



Clarification Coordination of Benefits Agreement (COBA) Medigap Claim-Based Crossover Process

Medicare coordinates a patient’s supplemental insurance benefits with the Medicare Coordination of Benefits Contractor (COBC) during claims processing. Certain supplemental insurance plans may provide an “automatic crossover” and the provider would only submit a claim to Medicare and would receive notification from Medicare plus the patient’s supplemental insurance. Patients with a Medigap plan may also take advantage of the automatic crossover, but there are some Medigap plans that are not set up for automatic crossover. Providers must then take an extra step and populate key Medigap plan information on the claim for the crossover to occur.

The TrailBlazer Web site provides a list of supplemental insurance plans that participate in the automatic claims crossover process and a list of those Medigap insurance plans that do not. Providers are encouraged to verify the patient’s supplemental insurance coverage to the lists to determine if any additional action should be taken prior to filing a claim.

The chart below will assist Medicare Part B providers in deciding whether to take the manual step to create the crossover action or allow the automatic process to occur.

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| Step 1 | <ul style="list-style-type: none"> Identify whether the patient owns a supplemental insurance policy. If yes, check the COBA Trading Partners’ Contact List in Production. The insurance plans on this list allow for the automatic crossover from Medicare to the supplemental insurance. http://www.cms.gov/COBAgreement/downloads/contacts.pdf If the insurer is listed, no further action is needed. After processing the claim, Medicare will automatically send the claim to that insurer. |
| Step 2 | <ul style="list-style-type: none"> If the insurance company is not listed on the COBA Trading Partners’ Contact List in Production, research the COBA Medigap Claim-Based ID List. The insurance plans on this list require providers to take an additional step when filing the Medicare claim(s). https://www.cms.gov/Medicare/Coordination-of-Benefits/COBAgreement/index.html If the insurance company is shown and the provider is “a participating provider,” specific information and the COBA identifier must be listed in Items 9–9d on the claim form (or the electronic equivalent). The COB identifier is a five-digit number ranging from 55000 to 59999. After processing the claim, Medicare will send the claim to that insurer for supplemental consideration. |

The instructions below are for the CMS-1500 claim form (paper) or the electronic equivalent and must be completed for Medigap crossover to occur:

Item 9

Enter the last name, first name and middle initial of the enrollee in a Medigap policy if it is different from that shown in Item 2. Otherwise, enter the word "SAME." If no Medigap benefits are assigned, leave blank.

Note: Only participating physicians and suppliers should complete Item 9 and its subdivisions and only when the beneficiary wishes to assign his benefits under a Medigap policy to the participating physician or supplier. 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 benefits under a Medigap policy to a participating physician/supplier is called a mandated Medigap transfer.

Medigap

Medigap policy meets the statutory definition of a "Medicare supplemental policy" contained in Section 1882(g)(1) of Title XVIII of the Social Security Act and the definition contained in the NAIC Model Regulation that is incorporated by reference to the statute. It is a health insurance policy or other health benefit plan offered by a private entity to those persons entitled to Medicare benefits and is specifically designed to supplement Medicare benefits. It fills in some of the "gaps" in Medicare coverage by providing payment for some of the charges for which Medicare does not have responsibility due to the applicability of deductibles, coinsurance amounts or other limitations imposed by Medicare. It does not include limited benefit coverage available to Medicare beneficiaries such as "specified disease" or "hospital indemnity" coverage. Also, it explicitly excludes 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.

Do not list other supplemental coverage in Item 9 and its subdivisions at the time a Medicare claim is filed. Other supplemental claims are forwarded automatically to the private insurer if the private insurer contracts with the carrier to send Medicare claim information electronically. If there is no such contract, the beneficiary must file his own supplemental claim.

If you are a participating provider or supplier and the beneficiary wants Medicare payment data forwarded to a Medigap insurer under a mandated Medigap transfer, all of the information in Items 9, 9a, 9b and 9d must be complete and accurate. Otherwise, the Medicare contractor cannot forward the claim information to the Medigap insurer.

Item 9a

Paper: Enter the policy and/or group number of the Medigap insured preceded by MEDIGAP, MG or MGAP.

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|-------------|-------|--|
| Electronic: | 2330B | NM108 Identification code qualifier |
| | | NM109 Payer primary identifier |
| | | NM103 Payer last name or organization name |
| | 2320 | SBR04 Insured's group name |

Item 13

Paper:

Currently, the signature in this item authorizes payment of mandated Medigap benefits to the participating physician or supplier if required. Medigap information is included in Item 9 and its subdivisions. The patient or his authorized representative signs this item, or the signature must be on file as a separate Medigap authorization. The Medigap assignment on file in the participating provider of service's/supplier's office must be insurer-specific. It may indicate that the authorization applies to all occasions of service until it is revoked.

Effective April 1, 2008, the patient's signature or the statement "signature on file" in this item authorizes payment of medical benefits to the physician or supplier. The patient or his authorized representative signs this item or the signature must be on file separately with the provider as an authorization. However, note that when payment under the Act can only be made on an assignment-related basis or when payment is for services furnished by a participating physician or supplier, a patient's signature or a "signature on file" is not required for Medicare payment to be made directly to the physician or supplier.

The presence of or lack of a signature or "signature on file" in this field will be indicated as such to any downstream coordination of benefits trading partners (supplemental insurers) with whom CMS has a payer-to-payer coordination of benefits relationship. Medicare has no control over how supplemental claims are processed, so it is important providers accurately address this field as it may affect supplemental payments to providers and/or their patients.

In addition, the signature in this item authorizes payment of mandated Medigap benefits to the participating physician or supplier if required. Medigap information is included in Item 9 and its subdivisions. The patient or his authorized representative signs this item, or the signature must be on file as a separate Medigap authorization. The Medigap assignment on file in the participating provider of service's/supplier's office must be insurer-specific. It may state that the authorization applies to all occasions of service until it is revoked.

Note: This can be "Signature on File" for paper or electronic claims. A computer-generated signature will be accepted for electronic claims only.

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| Electronic: | 2300 | CLM08 Condition or response code |
| | | CLM09 Release of information code |

Medigap Online Resources

TrailBlazer Web site:

- COB Information:
<http://www.trailblazerhealth.com/Claims/SupplementalInsurance.aspx>
- CMS-1500 Claim Form and Unprocessable/Rejected Claims manual:
<http://www.trailblazerhealth.com/Publications/Training Manual/claim form instructions.pdf>

CMS Web site:

- MLN Matters Number: MM5837, Clarification Regarding the Coordination of Benefits Agreement (COBA) Medigap Claim-based Crossover Process:
<http://www.cms.gov/MLNMattersArticles/downloads/MM5837.pdf>
- MLN Matters Number: MM5601, Transitioning the Mandatory Medigap (“Claim-based”) Crossover Process to the Coordination of Benefits Contractor (COBC):
<http://www.cms.gov/mlnmattersarticles/downloads/MM5601.pdf>
- CMS Change Request (CR) 5837:
<https://www.cms.gov/transmittals/downloads/R1420CP.pdf>
- CMS List of Automatic Crossover Trading Partners:
<http://www.cms.gov/COBAgreement/downloads/contacts.pdf>
- Internet Only Manual (IOM) Chapter 28-Coordination with Medigap, Medicaid, and other Complementary Insures:
<https://www.cms.gov/manuals/downloads/clm104c28.pdf>
- CMS COB Web site listing claim-based COB ID numbers:
<https://www.cms.gov/Medicare/Coordination-of-Benefits/COBAgreement/index.html>