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Introduction – Crossover Claims

Crossover is the transfer of processed claim data from Medicare operations to Medicaid (or state) agencies and private insurance companies that sell supplemental insurance benefits to Medicare beneficiaries. The Centers for Medicare & Medicaid Services (CMS) Coordination of Benefits (COB) program identifies the health benefits available to a Medicare beneficiary and coordinates the payment process to ensure appropriate payment of Medicare benefits. There are two ways for Medicare contractors to be notified that Medicare claim information should be crossed over to the beneficiary's supplemental insurance company:

- Coordination of Benefits Agreement (COBA) crossovers
- Medigap claim-based crossovers

1. Coordination of Benefits Agreement

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 28, §70.6

The Coordination of Benefits Agreement (COBA) program establishes a nationally-standard contract between the CMS Benefits Coordination and Recovery Center (BCRC) (formerly the Coordination of Benefits Contractor), and supplemental insurers and Medicaid agencies. This process consolidates the activities that support the collection, management, and reporting of other insurance coverage for Medicare beneficiaries. For eligibility-based COBA crossovers, private insurers and Medicaid agencies supply the BCRC with their eligibility file and indicate the types of claims they would like to receive. This information is stored at each CWF host site and is used to flag Medicare claims for crossover as they are sent to CWF for processing. The claims that have been flagged for crossover are then stored in the contractor's processing system until the claims have completed the processing cycle and are released for payment. At that time the contractor sends the claims to the BCRC. The BCRC will then combine all the claims for a particular insurer based on their COBA ID and send them to that insurer following the terms of the COBA that the insurer has on file with the BCRC. When claims are sent to the BCRC, the MA18 (supplemental insurance) or MA07 (Medicaid) codes will be reported on the Medicare remittance advice (RA) (see Chapter 17 of this manual for more information about remittance advice codes).

In some instances, claims that were flagged for crossover will be rejected from the BCRC because of claim data errors. You will be notified by letter advising you when a claim has been rejected from the crossover process. The letter will include specific information about the claim, such as the claim control number and the beneficiary's Medicare ID and last name, as well as an explanation of the data error. If a claim has been rejected from the crossover process, you will need to manually submit the claim with a copy of your RA to the beneficiary's crossover company.

2. Medigap

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 28

A Medigap policy is a health insurance policy or other health benefit plan offered by a private company to those entitled to Medicare benefits. It provides reimbursement for Medicare charges not reimbursable because of the applicability of deductibles, coinsurance amounts, or other Medicare imposed limitations. A policy or plan offered by an employer to employees or former employees, as well as that offered by a labor organization to members or former members, is not considered part of the Medigap provision.

The BCRC is responsible for Medigap claim-based crossover as well as eligibility-based Medigap crossover. Claim-based Medigap crossover is only available for participating suppliers. Beneficiaries must provide the claim-based Medigap COBA ID number of the supplemental insurer and their individual policy number to you for inclusion on each claim. The submitted COBA ID must be validated at CWF in order for claims to be flagged for crossover. After validation of the COBA ID, the claims are stored in the contractor's processing system and sent to the BCRC in the same manner as eligibility-based COBA crossover claims.

Medigap Procedures

Medicare beneficiaries initiate the automatic transmittal of claims information by exercising their right to assign payment of Medigap, as well as Medicare benefits, for the services of participating suppliers.

It is recommended that the beneficiaries show you their Medigap enrollment card (supplied by the Medigap insurer) to ensure actual coverage is available. The card should clearly indicate that the policy is designated as Medicare supplemental coverage. Always try to maintain a copy of the card in your beneficiary's file.

The Medigap policy information should be shown in items 9-9d of the CMS-1500 (02/12) claim form:

- The word "Medigap" (or an abbreviation of the word; e.g., MG) and individual Medigap policy number must be present on the claim in item 9a of the CMS-1500 form.
- The Medigap COBA ID number must be present on the claim in item 9d on the CMS-1500 form.

NOTE: Claim-based Medigap COBA ID numbers are 5-digit numbers in the range 55000-59999 and are assigned by the BCRC. A list of Medigap companies and their corresponding COBA ID numbers is available on the CMS website at https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/COBA-Trading-Partners/Coordination-of-Benefits-Agreements/Coordination-of-Benefits-Agreement-page.html in the Downloads Section. Refer to the PDF document titled *September 2020 – Medigap Claim-Based COBA IDs for Billing Purposes.*

Medicare beneficiaries must indicate that they have assigned their Medigap benefits to you by signing item 13 of the CMS 1500 (02/12) claim form. This authorization is in addition to their assignment of Medicare benefits as indicated by their signature in item 12. Separate signatures authorizing Medigap assignment must be retained in your files when signature on file is authorized.

The following is suggested wording for the Medigap assignment agreement authorization:

Patient's Assignment Authorization (CMS-1500, Item 13):

NAME OF BENEFICIARY

BENEFICIARY'S MEDICARE ID
MEDIGAP POLICY NUMBER

"I request that payment of authorized Medigap benefits be made on my behalf to_____for any services furnished me by that 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."

Signature_____ Date_____

Missing signature or the lack of an indication of signature on file is reason for the contractor not to transfer claim information to the BCRC.

If you bill electronically, you must enter the 5-digit Medigap claim-based COBA ID in field NM109 of the NM1 segment in loop 2330B and the Medigap policy number in field NM109 of the NM1 segment in loop 2330A of the Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X12-N 837 professional claim for purposes of triggering Medigap claim-based crossovers. Retail pharmacies that wish to trigger claim-based crossovers to Medigap when billing in the NCPDP format should enter the Medigap claim-based COBA ID in the 301-C1 (Group ID) portion of the Transmission Insurance Segment in the NCPDP format version D.0. The beneficiary's Medigap policy number is reported in the 359-2A (Medigap ID) portion of the Insurance Segment of the NCPDP format version D.0.

It should be noted that no development for missing or incomplete information will be done by the DME MAC. When any of the required information is missing or incomplete, no transfer of claim information will occur.

When submitting claims under this procedure, you agree:

1. To complete and submit promptly the appropriate Medicare billing form for all services covered by the request for payment.

2. To incorporate, by stamp or otherwise, the following information on any bills you send to Medicare beneficiaries: "Do not use this bill for claiming Medicare benefits. A claim has been or will be submitted to Medicare on your behalf." This requirement is necessary to prevent beneficiaries from submitting duplicate claims.

3. To cancel the authorization upon request of the beneficiary.

4. To make the beneficiary signature files available for contractor inspection upon request.

When Medigap claims are sent to the BCRC, the MA18 (supplemental insurance) code will be reported on the remittance advice. When Medigap claims are **not** sent to the BCRC due to incomplete or invalid information, the MA19 code will be reported on the remittance advice; you will have to file a separate claim to the Medigap insurer with a copy of the RA. Within a reasonable time, if you have not heard from the Medigap insurer, it will be necessary for you to **follow up with the Medigap insurer**.

The DME MAC's responsibility ends when Medicare payment data has been sent to the BCRC, thus we would be unable to furnish you any information about Medigap benefits. The law states that the Medigap insurer must treat the Medicare claim data as a request for payment if you are participating in the Medicare program.