CMS Manual System

Pub. 100-06 Medicare Financial Management

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

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CHANGE REQUEST 3218

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's 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.

The Coordination of Benefits Agreement (COBA) crossover consolidation initiative will initially be implemented on a limited scale during the period from July 6, 2004, to October 1, 2004. During this time, approximately eight COBA trading partners that will serve as beta-site testers will participate in a parallel production crossover process (a pilot only for COBA trading partners using production/live data). Beginning with the implementation of the October 2004 systems release, the COBA process will begin to be implemented on a larger scale.

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 to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS:
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	1/450/ Coordination of Medicare and Complementary Insurance Programs
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
	Recurring Update Notification

***Medicare contractors only**

450 - Coordination of Medicare and Complementary Insurance Programs

(Rev. 38, 04-09-04)

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. The effort to consolidate the claims crossover process, known as the Coordination of Benefits Agreement (COBA) initiative, will be implemented initially on a small-scale from July 6, 2004, to October 1, 2004. By July 6, 2004, the COBC will have started the process of marketing and entering into Agreements, known as Coordination of Benefits Agreements (COBAs), with trading partners that will initially participate as beta-site testers during a parallel production crossover period. The COBA process will not begin on a fuller-scale until the implementation of the October 2004 systems release. In addition to executing national COBAs, the COBC will also invoice, collect, and reconcile fees arising from the claims that it crosses over to trading partners. Refer to Pub.100-04, 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/about May 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.100-04, Chapter 28, §70.6.)

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

(Rev. 38, 04-09-04)

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 continue with claim-based Medigap crossovers until they receive direction from CMS, via a future instruction, to do otherwise.