare General Information, Eligibility, and Entitlement Manual.

70.3 - Standard Medicare Charges for COB Records

(Rev. 1, 10-01-03)

A1-1600, B1-4601

See Chapter 1 of Pub 100-6, the Medicare Financial Management Manual.

70.4 - General Guidelines for Intermediary or Carrier Transfer of Claims Information to Medigap Insurers

(Rev. 1, 10-01-03)

B1-4607

See Chapter 1 of Pub 100-6, the Medicare Financial Management Manual.

70. 5 - Audits

(Rev. 1, 10-01-03)

B1-4601, A1-1601.C

See Chapter 1 of Pub 100-6, the Medicare Financial Management Manual.

70. 6 – Consolidation of the Claims Crossover Process

(Rev. 158, 04-30-04)

The CMS has decided to streamline the claims crossover process to better serve our customers. Beginning with July 6, 2004, and running through October 1, 2004, approximately eight COBA trading partners will participate in the beta-site testing of the consolidated claims crossover or Coordination of Benefits Agreement (COBA) process. During this time, the COBA beta-site testers will participate in a parallel production crossover process (a pilot for only COBA trading partners using production/live data). During the parallel production period, the eight COBA trading partners will receive consolidated crossover claims as part of the COBA process. In addition, if the eight COBA trading partners have individual Trading Partner Agreements (TPAs) executed with Medicare contractors, they will receive crossover claims based on the terms and conditions of those TPAs. The *Coordination of Benefits Contractor (COBC)* will not charge the COBA beta-testers for crossed over claims during the parallel production period. *I*ntermediaries and carriers will, however, continue to charge these partners for claims that they continue to cross over to them during the beta-testing period.

Under the consolidated claims crossover process, trading partners will be transitioned from the current *TPA* process with intermediaries and carriers to new agreements called Coordination of Benefits Agreements (COBAs). These agreements, which will be negotiated on behalf of CMS by the COBC, will be entered into directly between CMS and the COBA trading partners. Through the COBA process, each COBA trading partner will send one national eligibility file that includes eligibility information for each Medicare beneficiary that it insures to the COBC. The COBC will transmit the beneficiary eligibility file(s) to the Common Working File (CWF) via a maintenance transaction. The transaction is known as the Beneficiary Other Insurance (BOI) auxiliary file. (See *c*hapter 27, §80.14, of Publication 100-4, Medicare Claims Processing Manual, for more details about the contents of the BOI auxiliary file.)

The *CWF* is being modified so that it will apply each COBA trading partner's claims selection criteria against processed claims with service dates that fall between the effective and termination date of one or more BOI records. After applying the claims selection options, CWF will return a BOI reply trailer (29) to the intermediary or carrier only in those instances when the COBA trading partner expects to receive a Medicare processed claim from the COBC. Upon receipt of a BOI reply trailer (29) that contains (a) COBA ID (s) and other crossover information required on the HIPAA 835 Electronic Remittance Advice (ERA), Intermediaries and Carriers will send processed claims via an 837 COB flat file or National Council for Prescription Drug Programs (NCPDP) file to the COBC. The COBC, in turn, will cross the claims to the COBA trading partner. The CWF is also being modified in preparation for future receipt of claim-based Medigap and/ or Medicaid COBA IDs in field 36 of the HUBC or HUDC query. For claim-based crossover, CWF will also be equipped to search the Coordination of Benefits Agreement Insurance File (COIF) to locate a matching COBA IDs; apply the Medigap claim-based

trading partner's claims selection criteria; and return a Claim-based reply trailer 37 to the carrier or DMERC if a claim-based COBA ID has been located and the claim is to be sent to the COBC to be crossed over.

In addition, CMS shall arrange for the invoicing of COBA trading partners for crossover fees.

The effort to consolidate the claims crossover function will be implemented via a phased-in approach, beginning with a small-scale implementation on July 6, 2004, involving approximately *eight* COBA trading partners that will serve as beta-site testers. The transition of existing eligibility-file based trading partners to the COBA process should be completed by April 30, 2005.

A. CWF Processing of the COBA Insurance File (COIF) and Returning of BOI Reply Trailers

Effective July 6, 2004, the COBC will begin to send initial copies of the COBA Insurance File (COIF) to the nine CWF host sites. The COIF will contain specific information that will identify the COBA trading partner, including name, COBA ID, address, and tax identification number (TIN). It will also contain each trading partner's claims selection criteria along with an indicator (Y=Yes or N=No) of whether the trading partner wishes its name to be printed on the Medicare Summary Notice (MSN). *Effective with the October 2004 systems release, the COIF will also contain a 1-digit Test/Production Indicator that will identify whether a COBA trading partner is in test (T) or production (P) mode. CWF will be required to return that information as part of the BOI reply trailer (29) to Medicare intermediaries and carriers.*

Upon receipt of a claim, CWF shall take the following actions:

> *1) Search for a COBA eligibility record on the BOI auxiliary record for each beneficiary and obtain the associated COBA ID(s) [NOTE: There may be multiple COBA IDs associated with each beneficiary.];*
>
> *2) Refer to the COIF associated with each COBA ID [NOTE: CWF shall pull the COBA ID from the BOI auxiliary record) to obtain the COBA trading partner's name and claims selection criteria;*
>
> *3) Apply the COBA trading partner's selection criteria; and*
>
> *4) Transmit a BOI reply trailer to the Medicare intermediary or carrier only if the claim is to be sent, via 837 COB flat file or NCPDP file, to the COBC to be crossed over.*

B. BOI Reply Trailer and Claim-based Reply Trailer Processes

1. BOI Reply Trailer Process

For eligibility file-based crossover, intermediaries and carriers shall send processed claims information to the COBC for crossover to a COBA trading partner in response to the receipt of a CWF BOI reply trailer (29). Intermediaries or carriers will only receive a BOI reply trailer (29) under the consolidated crossover process for claims that CWF has selected for crossover after reading each COBA trading partner's claims selection criteria as reported on the weekly COIF submission.

When a BOI reply trailer (29) is received, the COBA assigned ID will identify the type of crossover (see the Data Elements Required for the BOI Aux File Record Table in *c*hapter 27, §24). Although each COBA ID will consist of a five-digit prefix that will be all zeroes, Intermediaries and Carriers are only responsible for picking up the last five digits within these ranges, which will be right justified in the COBA number field. In addition to the trading partner's COBA ID, the BOI reply trailer shall also include the COBA trading partner name (s), an "A" crossover indicator that specifies that the claim has been selected to be crossed over, and a one-digit indicator ["Y"=Yes; "N"=No] that specifies whether the COBA trading partner's name should be printed on the beneficiary MSN. *As discussed above, effective with the October 2004 systems release, CWF shall also include a 1-digit Test/Production Indicator on the BOI reply trailer (29) that is returned to the intermediary or carrier.*

Larger-Scale Implementation of the COBA Process

MSN Crossover Messages

Effective with the October 2004 systems release, the intermediary or carrier will begin to receive BOI reply trailers (29) that contain an MSN indicator "Y" (Print trading partner name on MSN) or "N" (Do not print trading partner name on MSN).

Also, effective with the October 2004 systems release, when an intermediary or carrier receives a BOI reply trailer (29) that contains a Test/Production Indicator of "T," it shall ignore the MSN indicator on the trailer. Instead, the intermediary or carrier shall follow its existing procedures for inclusion of trading partner names on MSNs for those trading partners with whom it has existing TPAs.

When a COBA trading partner is in full production (Test/Production Indicator=P), the intermediary or carrier shall read the MSN indicator returned on the BOI reply trailer (29). If the intermediary or carrier receives an MSN indicator "N," it shall print its generic crossover message(s) on the MSN rather than including the trading partner's name. Examples of existing generic MSN messages include the following:

(For all COBA ID ranges other than Medigap)

MSN #35.1 - "This information is being sent to private insurer(s). Send any questions regarding your benefits to them."

(For the Medigap COBA ID range)

MSN#35.2- "We have sent your claim to your Medigap insurer. Send any questions regarding your Medigap benefits to them."

Beginning with the October 2004 systems release, contractors shall follow these procedures when determining whether to update its claims history to show that a beneficiary's claim was selected by CWF to be crossed over.

1) *If the intermediary or carrier receives a BOI reply trailer (29) that contains a Test/Production Indicator "T," it shall not update its claims history to show that a beneficiary's claim was selected by CWF to be crossed over.*

2) *If the intermediary or carrier receives a BOI reply trailer (29) that contains a Test/Production Indicator "P," it shall update its claims history to show that a beneficiary's claim was selected by CWF to be crossed over.*

Electronic Remittance Advice (835)/Provider Remittance Advice Crossover Messages

Beginning with the October 2004 release, when contractors receive a BOI reply trailer (29) that contains a "T" Test/Production Indicator, they shall not print information received from the BOI reply trailer (29) in the required crossover fields on the 835 Electronic Remittance Advice or other provider remittance advices that are in production. Contractors shall, however, populate the 835 ERA (or provider remittance advice(s) in production) with required crossover information when they have existing agreements with trading partners.

Beginning with the October 2004 release, when contractors receive a BOI reply trailer (29) that contains a "P" Test/Production Indicator, they shall use the returned BOI trailer information to take the following actions on the provider's 835 Electronic Remittance Advice:

1) *Record code 19 in CLP-02 (Claim Status Code) in Loop 2100 (Claim Payment Information) of the 835 ERA (v. 4010-A1). [NOTE: Record "20" in CLP-02 (Claim Status Code) in Loop 2100 (Claim Payment Information) when Medicare is the secondary payer.]*

2) *Update the 2100 Loop (Crossover Carrier Name) on the 835 ERA as follows:*

   - *NM101 [Entity Identifier Code]—Use "TT," as specified in the 835 Implementation Guide.*

   - *NM102 [Entity Type Qualifier]—Use "2," as specified in the 835 Implementation Guide.*

   - *NM103 [Name, Last or Organization Name]—Use the COBA trading partner's name that accompanies the first sorted COBA ID returned to you on the BOI reply trailer.*

   - *NM108 [Identification Code Qualifier]—Use "PI" (Payer Identification)*

- *NM109 [Identification Code]—Use the first COBA ID returned to you on the BOI reply trailer. (See line 24 of the BOI aux. file record*

If the 835 ERA is not in production and the contractor receives a "P" Test/Production Indicator, it shall use the information provided on the BOI reply trailer (29) to populate the existing provider remittance advices that it has in production.

CWF Sort Routine for Multiple COBA IDs

When a beneficiary's claim is associated with more than one COBA ID (i.e., the beneficiary has more than one health insurer/benefit plan that pays after Medicare), CWF shall sort the COBA IDs and trading partner names in the following order on the returned BOI reply trailer (29): 1) Eligibility-based Medigap, 2) Supplemental, 3) TRICARE, 4) Others, and 5) Eligibility-based Medicaid. When two or more COBA IDs fall in the same range (see element 24 of the "Data Elements Required for the BOI Aux File Record" Table in chapter 27, §80.14 for more details), CWF shall sort numerically within the same range.

2. Medicare Summary Notice (MSN) and Electronic Remittance Advice (ERA) Crossover Messages During the Parallel Production Period

During the COBA parallel production period (July 6, 2004, to October 1, 2004): 1) CWF will only return an "N" MSN indicator on the BOI reply trailer (29), in accordance with information received via the COIF submission; 2) If a "Y" indicator is returned, the intermediary or carrier shall ignore it; and 3) the intermediary or carrier shall follow its existing procedures for the printing of MSN crossover messages.

During the COBA parallel production period, intermediaries and carriers shall follow their current procedures for the reporting of crossover claims information in CLP-02 (Claim Status Payment) and in the NM101, NM102, NM103, NM108, and NM109 segments of Loop 2100 of the provider *ERA*. They shall also continue with their current procedure for inclusion of COB trading partner names on other kinds of provider remittance advices that you have in production.

3. Business Rules for Receipt of a CWF BOI Reply Trailer When Other Indicators of Crossover Are Present

COBA Parallel Production Period

During the COBA parallel production period (July 6, 2004, to October 1, 2004), the intermediary or carrier shall observe the following business rules when it receives a BOI reply trailer 29 and some other indication of crossover eligibility:

If the intermediary or carrier receives a BOI reply trailer 29 with COBA IDs that fall in the ranges of 00001-89999, it shall continue to cross over claims a) per your existing TPAs and b) when Medigap or Medicaid information is reported on the claim. (NOTE: The preceding claim-based scenario does not apply to intermediaries.) In addition, the intermediary or carrier shall send claims for which it receives BOI reply trailers to the

COBC on the 837 v4010A1 flat file or National Council for Prescription Drug Programs (NCPDP) file. (NOTE: The COBA trading partner will only be charged for the claims that the intermediary or carrier continues to cross to it during the parallel production period.)

During the parallel production period, the intermediary or carrier shall not change its current procedures regarding suppression of Medicaid claims when a beneficiary has non-Medigap and/or Medigap insurance. The intermediary or carrier's Medicaid suppression logic should remain the same as today with its existing trading partners, even when it receives a BOI reply trailer that includes a Medicaid COBA ID.

Larger-Scale Implementation of the COBA Process

Beginning with the October 2004 release, intermediaries or carriers shall follow these rules when they receive a BOI reply trailer (29) that contains Test/Production Indicator "T" and there is some other indication of crossover eligibility:

*If the contractor receives a BOI reply trailer (29) with COBA IDs that fall in the ranges of 00001-89999 (See Attachment A, element 24), it shall cross over claims 1) per its existing TPAs or 2) when Medigap or Medicaid information is reported on the claim (if that is how the carrier or DMERC currently crosses over claims to Medicaid). (**NOTE:** Claim-based crossover scenarios only apply to carriers and DMERCs.)*

In addition, the contractor shall send claims for which it receives BOI reply trailer to the COBC on the 837 v4010A1 flat file or National Council for Prescription Drug Programs (NCPDP) file.

When a COBA trading partner is in test mode, the contractor shall not change its current procedures regarding suppression of Medicaid claims when a beneficiary has non-Medigap and/or Medigap insurance. The contractor's Medicaid suppression logic should remain the same as with current existing trading partners, even when you receive a BOI reply trailer (29) that includes a Medicaid COBA ID.

Beginning with the October 2004 release, contractors shall follow these rules when they receive a BOI reply trailer (29) that contains Test/Production Indicator "P" and there is some other indication of crossover eligibility:

1. *If the intermediary or carrier receives a BOI reply trailer (29) with a COBA ID that falls in the Medigap eligibility-based range (30000-54999), it shall not cross over claims based on an existing Medigap TPA or when Medigap information is reported on the claim. Instead, the intermediary or carrier shall send the claim to the COBC (based on the BOI reply trailer 29) on the 837 v4010A1 flat file or NCPDP file for crossover by the COBC to the COBA trading partner. (NOTE: The assumption is that a beneficiary will have only one true Medigap insurer.)*

2. *If the intermediary or carrier receives a COBA ID via a BOI reply trailer (29) that falls in the Supplemental range (00001-29999) and it has an existing TPA with a supplemental insurer for the beneficiary, it shall transmit the claim to the*

COBC for crossover to the COBA trading partner and cross the claim to your existing trading partner.

3. *If the intermediary or carrier receives a COBA ID via a BOI reply trailer (29) that falls in the Supplemental range (00001-29999), and it also receives Medigap crossover information on the claim, it shall cross the claim to the Medigap insurer identified on the claim and transmit the claim to the COBC for crossover to the COBA trading partner based on the Supplemental COBA ID.*

4. *If the intermediary or carrier receives a COBA ID via a BOI reply trailer (29) that falls in the Medicaid range (70000-77999), it shall not cross over claims based on an existing Medicaid TPA or when Medicaid information is reported on the claim (if that is how the carrier or DMERC currently crosses over claims to Medicaid). Instead, the intermediary or carrier shall send the claim to the COBC (based on the BOI reply trailer 29) on the 837 v4010A1 flat file or NCPDP file for crossover by the COBC to the COBA trading partner.*

5. *If the intermediary or carrier receives a BOI reply trailer (29) that contains a Medicaid COBA ID (70000-77999) and it has an existing TPA with a supplemental insurer or Medigap insurer, it shall suppress the Medicaid claim from inclusion on the COB 837 flat file or NCPDP file and cross the claim to the supplemental insurer.*

6. *If the intermediary or carrier receives a BOI reply trailer (29) that contains a Supplemental COBA ID (00001-29999) or a Medigap eligibility-based COBA ID (30000-54999) and it has an existing TPA with Medicaid, it shall suppress its crossover to Medicaid but send the claim to the COBC.*

NOTE: *For the scenarios above, the trading partner shall be responsible for canceling any existing TPA that it has with the intermediary or carrier once it has signed a COBA with the Coordination of Benefits Contractor (COBC).*

C. Transmission of the COB Flat File or NCPDP File to the COBC

Regardless of whether a COBA trading partner is in test mode (Test/Production Indicator returned via the BOI reply trailer 29=T) or production mode (Test/Production Indicator returned via the BOI reply trailer 29=P), intermediaries or carriers shall transmit all non-NCPDP claims received with a COBA ID via a BOI reply trailer to the COBC in an 837 v.4010A1 flat file, as described in Transmittal AB-03-060. In a separate transmission, DMERCs shall send the claims received in the NCPDP file format to the COBC. Intermediaries and Carriers shall enter the 5-digit COBA ID picked up from the BOI reply trailer (29) in the 1000B loop of the NM1 segment in the NM109 field. In a situation where multiple COBA IDs are received for a claim, intermediaries and carriers shall send a separate 837 or NCPDP transaction to the COBC for each COBA ID. Intermediaries and carriers shall perform the transmission at the end of their regular batch cycle, when claims come off the payment floor, to ensure crossover claims are not processed by the COBA trading partner prior to Medicare's final payment. Transmission

should occur via Network Data Mover (NDM) over AGNS (AT&T Global Network Services).

With respect to 837 COB flat file submissions to the COBC, carriers and DMERCs shall observe these process rules:

1. The following segments shall not be passed to the COBC:

    a) ISA (Interchange Control Header Segment);

    b) IEA (Interchange Control Trailer Segment);

    c) GS (Functional Group Header Segment); and

    d) GE (Functional Group Trailer Segment).

The 1000B loop of the NM1 segment denotes the crossover partner. If multiple COBA IDs are received via the BOI reply trailer, a separate 837 transaction should be submitted for each COBA ID received. As the crossover partner information will be unknown to the standard systems, the following fields should be formatted as indicated for the NM1 segment:

NM103—Use spaces; and

NM109—Include COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29).

The 2010BA loop denotes the subscriber information. If available, the subscriber name, address, and policy number should be used to complete the NM1, N3, and N4 segments. If unknown, the segments should be formatted as follows, with COBC completing any missing information:

NM1 segment—For NM103, NM104, NM105, and NM107, use spaces;

NM1 segment—For NM109, include HICN;

N3 segment—Use all spaces; and

N4 segment—Use all spaces.

The 2010BB loop denotes the payer name. Per the HIPAA Implementation Guide (IG), this loop should define the secondary payer when sending the claim to the second destination payer. Consequently, given that the payer related to the COBA ID will be unknown by the standard systems, the NM1, N3, and N4 segments should be formatted as follows, with COBC completing any missing information:

NM1 segment—For NM103, use spaces;

NM1 segment—For NM109, include the COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29);

N3 segment—Use all spaces; and

N4 segment—Use all spaces.

The 2330B loop denotes other payers for the claim. If multiple COBA IDs are returned via the BOI reply trailer, payer information for the additional COBA IDs will be unknown. As with the 2010BB loop, the NM1 segment should be formatted as follows, with COBC completing any missing information:

NM103—Use spaces; and

NM109—Include COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29).

The 2330B loop shall be repeated to allow for the inclusion of the name (NM103) and associated Trading Partner ID (NM109) for each existing trading partner.

The 2320 loop denotes other subscriber information. Within the SBR segment, the SBR03 and SBR04 segments are used to define the group/policy number and insured group name, respectively. If the information is available for these fields, those values should be propagated accordingly for both current trading partners and COBA trading partners. The COBC will inspect these values for COBA related eligibility based claims and overlay as appropriate. Spaces should only be used for COBA-related situations.

---SBR01—Treat as normally do.

With respect to 837 COB flat file submissions to the COBC, intermediaries shall observe these process rules:

As the ISA, IEA, and GS segments are included in the '100' record with other required segments, the '100' record must be passed to the COBC. However, as the values for these segments will be recalculated, spaces may be placed in all of the fields related to the ISA, IEA, and GS segments.

The 1000B loop of the NM1 segment denotes the crossover trading partner. If multiple COBA IDs are received via the BOI reply trailer, a separate 837 transaction should be submitted for each COBA ID received. As the crossover trading partner information will be unknown to the standard systems, the following fields should be formatted as follows for the NM1 segment on the'100' record:

NM103—Use spaces; and

NM109—Include COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29).

The 2010BA loop denotes the subscriber information. If available, the subscriber name, address, and policy number should be used to complete the NM1, N3, and N4 segments. If unknown, the segments should be formatted as follows for the '300' record, with COBC completing any missing information:

NM1 segment – For NM103, NM104, NM105, and NM107, use spaces;

NM1 segment—For NM109, include HICN;

N3 segment—Use all spaces; and

N4 segment—Use all spaces.

The 2010BC loop denotes the payer name. Per the HIPAA IG, this loop should define the secondary payer when sending the claim to the second destination payer. Consequently, since the payer related to the COBA ID will be unknown to the standard systems, the NM1, N3, and N4 segments should be formatted as follows for the '300' record, with COBC completing any missing information:

NM1 segment—For NM103, use spaces;

NM1 segment—For NM109, include COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29);

N3 segment—Use all spaces; and

N4 segment—Use all spaces.

The 2330B loop of the '575' record denotes other payers for the claim. If multiple COBA IDs are returned via the BOI reply trailer, payer information for the additional COBA IDs will be unknown. As with the 2010BC loop, the NM1 segment should be formatted as follows, with COBC completing any missing information:

NM103—Use spaces; and

NM109—Include COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29).

The 2330B loop shall be repeated to allow for the inclusion of the name (NM103) and associated Trading Partner ID (NM109) for each existing trading partner.

The 2320 loop denotes other subscriber information. Within the SBR segment, the SBR03 and SBR04 segments are used to define the group/policy number and insured group name, respectively. If the information is available for these fields, those values should be propagated accordingly for both current trading partners and COBA trading partners. The COBC will inspect these values for COBA related eligibility based claims and overlay as appropriate. Spaces should only be used for COBA-related situations.

---SBR01—Treat as normally do.

D. COBC Processing of COB Flat Files or NCPDP Files

When an intermediary or carrier receives the reject indicator "R" via the Claims Response File, it is to retransmit the entire file to the COBC. If the intermediary or carrier receives an acceptance indicator "A," this confirms that its entire COB flat file or

NCPDP file transmission was accepted. Once COB flat files or NCPDP files are accepted and translated into the appropriate outbound format(s), COBC will cross the claims to the COBA trading partner. The format of the Claims Response File that will be returned to each intermediary or carrier by the COBC, following its COB 837 flat file or NCPDP file transmission, appears in the table below.

Claims Response File Layout (80 bytes)				
Field	Name	Size	Displacement	Description
1.	Contractor Number	5	1-5	Contractor Identification Number
2.	Transaction Set Control Number/Batch Number	9	6-14	Found within the ST02 data element from the ST segment of the ANSI 837 flat file or in field 806-5C from the batch header of the NCPDP file.
3.	Number of claims	9	15-23	Number of Claims contained in the ANSI 837 flat file or NCPDP file. This is a numeric field that will be right justified and zero-filled.
4.	Receipt Date	8	24-31	Receipt Date of ANSI 837 flat file or NCPDP file in CCYYMMDD format
5.	Accept/Reject indicator	1	32	Indicator of either the acceptance or rejection of the ANSI 837 flat file or NCPDP file. Values will either be an "A" for accepted or "R" for rejected.
6.	Filler	48	33-80	Spaces

Claims response files will be returned *to contractors* after receipt and initial processing of a claim file. Thus, for example, if an intermediary or carrier sends a COB flat file daily, the COBC will return a claim response file to that contractor on a daily basis.

COB 837 flat files and NCPDP files that will be transmitted by the intermediary or carrier to the COBC will be assigned the following file names*, regardless of whether a COBA trading partner is in test or production mode:*

PCOB.BA.NDM.COBA.Cxxxxx.PARTA(+1) [Used for Institutional Claims]

PCOB.BA.NDM.COBA.Cxxxxx.PARTB(+1) [Used for Professional Claims]

PCOB.BA.NDM.COBA.Cxxxxx.NCPDP(+1). [Used for Drug Claims]

Note that "xxxxx" denotes the Medicare contractor number.

Intermediaries or carriers shall perform the 837 flat file and NCPDP file transmission at the end of the regular batch cycle, when claims come off the payment floor, to ensure crossover claims are not processed by the COBA trading partner prior to Medicare's final payment.

Files transmitted by the intermediary, carrier, or DMERC to the COBC shall be stored for 51 business days from the date of transmission.

The file names for the Claims Response File returned to the intermediary or carrier will be created as part of the NDM set-up process.

Outbound COB files transmitted by COBC to the COBA trading partners will be maintained for 50 business days following the date of transmission.

E. The Future COBA Claim-Based Process Involving CWF

The CWF shall load the initial COIF submission from COBC as well as all future updates that pertain to claim-based Medigap insurers and State Medicaid Agencies.

Once claim-based crossover becomes effective in the future, CWF shall only search the COIF if the carrier or DMERC has included a claim-based Medigap ID (55000-59999) or claim-based Medicaid ID (78000-79999) in field 36 of the HUBC or HUDC query. During the parallel production period (July 6, 2004, to October 1, 2004) and until the future implementation date for the claim-based COBA crossover process, CWF shall ignore claim-based COBA ID values if entered in field 36 of the HUBC or HUDC query.

Beginning with the implementation of the COBA claim-based crossover process, if claim-based COBA IDs are entered in field 36 of the HUBC or HUDC query, CWF shall:

Search the COIF to locate the claim-based Medicaid and/or Medigap COBA ID and corresponding COBA trading partner name;

Apply the Medigap claim-based trading partner's claims selection criteria;

Return a Claim-based reply trailer 37 that includes values for claim-based COBA ID (sorted by Medigap, then Medicaid), COBA Trading Partner Name, and MSN Indicator when a claim-based COBA ID is found on the COIF and the claim is to be sent to the COBC to be crossed over;

Return an alert code 7704 on the "01" response via a Claim-based alert trailer 21 to the carrier or DMERC if a claim-based COBA ID in the Medigap claim-based range (55000-59999) is not located on the COIF;

Return nothing to the carrier of DMERC is a Medicaid claim-based COBA ID (78000-79999) is not found on the COIF.

F. COBA Claim-Based Crossover Process

Until further notice from CMS, carriers and DMERCs shall not cease their existing claim-based Medigap and/or Medicaid crossover processes. Carriers and DMERCs will receive COBA claim-based crossover requirements as part of a future instruction.

G. Transition to the National COBA and Customer Service Issues

1. Maintenance of Current Crossover Processes, Including Entry into New Claims Crossover Agreements (also known as Trading Partner Agreements or TPAs)

Intermediaries and carriers shall keep their present crossover process in place, including invoicing for claims crossed to current trading partners, as described in Pub. 100-6, Financial Management, chapter 1, §450 and §460, until each of their present trading partners has been transitioned to the COBA process. As trading partners are signed on to national COBAs, they will be advised that it is their responsibility to simultaneously cancel current agreements with intermediaries and carriers and to cease submission of eligibility files. (NOTE: During the parallel production period, the COBA trading partner will be instructed by CMS to not cancel current TPAs with you.) By current estimates, CMS expects to complete the transition of current eligibility file-based trading partners to COBAs by April 30, 2005.

Given CMS's initial plans for a small-scale implementation of the COBA process on July 6, 2004, you shall continue to execute new crossover agreements (Trading Partner Agreements or TPAs) for trading partners that wish to go into live production by August 1, 2004. These new TPAs and extensions of existing TPAs shall allow for future termination no later than April 30, 2005. Trading partners that either wish to go into live crossover production after August 1, 2004, or have current questions regarding the COBA process shall be referred to the COBC at 1-800-999-1118.

2. Workload Reporting In Light of COBA

For workload reporting purposes, intermediaries and carriers shall provide counts for those claims that they individually cross to current trading partners (including Medicaid), just as they currently do in CAFM II and in CROWD. Intermediaries and carriers shall separately track claims transmitted to the COBC for crossover to the COBA trading partners for future reporting requirements by COBA ID.

3. Customer Service

A. COBA Parallel Production

During the parallel production period (July 6, 2004, to October 1, 2004), the intermediary and carrier shall proceed with its current claims crossover customer service process. In addition, the intermediary or carrier's claims history shall not be updated with crossover information based upon the receipt of a CWF BOI reply trailer 29.

B. Updating of the HIMR Detailed History Screens By CWF and the Larger Scale Implementation of COBA

Effective with the October 2004 release, when a COBA trading partner is in production mode (Test/Production Indicator=P), CWF shall annotate each processed claim on detailed history within the Health Insurance Master Record (HIMR) with an indicator that will inform all users of the claim's crossover status. (See Pub.100-4, chapter 27, §80.15 for more information.). CWF shall allow for repeating of the application of crossover disposition indicators for up to ten (10) COBA IDs.

In addition, CWF shall annotate each processed claim with a 10-position COBA ID (5-digit COBA ID preceded by 5 zeroes) to identify the entity to which the claim was crossed or not crossed, in accordance with the COBA.

CWF shall not annotate processed claims on the detailed history screens in HIMR when a COBA trading partner is in test mode (Test/Production Indicator=T).

Effective with the October 2004 systems release, when a COBA trading partner is in production mode, the intermediary or carrier's customer service personnel shall answer provider/supplier and beneficiary questions about a claim's crossover status by referring to your internal claims history. In addition, the intermediary or carrier's customer service staff shall access information regarding why a claim did not cross by referring to the detailed history screens on HIMR (e.g., INPH, OUTH, HOSH, PTBH, DMEH, and HHAH). [See *c*hapter 27, §80.15 of the Medicare Claims Processing Manual for a listing of all claims crossover disposition indicators.] *These screens will also display indicator "A" when a claim was selected by CWF to be crossed over to the COBA ID shown. The BOI auxiliary file will identify the name associated with the COBA ID. Such information may also be available to contractor customer service staff via the Next Generation Desktop (NGD) application.*

The CWF maintainer will issue instructions on the use of the new HIMR screens as part of the October 2004 release.

80 - Electronic Transmission - General Requirements

(Rev. 1, 10-01-03)

PM-A-01-20, PM-A-01-63, PM-B-01-06, B3-4707

FI/Carriers must enter into formal agreements with individual Medigap insurers for the transmission of claim information electronically (see §80.3). The agreement should specify whether the Medigap insurer will submit an eligibility file. If the Medigap insurer wants to send a periodic eligibility file the agreement must specify how Medicare costs are to be paid by the Medigap insurer.

The CMS requires that the outbound format for the transfer of Health Care claim information is the ANSI X12N 837 COB (version 4010), or for transmissions before the required implementation date for X12N, the NSF or UB-92 outbound format may be used. Also, if the recipient wants electronic attachments, attachment data must be furnished in UB-92 or NSF format because X12N does not support electronic attachments (e.g., UB-92 RTs 74, 75, 76). Only the attachment records will be furnished in UB-92 or NSF format after X12N becomes mandatory. Other data will be in the X12N format. The recipient must coordinate any attachments received with the claim record.

Detailed specifications on the electronic formats can be obtained at http://www.cms.hhs.gov/providers/edi/edi3.asp.

The outbound COB transaction is a post-adjudicative transaction. This transaction includes the incoming claim data as well as the COB data. The intermediary or carrier is required to receive all possible data on the incoming 837, although they do not have to process non-Medicare data. However, the shared system must store that data in a store-and-forward repository (SFR). This repository file is designed and maintained by the shared system. This data must be reassociated with the Medicare claim and payment data in order to create a compliant outbound COB transaction using the Medicare Claim/COB flat file as input. The shared system is to use post-adjudicative Medicare data (data used from history and reference files to adjudicate the claim) instead of data received when building the outbound COB transaction. This is to show any changes in data element values as a result of claims adjudication. The shared system must retain the data in the SFR for a minimum of six months.

The Medicare Claim/COB flat file is the format to be used to reassociate all data required to map to the COB transaction. The FI/Carrier's translator will built their outbound COB transaction from the Medicare Claim/COB flat file.

The CMS recommends the FI/Carrier send the outbound COB transaction over a wire connection. However, tape or diskettes may be sent to those trading partners that do not wish to receive transmissions via wire. The FI/Carrier and their trading partners will need

to reach agreement on telecommunications protocols. It is the FI/Carrier choice as to whether they wish to process the X12N 997 Functional Acknowledgment from their COB trading partners.

Data on claims that the intermediary or carrier receives from its keyshop or image processing systems may not be included on the SFR, depending on the shared system design. They will create the Medicare claim/COB flat file using data available from claims history and reference files. Since some data will not be available on these "paper" claims, the outbound COB transaction will be built as a "minimum "data set. It will contain all "required" COB transactions segments and post-adjudicative Medicare data. For a Medicare Claim/COB flat file layout see http://www.cms.hhs.gov/providers/edi/hipaadoc.asp.

The steps from receipt of the incoming claim to creation of the outbound COB are summarized below:

- Contractor's translator performs syntax edits and maps incoming claim data to the X12N flat file;
- Standard system creates implementation guide and Medicare edits for the flat file data;
- Medicare data on ANSI X12N flat file is mapped to the core system;

NOTE: There are no changes in core system data fields or field sizes.

Non-Medicare data (and Medicare data elements where field sizes are in excess of the core system) are written to the SFR; and

Adjudicated data is combined with repository data to create the outbound COB.

80.1 - HIPPA Provisions Affecting Medigap Transactions

(Rev. 1, 10-01-03)

PM-A-01-20

The HIPAA administrative simplification provisions have the following impact on data communications with Medigap and other complementary insurers.

- Medicare will switch to exclusive use of the outbound COB by October 16, 2003;
- Medicare will cease issuance of non-version 4010 COB transactions and acceptance of non-837 version 4010 electronic claims by October 2003;
- Medicare will cease support of DDE for Part B claims submission;

- Each provider that has elected to submit claims electronically must submit all of their claims in compliance with the HIPAA Implementation Guide (IG) requirements for ANSI X12N 837 version 4010. Vendors that submit electronic claims for Medicare providers must also comply with the IG requirements;

- Each trading partner that has elected to accept COB electronically must accept the IG outbound claim format, or contract with a [health] clearinghouse to translate its claim data from the IG format. An entity that elects to use a clearinghouse for translation services is liable for those costs; and

- COB trading partners must either request system compatibility testing for use of the COB transaction prior to October 2003, or be confident that they have completed system changes as required to accept production COB transactions by October 2003. Any trading partner that prefers to have COB testing conducted prior to transmission of production data must schedule testing with the intermediary or carrier as soon as possible to assure testing will be completed before October 2003. Current trading partners either accept production ANSI X12N 837 COB transactions starting October 2003, or advise their contractor that they are terminating their COB agreement. If the trading partner has not advised the FI or carrier which alternative it intends to pursue, the FI or carrier terminates sending COB transactions after September, 2003.

The Implementation Guide and X12N data dictionary can be downloaded without charge from www.wpc-edi.com/HIPAA.

There is no Medicare charge for furnishing test files for this system testing.

Medigap carriers should refer to http://www.cms.hhs.gov/providers/edi/edi3.asp for specifications for Version 6.0 of the COB UB-92 flat file as well as the NSF and ANSI X12N 837 formats.

80.2 - ANSI X12N 837 COB (Version 4010) Transaction Fee Collection

(Rev. 1, 10-01-03)

The intermediary or carrier charges Medigap and other complementary insurers (but not Medicaid) for the cost of preparing and sending COB transactions. The transfer agreement must include a description of data elements on the invoice (bill). (See §70.3 above.)

If a Medigap insurer refuses to pay or does not pay it regularly and completely, the FI/Carrier should notify the appropriate State insurance commission that the Medigap insurer is not complying with the payment provisions of §4081 of OBRA 1987. First, the FI/Carrier should contact the insurance department of the State in which the policyholder resides. If that State insurance department does not accept jurisdiction, the FI or carrier informs the appropriate RO. The RO contacts CMS Central Office for assistance in determining the department of jurisdiction. If, after contacting the insurance department

recommended by CMS, the problem is unresolved, the FI or carrier treats it as a CMS debt under 42 CFR 401.601-401.625.

The requirements in §§20 - 30.1 do not supplant existing agreements which the intermediary or carrier may have with any other insurer to exchange complementary insurance information except for possible amendment to recognize the beneficiary's right to assign Medigap payment to participating physicians and suppliers on a claim-by-claim basis. The intermediary or carrier should modify these agreements to state that it is the beneficiary's right to designate a particular insurer to receive a notice for payment. If they have transmitted an ANSI X12N 837 COB (Version 4010) Transaction to a designated Medigap insurer based on a properly executed assignment, that insurer should send claims information to other insurers under complementary arrangements.

80.3 - Medigap Electronic Claims Transfer Agreements

(Rev. 1, 10-01-03)

B3-4709, B4-2110.1

For electronic transfers occurring on a frequent basis, Medigap and other insurers must enter into agreements with the intermediary or carrier. These agreements may alter the procedures applying to existing agreements with complementary insurers, including Medigap assignment provisions.

At a minimum, all transfer agreements include:

- Functions of the carrier;
- Functions of the Medigap insurer;
- Fees and payment schedules;
- Confidentiality/Disclosure of information furnished;
- Office of Inspector General (OIG) review access;
- Contract periods and automatic renewal provisions;
- Contract termination provisions; and
- Dated signatures of authorized carrier/Medigap insurer representatives

FIs/carriers can negotiate other provisions that the Medigap insurer may want but are not required to by §§20 - 80. The standard formats as described by these sections must be used.

80.3.1 - Intermediary Crossover Claim Requirements

(Rev. 1, 10-01-03)

A-01-20, A-02-069, A-02-077, A-02-078, AB-02-20

A - Standards

External Keyshop or Imaging Processing

Intermediaries support only the UB-92 version 6.0 as the output format for paper claims received from their external keyshop or imaging processes. However, since CMS will cease to support the UB-92 version 6.0, eventual migration to the Medicare Part A Claim/COB flat file as the output format for these claims must occur by October 1, 2003. If intermediaries decide to use the Medicare Part A Claim/COB flat file as output for these claims, intermediaries may bypass the IG edits since these claims will not contain all of the data on the inbound ANSI X12N 837 transaction.

Provider Direct Data Entry (DDE)

DDE systems are not subject to the syntax (format) requirements of the standards, but must contain "applicable data content" for the claim. Intermediaries may continue to use existing DDE screens for claim corrections since this function is not subject to HIPAA. DDE systems are proprietary by definition. They are a direct link between a particular health plan (Medicare) and its providers, and the software (and sometimes hardware) is unique to and maintained by the plan. The CMS recognizes that DDE is currently the only viable means of EDI available to some providers, particularly small providers. The widespread use of the standard HIPAA transactions will make it economically feasible for more providers to procure or develop their own EDI products that can be used with all plans. The use of DDE should decrease over time as a result. The requirement for "applicable data content" is meant to facilitate that eventual conversion. Implementing the data content portion of the standards now means that a provider's change from DDE to its own EDI software (or to use of a clearinghouse) would be simplified, and plans would be able to accommodate DDE-generated data and HIPAA standard transaction-generated data in the same databases.

In this context, "applicable data content" means the shared system's DDE system must:

- Collect all fields that are **required** in the IG as well as those **situational** elements that are needed for Medicare processing (unless the data is already available to the payer's system);

- Use **only** the internal and external code sets designated in the IG with no additions or substitutions;

- Provide for **at least** the field size minimums noted in the IG, but no more than the maximum sizes (Do not expand the shared system's internal claim records); and

- Permit **at least** the minimum number of field repeats noted in the IG, but no more than the maximum number.

Additionally, (effective January 1, 2003) DDE systems must:

- Allow for **only** one investigational device exemption number (IDE) per claim (at the claim level);
- Remove employment status code, employer name, and employer address information;
- Allow Other Subscriber Demographic Information (date of birth and gender) if the other subscriber is a person;
- Allow for discharge hour and minute information in the numeric form of HHMM; and
- Allow for correct processing of the unique physicians identifier number in the 2310A (Attending Physician) loop.

There is no need to collect non-Medicare data. Claims correction via DDE should be limited to Medicare data (non-Medicare data in error should be purged with an appropriate error message to the DDE user). With Medicare data plus some information from shared system files, an IG compliant COB transaction can be written.

NOTE: Additional edits may be needed based on further analysis and issues that may be encountered during implementation.

B - Edits Performed by the Intermediary

Intermediaries are to perform standard and IG edits as explained in the IG. IG edits should be standard among all intermediaries. If a syntax error occurs at the IG level, the intermediary may reject the entire transmission, the functional group, batch, or claim. At a minimum, it must return the claim to the provider (RTP) if it is not HIPAA compliant. Amounts, percentages, integers, and other fields designated in the IG as numeric will be right-justified and zero-filled if the incoming data is smaller than the Medicare Part A Claim/COB flat file field size. Fields designated in the IG as alphanumeric will be left-justified and space filled if the incoming data is smaller than the Medicare Part A Claim/COB flat file field size. All non-Medicare data field lengths will correspond to the maximum IG length. Incoming alphanumeric non-Medicare data will be left-justified and space filled if the data is smaller than the Medicare Part A Claim/COB flat file field size. Incoming numeric non-Medicare data will be right-justified and zero-filled if the data is smaller than the Medicare Part A Claim/COB flat file field size. Non-Medicare data (and Medicare data elements where field sizes are in excess of the core system) will be mapped to the Medicare Part A Claim/COB flat file (and later written to the store-and-forward repository (SFR) by the shared system). The following programmatic edits override the IG:

Claims where the ZIP code exceeds nine positions will be left adjusted and the claim will be processed.

Data where there is an IG note, internal code list, external code list, or qualifier will be limited by the reference. Claims where data exceeds referenced sizes are to be flagged so the shared system can RTP with an appropriate error message.

The submitter Employer Identification Number (EIN) will not exceed 10 positions. Claims where the EIN exceeds 10 positions are to be rejected with an appropriate error message.

Incoming data mapping to data elements marked "NOT USED" in the IG will be disregarded.

All date data will not exceed eight digits (CCYYMMDD), except for date ranges. Claims where the date data exceeds eight positions (and not a valid date range) are to be rejected with an appropriate error message.

Claims where the attending, referring, or operating physician numbers exceed 16 positions are to be flagged so the shared systems can RTP with an appropriate error message.

Units of service will not exceed seven positions. Claims where the Units of service exceed seven positions are to be flagged so the shared system can RTP with an appropriate error message.

Number of days (covered, lifetime reserve, etc.) will not exceed four positions. Claims where the number of days exceeds four positions are to be flagged so the shared systems can RTP with an appropriate error message.

Credit card and foreign currency data will be disregarded per note in the IG stating that this information must never be sent to the payer and therefore would not be included on the COB transaction.

IG edit process will map amounts to the Medicare Part A Claim/COB flat file using the COBOL picture of S9(8)V99 (10 positions). Other numeric data elements will be mapped to the data size described within the Medicare Part A Claim/COB flat file document. Numeric data fields larger than the data size described within the Medicare Part A Claim/COB flat file document will be populated with "HIGH-VALUES." HIGH-VALUES has the hexadecimal value X"FF" (a character code of all binary ones).

As of April 2003, the CMS changed the service line limit to 449. For claims exceeding 449 service lines, write the first 449 lines to the Medicare Part A Claim/COB flat file (the claim will later be RTP'd by the shared system with an appropriate error message based on the missing 0001 line).

All spaces will be passed to the Medicare Part A Claim/COB flat file for fields that are not present in the inbound ANSI X12N 837 version 4010A1.

The IG allows for the units of service segment to contain a decimal. However, Medicare does not process units of service that contain any decimals. Intermediaries must round units of service that contain decimals so the shared system can process the resulting numeric unit of service (i.e., if the number to the right of the decimal is four or less, round down. If the number to the right of the decimal is five or greater, round up).

The IG allows for diagnosis codes to contain a decimal. However, the intermediary systems do not process diagnosis codes containing decimals. If an incoming claim contains a diagnosis code with a decimal in the correct position based on the external code source, the intermediary must reformat the diagnosis code into a 6-position alphanumeric field as defined in the Medicare Part A/COB flat file (flat file) where the digits are left justified and space filled when translating the data into the flat file format. The decimal will be assumed between the third and fourth digit (i.e., 999V9bb - "V" represents the assumed decimal and "b" represents a space). If an incoming claim contains a diagnosis code with a decimal in an incorrect position based on the external code source populate (flag) the field with ampersands.

Intermediaries must suppress the one HCPCS code per Revenue Code edit in their translators to avoid rejecting outpatient claims with line level revenue codes but no HCPCS code.

Intermediaries must also suppress their translator edit for the absence of a date of service where there are no HCPCS codes.

C - Edits Performed by the Standard Systems

Claims containing a diagnosis code flagged with ampersands will be returned to the provider/submitter, via the intermediary, with an appropriate error message

Claims with numeric data elements containing HIGH-VALUES are to be returned by the shared system to the provider via the intermediary with an appropriate error message.

Claims with S9(8)V99 numeric data elements containing an amount greater than corresponding fields set in the core system at 9 digits (S9(7)V99) are to be returned by the shared system to the provider via the intermediary with an appropriate error message.

Data residing on the Medicare Part A Claim/COB flat file as a result of data received in loop 2010BD RESPONSIBLE PARTY NAME of the X12N 837 will be RTP'd with an appropriate error message because Medicare policy requires a signature on file for payment.

Standard systems are not to return non-Medicare data to the provider.

For more information on edits, refer to the Medicare Edits Document available at http://www.cms.hhs.gov/providers/edi/hipaadoc.asp.

D - Outbound COB

The outbound COB transaction is a post-adjudicative transaction. This transaction includes the incoming claim data as well as COB data. Intermediaries are required to receive all possible data on the incoming ANSI X12N 837 although they do not have to process non-Medicare data. However, the shared system must store that data in a SFR. This repository file will be designed and maintained by the shared system. This data must be reassociated with Medicare claim and payment data in order to create an IG compliant outbound COB transaction using the Medicare Part A Claim/COB flat file as input. The shared system is to use post-adjudicated Medicare data (data used from history and reference files to adjudicate the claim) instead of data received when building the outbound COB transaction. The shared system must retain the data in the SFR for a minimum of six months.

The Medicare Part A Claim/COB flat file is the format to be used to reassociate all data required to map to the COB transaction. The translator will build the outbound COB transaction from the Medicare Part A Claim/COB flat file.

Intermediaries are not required to process an incoming ANSI X12N 997. They may create and use their own proprietary report(s) for feedback purposes.

The shared system maintainer must accommodate the COB transaction.

E - Transmission Mode

The CMS recommends that the outbound COB transaction be sent over a wire connection. However, tape or diskettes may be sent to those trading partners that do not wish to receive transmissions via wire. COB trading partners will need to reach agreement on telecommunication protocols. It is the intermediary choice as to whether it wishes to process the ANSI X12N 997 Functional Acknowledgment from COB trading partners.

F - External Keyshop or Imaging Processing

Data on claims received from the keyshop or image processing systems may not be included on the SFR, depending on shared system design. Intermediaries must create their Medicare Part A Claim/COB flat file using data available from claim history and reference files. Since some data will not be available on these “paper” claims, the outbound COB transaction will be built as a “minimum” data set. It will contain all “required” COB transaction segments and post-adjudicated Medicare data.

G - Summary of Process

The following summarizes all intermediary steps from receipt of the incoming claim to creation of the outbound COB:

> Intermediary’s translator performs syntax edits, IG edits, and Medicare edits and maps incoming claim data to the Medicare Part A Claim/COB flat file;

Medicare data on the Medicare Part A Claim/COB flat file is mapped to the core system by the shared system.

NOTE: No changes are being made to core system data fields or field sizes;

Non-Medicare data (and Medicare data elements where field sizes are in excess of the core system) are written to the SFR by the intermediary's shared system; and

Adjudicated data is combined with SFR data to create the outbound COB transaction.

80.3.2 - Carrier/DMERC Crossover Claim Requirements

(Rev. 1, 10-01-03)

B-01-32, B-01-06, OCR/ICR definition created through outside IS text

A - Decimal Data Elements

Refer to the ANSI X12N 837 IG download site (http://www.wpc-edi.com/) for a more detailed explanation of control structure/loop references made in this section.

All decimal data elements are defined as "R" based on ANSI X12N protocol. The translator should write these data elements to the ANSI 12N-based flat file at their maximum field size, which will be initialized to spaces. The COBOL picture found under the ANSI X12N 837 element name will be used to limit the size of the amounts. These positions are right justified and zero-filled. Translators are to convert signed values using the conversion table shown below. This value is to be placed in the last position of the COBOL-defined field length. The last position of maximum defined field length of the ANSI X12N-based flat file data element will be used as a placeholder to report an error code if an "R" defined data element exceeds the limitation that the Medicare system is authorized to process. The error code values are: "X" = value exceeds maximum amount based on the COBOL picture, "Y" = value exceeds maximum decimal places based on the COBOL picture, "Z" = value exceeds x-number of precision places, and "b" blank will represent no error. For example, a dollar amount with the implementation guide maximum of 18-digits would look like 12345678.90. The translator will map this amount to the ANSI X12N-based flat file using the COBOL picture of S9(7)V99. The flat file amount will look like 23456789{bbbbbbbbX. The "{" is the converted sign value for positive "0." The error switch value is "X" since this value exceeded the COBOL picture of S9(7)V99.

Conversion Table

Positive Values	Negative Values
1 = A	-1 = J
2 = B	-2 = K
3 = C	-3 = L
4 = D	-4 = M
5 = E	-5 = N
6 = F	-6 = O
7 = G	-7 = P
8 = H	-8 = Q
9 = I	-9 = R
0 = {	-0 = }

B - Keyshop and Optical Character Recognition (OCR)/Image Character Recognition (ICR)

OCR/ICR are data input technologies based on the recognition of numbers or text through special input devices.

Carriers may continue to use the National Standard Format (NSF) as the output format for paper claims received from keyshop and OCR/ICR. However, since CMS will cease to support the NSF, eventual migration to the ANSI X12N-based flat file as the output format for these claims will need to occur. If carriers decide to use the X12N-based flat file as output for these claims, they may bypass the implementation guide edits since these claims will not contain all of the data on the inbound ANSI X12N 837 transaction.

C - Provider Direct Data Entry (DDE)

Since there is little provider use of DDE, it is not cost effective to redesign any existing DDE screens. Carriers are to eliminate support of DDE in conjunction with the elimination of the NSF for claim submission. Carriers may continue to use existing DDE screens for claim corrections since this function is not subject to HIPAA.

D - Implementation Guide Edits

The shared system will program edits per Medicare instructions and edits should be standard between all shared systems.

E - Outbound Coordination of Benefits (COB)

The outbound COB transaction is a post-adjudicative transaction. This transaction includes incoming claim data as well as COB data. Carriers are required to receive all possible data on the incoming ANSI X12N 837 although they do not have to process non-Medicare data. However, they must store that data in a store-and-forward repository (SFR). This repository will be designed by the shared system. This data must be reassociated with Medicare claim and payment data in order to create an outbound ANSI X12N 837 COB transaction. The shared systems maintainer is to use post-adjudicated Medicare data (data used from history and reference files to adjudicate the claim) instead of data received when building the outbound COB transaction. Carriers must retain the data in the SFR for a minimum of six months.

The ANSI X12N-based flat file is the format to be used to reassociate all data required to map to the outbound ANSI X12N 837 (4010A1). The translator will build the outbound ANSI X12N 837 COB from the ANSI X12N-based flat file.

The shared system maintainer must create the outbound ANSI X12N 837.

F - Transmission Mode

The CMS recommends that carriers send the outbound ANSI X12N 837 COB transaction over a wire connection. However, they may send tape or diskettes to those trading partners that do not wish to receive transmissions via wire. COB trading partners will need to reach agreement on telecommunication protocols. It is the carrier choice as to whether it wishes to process the ANSI X12N 997 Functional Acknowledgment from COB trading partners.

G - Keyshop and OCR/ICR

Data on claims received from the carrier keyshop or OCR/ICR may not be included on the SFR, depending on the shared system design. Carriers must create the X12N-based flat file using data available from claim history and reference files. Since some data will not be available on these “paper” claims, the outbound ANSI X12N 837 COB will be built as a “minimum” data set. It will contain all “required” ANSI X12N 837 COB segments and post-adjudicated Medicare data.

H - Summary of Process

The following summarizes all the steps from receipt of the incoming claim to creation of the outbound COB:

- Carrier's translator performs syntax edits and maps incoming claim data to the ANSI X12N flat file;
- Standard system creates implementation guide and Medicare edits for the flat file data;
- Medicare data on ANSI X12N flat file is mapped to the core system;

  NOTE: No changes are being made to core system data fields or field sizes.
- Non-Medicare data (and Medicare data elements where field sizes are in excess of the core system) are written to the store-and-forward repository; and
- Adjudicated data is combined with repository data to create the outbound COB.

I - Additional DMERC Requirements

If the DMERC or the shared system maintainer encounters an error when editing non-Medicare data, DMERCS must include language on reports that not only is the data in error, but the data is not required by Medicare.

90 - Paper Submission

(Rev. 1, 10-01-03)

B3-4708

On paper submissions to Medigap insurers, the intermediary or carrier must include all of the same elements that are required on electronically transmitted claims notices **except** that the date of birth may be omitted. These elements are:

- Beneficiary Data;
- HICN;
- Name;
- Address;
- Date of Birth (not required);
- Medigap policy number;
- Claims Data;
- Medigap Assignment Indicator;
- Date of Service;

- Procedure Code (modifiers);
- Submitted Charge;
- Allowed Charge;
- Medicare Paid Amount;
- Amount Applied to Deductible;
- Part B Blood Deductible;
- Participating Physician/Supplier Data;
- Name;
- Address; and
- Tax Identification Number.

Medigap carriers that do not have trading partner agreements with the Medicare carriers or FIs usually receive paper claims consisting of Form CMS-1500 and UB-92 forms and/or Provider Remittance Advice (RA) from the provider. Medigap carriers that receive paper claims generally use claim level summary data to process and pay claims.

While Version 4A.01 of the electronic remittance advice will carry line-by-line payment and adjustment information that corresponds to each service line submitted on a claim, earlier versions of the electronic remittance advice and corresponding PC print version will support summary, claim level data only. Also the standard paper remittance advice reports summary, claim level payment data. There are no plans to change to include line level data.

100 - Medigap Insurers Fraud Referral

(Rev. 1, 10-01-03)

AB-00-23

Carriers and FI's should give high priority to fraud complaints made by Medicare supplemental insurers. If the referral by a Medigap insurer includes investigatory findings indicating fraud stemming from site reviews, beneficiary interviews, provider interviews and /or medical record reviews, contractors should (a) conduct an immediate data run to determine possible Medicare losses and (b) refer the case to the Office of the Inspector General (OIG).

In addition to the referral of such cases to the OIG, contractors should also identify and take additional corrective action to prevent future improper payments (e.g., by placing the

provider or supplier's claims on prepayment review). Contractors are responsible for taking reasonable and appropriate measures to protect the Trust Fund.

110 - Medigap Criminal Penalties/Types of Complaints Under Section 1882(d)

(Rev. 1, 10-01-03)

RO-2700

Although most States have some type of penalty provisions regarding fraud and misrepresentation in the sale of health insurance policies, Congress considered that many State laws either did not directly address the following types of abuses, or else the sanctions generally available under State laws were considered too limited. Therefore, in order to provide an additional avenue for prosecution of these cases as well as to provide stiff penalties (fines up to $25,000 and/or imprisonment for up to five years) these provisions were included in Section 507 of P.L. 96-265.

A - Section 1882(d)(l) - This paragraph prohibits the making of a false representation with regard to the compliance of a policy with the Federal requirements contained in this law. Additionally, it prohibits the making of any false statement or misrepresentation with respect to the use of the emblem that signifies the Secretary's certification of a policy under the Voluntary Certification Program. Policies submitted under this Voluntary Certification Program were accepted for review by the Medigap Operations Staff beginning January l, 1982. Any agent or company which represents that its policy has received the Secretary's certification, or that its policy has received or is eligible for the Secretary's emblem, when, in fact, it has not received such certification or emblem, can be prosecuted under this paragraph. This paragraph became effective June 9, 1980.

B - Section 1882(d)(2) - This paragraph prohibits the false representation of an association or agency relationship with the Medicare program or any Federal agency for the purpose of selling insurance. Of the complaints received by CMS, the majority involves alleged violations of this paragraph. These complaints indicate that agents gained entry and, in some cases, sold policies by misrepresenting, either by direct statement or by implication, that they were associated with Medicare, CMS, or the Social Security Administration. This paragraph became effective June 9, 1980.

C - Section 1882(d)(3) - This paragraph provides penalties for knowingly selling duplicative coverage (sometimes referred to as "stacking" or "loading)." This occurs when an agent sells insurance to an individual knowing that it duplicates coverage that he/she already has without duplicating benefits. This paragraph became effective June 9, 1980.

Although many States have statutes that specifically prohibit "twisting" (misrepresentations made by an agent for the purpose of inducing the policyholder to lapse, forfeit, or convert a policy), few States have specific prohibitions against "stacking." Therefore, Federal prosecution under §1882(d)(3) may prove to be a useful

approach where the available State statute does not specifically prohibit "stacking." Moreover, the Federal sanctions available for misrepresentations and "stacking" may prove to be useful for prosecution where the available State sanctions are more limited.

D - Section 1882(d)(4) - This paragraph provides penalties for knowingly soliciting, advertising, or offering for sale Medicare supplemental health insurance policies by mail into a State if these policies have not been approved by the Commissioner of Insurance for sale within the State or are not deemed to be approved for sale within the State. Section 1882(d)(4)(B) sets out the situations for deeming that a policy is approved within a State.

110.1 - Outline of Complaint Referral Process

(Rev. 1, 10-01-03)

RO-2700

Representatives of CMS, the Office of the Inspector General (OIG) and the Department of Justice (DOJ) have consulted to develop a coordinated procedure for the screening, investigation, and prosecution of cases arising under these penalty provisions.

The Fraud Section, DOJ, has expressed great interest in the prosecution of these cases and has sent an official communiqué to all U.S. Attorneys addressing the existence and importance of the Medigap law and alerting them to the probability of referrals of cases developed jointly by CMS, OIG, and by State Insurance Departments.

A - CMS/OIG Agreement - CMS and OIG have reached the following agreement as to the division of functional responsibilities with regard to the screening and investigation of alleged violations of §1882(d):

1 - CMS, through its Regional Offices, is responsible for the preliminary screening of complaints and for providing information regarding the complaints to the appropriate State Insurance Department.

2 - The OIG is responsible for the investigation of cases referred by the CMS RO and for coordinating investigatory activities with the State Insurance Departments if requested and warranted. Further, OIG will provide any necessary liaison between State Insurance Departments and the U.S. Attorneys.

B - CMS RO Responsibilities - Upon receipt of a complaint, the RO sends an informational copy of the complaint and any supporting documentation to the Regional Office of the Inspector General. The Special Agents in Charge will serve as the OIG contact point for CMS referrals.

Additionally, the RO sends a copy of the original complaint and any supporting documentation to the appropriate State Insurance Department. This is to be accompanied by a request for information as to the status of any State investigation regarding the same agent or company or the specific case in question.

l - If the State indicates that it is currently investigating, or intends to investigate the agent or company, the RO provides any information which may be helpful to the State and advise the State of the existence of the Federal penalty provisions and the availability of investigatory advice and/or assistance from the Regional Office of the Inspector General.

If the facts also indicate that a Federal violation may exist, the RO should keep the file open and request that the State advise them as to the status and, eventually, the disposition of the case.

If the facts indicate a possible State violation but no Federal violation, the RO out the case after referring it to the appropriate State Insurance Department.

In either event, the RO should respond to the complainant that the case has been referred to the State Insurance Department for investigation. The RO sends a copy of this response to the State, Regional OIG, and to the Medigap Operations Staff (MOS).

2 - Where the State indicates that it does not plan to take action on the case, or where no response is received from the State within a reasonable period of time, i.e., not more than 30 days, the RO should proceed to screen the case. This activity consists of:

- Verifying the facts alleged in the complaint; and
- Determining whether the facts appear to constitute prohibited activity.

3 - Where preliminary screening indicates that a mistake of fact exists, or that the facts do not indicate a Federal violation, the RO should respond to the complainant and attempt to clarify the misunderstanding. The RO sends a copy of the RO response to the complainant to MOS, the Special Agent in Charge, and the appropriate State Insurance Department.

Verification of Facts - The carrier or intermediary logs in complaints as they are received and establishes appropriate procedures to ensure that follow-up action is taken on any request for additional information. Verification of facts may include interviewing the complainant (either by phone or in person, as appropriate) to:

- Determine whether the facts, as originally reported, are accurate and precise;
- Clarify statements that are confusing or contradictory as originally recorded.
- Secure any missing or additional information; and
- Determine whether any similar complaints or additional information may be derived from others (e.g., relatives or neighbors).

In interviewing the complainant and others, keep in mind the substantive facts that may lead to prosecution. The carrier or intermediary uses the suggested format for referral to the Regional OIG as a checklist for the interview. As far as possible, the RO should keep the complainant informed of the status of the action taken on the complaint. So as to maintain a high level of cooperation; inform the complainant when he can expect to be contacted again, who will contact him, etc.

It is important that the RO **not** directly contact either the agent or the insurance company involved since this falls within the purview of investigation and is the function of the OIG.

Referral to the Regional Office of the Inspector General - When the preliminary screening process reveals an indication that the Federal law has been violated, refer the case to the Regional OIG for additional development. The OIG performs the necessary investigation and coordinates with the appropriate U.S. Attorney for prosecution. At this point, CMS will cooperate with any request by the U.S. Attorney, State Insurance Department, and OIG to promote timely and successful prosecution.

If there should be any questions regarding this screening and referral activity, contact the Director, Medigap Operations Staff at the address below.

Centers for Medicare & Medicaid Services
Director, Medigap Operations Staff
7500 Security Blvd.
Baltimore, Maryland 21244-1850

110.2 - Preliminary Screening and Referral to Regional Office of the Inspector General

(Rev. 1, 10-01-03)

RO-2700

The Regional Office should perform preliminary screening activities, which may include interviewing the complainant in person or by phone (if appropriate), in order to reach a determination as to referral of the case for further investigation to the Special Agent in Charge, Office of Investigations, Regional Office of the Inspector General, HHS.

At the point where the RO believes that there exists an indication of the violation of one of the Federal penalty provisions, the RO should prepare a formal referral to the Regional OIG. In cases where there is uncertainty as to whether the Federal law has been violated, the case should be referred notwithstanding the uncertainty. The referral should reflect the following information:

A. Type of violation, e.g., the complainant alleges a violation of §1882(d)(2);

B. Name, address, and telephone number of the complainant; and

C. A narrative description of the facts, which should include:

1. All circumstances regarding the contact made by the subject with the beneficiary:

    a. Type of contact (phone, personal);

    b. Stated reason (if any) for selection of the beneficiary by the subject making the contact, e.g.:

        i. Beneficiary lives in a senior citizens community or complex;

        ii. The existence of another insurance policy with the same company; and

        iii. Referral by a third party.

2. Date, time, place, and duration of all contacts;

3. Words that were used to gain entry into the beneficiary's home, e.g., "I'm from Medicare," "…SSA," or other Federal Government agency;

4. Details of the subject's sales pitch or presentation:

    a. Was there a discussion of the existence of other health insurance policies currently held by the beneficiary?

    b. Did the agent know that his policy was duplicative of Medicare or a currently held policy?

    c. Amount of premium of policy that agent was trying to sell. Obtain a copy of the policy if possible;

    d. Existence of any hard sell or intimidation tactics on the part of the agent.

5. Details of the Agent's exit:

    a. Business card left by agent; and

    b. Follow-up calls by agent or others.

D. Other Information:

1. Name of contact person in the Regional Office;

2. Copy of the original complaint; and

3. Any other supporting documentation.

110.3 - CMS Regional Office Quarterly Report on Medicare Supplemental Health Insurance Penalty Provision Activity

(Rev. 1, 10-01-03)

RO-2700

RO's should submit to the Director, Medigap Operations Staff, a report summarizing activities with regard to the screening and referral of complaints falling under the penalty provisions of §1882(d). This report will be used to compile the Secretary's report to Congress as required by §1882(f)(2). Under the terms of this paragraph, the Secretary must submit a report to Congress beginning July 1, 1982 (and at least every two years thereafter) evaluating, among other things, the effectiveness of the criminal penalties. The following information from the Regional Offices is necessary for that evaluation.

110.3.1 - Statistics

(Rev. 1, 10-01-03)

RO-2700

The number of complaints received broken down by the type of alleged violation, e.g., §1882(d)(2).

The origin of the complaints:

- Complaint was made directly to RO;
- Complaint was referred by other Federal agency; State agency;
- Complaint was referred by consumer group;
- Other;
- The number of interviews (contacts) held to validate the facts of the case;
- The number referred (after screening) to the Regional Office of the Inspector General for investigation; and
- The number of cases closed-out:
    - For mistake or misunderstanding;
    - Referral to State for violations of State law;
    - Other.

- The number of cases prosecuted and, for each, the name of the agent/company and disposition of the case; and

- The number of cases currently pending.

110.3.2 - Narrative

(Rev. 1, 10-01-03)

RO-2700

The RO provides information as to the overall success of the complaint validation and referral procedure including the extent of cooperation among CMS, OIG, State Insurance Departments, and the U.S. Attorneys. This information will be used to correct or strengthen existing procedures.

This report should be submitted by the 15th of the month following the report quarter.