CMS Manual System

Pub. 100-06 Medicare Financial Management

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

Transmittal 33 **Date: February 6, 2004**

CHANGE REQUEST 3109

I. SUMMARY OF CHANGES: The CMS has decided to streamline the claims crossover process to better serve our customers. Medicare complementary insurers (i.e., non-Medigap plans), Title XIX State Medicaid Agencies, and Medigap plans—collectively known as coordination of benefit (COB) trading partners—that are eligible to receive Medicare paid claims directly from CMS for purposes of calculating their secondary liability will no longer have to sign separate agreements with individual Medicare contractors. Each COB trading partner will now enter into one national Coordination of Benefits Agreement (COBA) with CMS' consolidated claims crossover contractor, the Coordination of Benefits Contractor (COBC). Likewise, each COB trading partner will no longer need to prepare and send separate eligibility files to Medicare intermediaries or carriers nor receive numerous crossover files. The COBC shall be designated to collect crossover fees from all COB trading partners (except for Title XIX State Medicaid Agencies which are exempt from such fees) on behalf of CMS.

Within the revised manual sections, Medicare intermediaries and carriers are notified about changes to financial management claims crossover processes that will result from the implementation of COBA. They are also directed to a section within Chapter 28 of the Medicare Claims Processing Manual where they can obtain more specific operational guidance regarding the new consolidated claims crossover process.

NEW/REVISED MATERIAL - EFFECTIVE DATE: July 1, 2004
***IMPLEMENTATION DATE:** July 6, 2004

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	1/450/ Coordination of Medicare and Complementary Insurance Programs
R	1/460/ Coordination of Medicare with the Federal Grants-In-Aid Program (MEDICAID)
R	1/460.1/ Furnishing Title XVIII Claims Information
R	1/460.2/ Treatment of Administrative Cost of Furnishing Information to State Agencies

R	1/480/ Coordination of Medicare and Medicare Supplemental (Medigap) Health Insurance Policies

***III. FUNDING:**

These instructions should be implemented within your current operating budget.

IV. ATTACHMENTS:

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

***Medicare contractors only**

450 - Coordination of Medicare and Complementary Insurance Programs

(Rev. 33, 2-6-04)

A1-1601, B1-4601

The release of title XVIII claims information for complementary health insurance purposes is permitted (under specified conditions) by Regulation No. 1 (Disclosure of Official Records and Information). This section establishes financial policies concerning identification of costs related to the release of this information by the contractor.

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

A complementary insurer must pay the required charges for the release of Medicare claims information. The Medicare program absorbs charges for supplying duplicate Medicare Summary Notice (MSN) or billing forms to beneficiaries, their authorized representatives, and to SSOs. (See Medicare Bill Processing, Chapter 21, Medicare Summary Notice).) If a contractor has a written agreement with a complementary insurer to provide Medicare claims information, it may not charge a fee to anyone, other than the complementary insurer, for this effort.

The CMS will begin efforts to consolidate the claims crossover process under the Coordination of Benefits Contractor (COBC) starting on July 6, 2004. By that time, the COBC will have started the process of marketing and entering into Agreements, known as Coordination of Benefits Agreements (COBAs), with complementary insurers as well as other trading partners. The COBC will also collect the associated crossover fees once COBAs have been executed. Refer to Pub.100-4, Medicare Claims Processing Manual, §70.6 for more details.

A - Release to an Outside Organization

Under appropriate conditions, the contractor is **required** to release Medicare billing information to another insurer that may or may not be a Medicare contractor or a local Government agency which is **not** participating in a Federal grants-in-aid program. This may involve occasional requests for claims information and arrangements for the routine release of information on **every** bill on which the requestor is identified as the complementary insurer. CMS assumes that complementary insurers desiring the routine release of Medicare claims information will accept these Medicare claim records in electronic format.

1. Where complementary insurers **occasionally** request Medicare claims information, the contractor shall furnish it at a standard charge of $1.70 per item. (The standard charge is intended to cover the costs of processing, handling, correspondence, files search, and copying.) It is the contractor's responsibility to determine that the request meets the conditions for the release of confidential information and to bill and account for resulting revenues.

2. Where a complementary insurer routinely desires to have Medicare claims information, the contractor shall charge the standard rate set forth in the initial budget and

performance requirements (BPR) package for that fiscal year. It shall charge the costs of releasing claims information to outside organizations to the Medicare program, and credit income to the program. The chief difference between the above alternatives is the willingness of the requestor to accept and pay for information on **selected** bills (including paper claims) or **all** bills (electronic transfers) designating the requestor as complementary insurer.

3. To ensure that direct costs are covered for low volume complementary insurers, contractors may charge the standard rate per claim or a monthly fee of $100.00, whichever is greater, for electronic or manual claims.

B - Cost Accounting

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

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

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

*17 percent of line 1 is attributable to inquiries.

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

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

The complementary insurance rate will be the determined shared cost (50 percent) of the national average cost per claim of all contractors, computed in accordance with the criteria contained in this section. The rate will be reviewed and updated bi-annually and will be included in the initial

BPR package each fiscal year. CMS has determined that the above criteria are necessary to fulfill normal claims processing requirements and are of mutual benefit to Medicare and the complementary insurer.

The contractor shall include the credit for Medicare claims information transferred on the appropriate line of the face-sheet and Schedule A of Form CMS 1523 or 1524 for each reporting use of the form (Budget Request (BR), Interim Expenditure Report (IER), and FACP). On an annual basis, the contractor shall report the detail of these credits on the credit schedule report of Form CMS 1523 or 1524 (FACP).

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

Once CMS has fully consolidated the claims crossover process under the COBC on February 1, 2005, that entity will have exclusive responsibility for collection and reconciliation of crossover claim fees for those Medigap and non-Medigap claims sent to it by intermediaries and carriers to be crossed over to COBA trading partners. (See Pub.100-4, Chapter 28, §70.6.)

460 - Coordination of Medicare with The Federal Grants-In-Aid Program (Medicaid)

(Rev. 33, 2-6-04)

A1-1602, B1-4602

CMS furnishes Medicare billing information to State agencies or their fiscal agents for Medicaid purposes at no charge to the State or claims submitter. This section establishes the policy related to transmitting the Medicare billing information to Medicaid. (See The Medicare Claims Processing Manual, Chapter 22, Medicare Summary Notices and other Beneficiary Notices for requirements for disclosure.) *Once CMS implements the consolidated claims crossover process, it will furnish Medicare billing information to State Medicaid Agencies (SMAs) through its consolidated claims crossover contractor, the COBC.*

460.1 - Furnishing Title XVIII Claims Information

(Rev. 33, 2-6-04)

A1-1602.1, B1-4602.1

The contractor shall furnish Medicare billing information to Medicaid upon request of the State agency or its fiscal agents. It shall provide it at no charge to Medicaid as long as the information can be used in the format given by Medicare:

- A copy of the billing/claims form;
- A copy of the Medicare Summary Notice;

- A copy of the billing form and any attachments thereto; or
- Electronic transfer containing the information described in Claims Processing Manual Chapter 28.

Where the State has the systems capacity to process data generated in electronic media, the contractor shall provide the information at no charge. Where the State does not have the capacity to process electronic data but must use hardcopy, there is no charge for the information. If, however, the State or its fiscal agent has the capacity to process electronic data, but requests the information on hardcopy, the contractor shall charge the State $.30 per claim for the information furnished. The RO has the responsibility of determining whether the States have the systems capacity.

Some State agencies may want the contractor to furnish the information in a format other than the standard format described in Claims Processing Manual Chapter 28. If the contractor is willing to undertake such additional services for the State, it shall develop an agreement with the State. It shall include terms by which the State will reimburse it on a reasonable cost basis for the additional service provided. The cost includes both direct and indirect costs.

For more details regarding how the crossing over of claims to State Medicaid Agencies will be handled under the COBA process, refer to Pub.100-4, Chapter 28, § 70.6

460.2 - Treatment of Administrative Cost of Furnishing Information to State Agencies

(Rev. 33, 2-6-04)

A1-1602.2, 4602.2

*Until CMS consolidates the Medicaid claims crossover process under its Coordination of Benefits Contractor (COBC), t*he contractor shall charge the administrative costs incurred in furnishing billing information for Federal grants-in-aid program purposes, including the cost of transfer, to the title XVIII program in the appropriate departments.

It shall treat amounts collected from State agencies for information furnished on hardcopy where the State has the systems capacity to process electronic data as a credit to Medicare. It shall report this on Form CMS-1523B/1524B in the credit section.

The contractor shall deposit in its regular bank account amounts collected from State agencies for additional services performed. It shall clearly identify those funds as to source and purpose to facilitate auditing. The funds must be deposited in the regular bank account because the cash outlay for the cost of furnishing billing/claims information comes initially from this account.

480 - Coordination of Medicare and Medicare Supplemental (Medigap) Health Insurance Policies

(Rev. 33, 2-6-04)

B1-4607

The transfer of title XVIII claims information to Medicare supplemental insurers is **required** (under specified conditions) by §1842(h)(3)(B) of the Social Security Act, as enacted by §4081 of OBRA 87.

- The physician or supplier involved must be a participating, physician or supplier,
- The beneficiary must assign Medigap benefits to the physician or supplier, and
- The policy named by the beneficiary must be a true Medigap policy to the exclusion of employer coverage and plans operated by labor organizations.

Refer to Section 480.1 Exhibit for a list of Medigap insurers.

*Carriers and DMERCs shall cease claim-based Medigap crossover effective October 4, 2004. CMS shall have consolidated all claim-based Medigap crossover activities under its Coordination of Benefits Contractor (COBC) by that date. Under CMS' Coordination of Benefits Agreement (COBA) Initiative, participating providers and suppliers will be **required** to include a five-digit claim-based COBA ID on the beneficiary's incoming claim in order for the transfer of Medicare claims to Medigap insurers that do not submit eligibility files to identify their insureds to occur. (See Pub.100-4, Chapter 28, §70.6.)*