Twelfth National Education Call on Medicare Fee-For-Service (FFS) Implementation of HIPAA Version 5010 and D.0: Coordination of Benefits (COB)

Brian R. Pabst
Technical Advisor &
COBA Government Task Leader
Division of Medicare Benefits Coordination
Office of Financial Management
Centers for Medicare & Medicaid Services
November 17, 2010

Purpose of Today's Call

1. To provide a general overview of the Medicare FFS crossover/COB process
2. To discuss major areas of change from HIPAA 4010A1 to HIPAA 5010 (including Errata) in a Medicare FFS COB context
3. To highlight important Medicare FFS COB-specific information related to NCPDP D.0 claims
4. To review timelines for testing and deadlines for production
5. To provide guidance regarding how to prepare
6. To obtain feedback from participants regarding questions and concerns within a Medicare FFS COB context

Today's Agenda

- General Overview
- Medicare Specific COB Changes
- Timelines and Deadlines
- What you need to do to prepare
- Q & A

General Overview of the Medicare FFS COB/Crossover Process

- What is Coordination of Benefits (COB)?
  - Generically, “COB” refers to processes or methods that are applied to ensure that various insurers and health benefit plans pay in the correct order
  - Under FFS Medicare, COB relates to Medicare Secondary Payer (MSP) processes as well as the Medicare FFS crossover (or Coordination of Benefits Agreement/COBA) process

- What is Crossover?
  - “Crossover” is a FFS Medicare term of art; no other insurer uses this term for its own COB process.
  - Crossover refers to the process whereby the Coordination of Benefits Contractor (COBC), on behalf of CMS, transfers Medicare FFS claims electronically to other insurers or health plans
  - There are two types of crossover: automatic (eligibility-file based) & Medigap claim-based

General Overview of the Medicare FFS COB/Crossover Process

- How Does the Automatic Crossover Process Work?
  - Insurer/payer signs a standard crossover agreement with the COBC
  - Within the COBA crossover agreement, the insurer/payer designates its claims selection criteria and file frequency specifications
  - Insurer/payer sends a file containing eligibility information for its covered members to the COBC
  -
  - The COBC sends the covered members via a secure maintenance transaction to Medicare's Common Working File (CWF), where the supplemental insurer/payer's eligibility information is then posted. (This information may be updated bi-weekly or monthly.)
  - The COBC also sends the insurer/payer's claims selection criteria to CWF on a weekly basis
  - After the Medicare Administrative Contractors (MACs) and Durable Medical Equipment MACs (DME MACs) adjudicate their claims, they send them to CWF for normal approval processing

General Overview of the Medicare FFS COB/Crossover Process

- How Does the Automatic Crossover Process Work? (cont.)
  - CWF searches for the insurer/payer eligibility information and claims selection criteria in association with specific claims while performing its normal processing routines
  - CWF either selects or excludes individual claims from being eligible for crossing over
  - CWF marks claims history to indicate whether it selected or excluded each claim. (This information is made available to Medicare MACs and DME MACs as well as 1-800 Medicare staff.)
  - If CWF selects a claim to cross over, it returns a trailer to the Medicare contractor through its shared system, causing it to send the claim to the COBC after the claim has exited the contractor's payment floor and finalized
  - COBC subjects incoming claims to business-level (claim structure) edits. "Passed" claims then go on for HIPAA translation and edit validation

General Overview of the Medicare FFS COB/Crossover Process

- How Does the Automatic Crossover Process Work? (cont.)
  - COBC sends resulting HIPAA compliant claims to the appropriate insurers/payers on either a daily or weekly basis, as per individual insurer/payer specifications
  - COBC sends a detailed reporting of claims that do not pass business level editing or HIPAA compliance back to the originating Medicare contractors
  - Various insurers/payers also notify the COBC when they cannot accept crossover claims. The COBC, in turn, includes this information on the detailed reporting that it returns to the originating Medicare contractors
  - Contractors issue special notification letters denoting reasons why the claims could not be crossed over to the “participating” Medicare FFS providers/physicians/suppliers that originally billed the claims to Medicare

General Overview of the Medicare FFS COB/Crossover Process

- How does the Medigap claim-based crossover process work?
  - A very small number of Medigap insurers do not participate in the automatic (eligibility file-based) crossover process.
  - A listing of entities that participate in this process may be referenced at: <http://www.cms.gov/COBAgreement/Downloads/Medigap%20Claim-based%20COBA%20IDs%20for%20Billing%20Purpose.pdf>.
  - Mechanics of the COB processes are equivalent to the automatic process, with the following exceptions:
    - Only occurs on Part B or DMEPOS claims when the physician or supplier participates with FFS Medicare; does not apply to Part A providers.
    - Only occurs when the beneficiary assigns benefits to the physician or supplier; and
    - Only occurs when the physician or supplier enters a 5-byte COBA ID (range 55000 through 55999) within item 9D of the CMS-1500 form or within the NM109 element of loop 2330B of the incoming 837 professional claim
    - For incoming NCPDP claims, the retail pharmacy supplier, or its billing agent, needs to enter the 5-byte COBA ID within field 301-C1 of the T04 segment

Medicare Specific COB Changes

- Review of HIPAA 5010 COB Changes—General
  - New 2320 AMT COB Total Non-Covered Amount element added
  - Numerous AMT segments were removed; only the 2300 AMT*F3, 2300 AMT*F5, and 2320 AMT*D will potentially appear on 837 COB claims
  - Present on Admission (POA) Indicators will be reported within various diagnosis portions of the 2300 HI segment
  - Very limited use of Secondary REF segments--only within loop 2010AA.
  - The 4010A1 837 professional claim restrictions governing group taxonomy code reporting at the 2000A PRV no longer apply
  - Covered, non-covered, co-insurance, and life-time reserve days will be reported as whole numbers, qualified by appropriate value code 80-83, within the 2300 HI segment. (Formerly reported in 2300 QTY01 or QTY02.)
  - All 837 COB claims must balance. With full 5010 implementation, claims that do not balance will be ineligible for crossing over

Medicare Specific COB Changes

- Review of HIPAA 5010 COB Changes—General
  - Anesthesia timed units will always be expressed as minutes rather than units
  - 2010AA NM109 (NPI) information for COB claims will be derived from the claim for 837-I claims but will be derived from internal provider files utilized during claims adjudication for 837-P claims
  - 2010AB N3 & N4 information will be derived from the Medicare contractor's internal provider files. (Only created when address information differs from that in the 2010AA N3 & N4 segments.)
  - For provider loop N403 elements, in most cases the required 9-digit zip code will be available, as per the data within PECOS
    - If only the base 5 zip code is available, the FFS Medicare shared system will apply a gap fill value of "9998" to complete the zip code

Medicare Specific COB Changes

- Review of HIPAA 5010 COB Changes—General
  - FFS Medicare will only create the 2010AA PER if the provider has supplied Medicare with complete contact information
  - For COB, the 2000B SBR01 [for destination payer after FFS Medicare] will always=“U”; 2000B SBR09 will always=“ZZ,” unless the payer is Medicaid, where the qualifier will be “MC”
  - For COB, the 2320 SBR01 [for all destination payers after Medicare] will always=“U”; SBR01 will always=“18”; and SBR09 will always=“ZZ”
  - Remark codes MA07, MA18, and N89 will appear in the 2320 MIA segment and within 2320 MOA segment as appropriate
  - For 837 institutional claims, Medicare FFS will not map out 2320 AMT Remaining Patient Liability segment for COB claims. For 837 professional DMEPOS claims, Medicare FFS will also not map out this segment for COB claims

Medicare Specific COB Changes

- Review of HIPAA 5010 COB Changes—General
  - For 837 professional physician-oriented claims, Medicare FFS will map out the 2320 AMT Remaining Patient Liability
  - None of the Medicare FFS claims processing systems will map out 2320 AMT COB Total Non-Covered for the Medicare crossover process in light of the rules within the TR-3 Guide
  - 2300 level PWK data will not be sent for 837 COB
  - Medicare FFS will not create the following on 837 COB claims:
    - 2000A CUR (Foreign Currency Information);
    - 2010BB REF (Payer Secondary Identifier);
    - 2010BB REF (Billing Provider Secondary Identifier);
    - 2000C HL (Patient Hierarchical Level);
    - 2000C PAT (Patient Information); and
    - 2010CA (Patient Name)

Medicare Specific COB Changes

- Review of Gap-Filling Standards
  - Gap-filling will chiefly become necessary in qualified cases when the incoming claim is 4010A1, hard copy, or DDE, but the insurer/payer is requesting a 5010 COB claim and vice-a-versa
  - For incoming paper or DDE-entered claims where the dosage qualifier information needed to create 2410 CTP05-1 is not available, Medicare FFS will always map “F2”
  - For instances involving Part B claims where the date of admission is required but not available, Medicare FFS will map the claim’s earliest service date to fulfill the 2330 DTP03 requirement when the place of service reported in loop 2300 CLM05-1=21, 41, 51, or 61
  - For the creation of the N3 segment within loops 2310E and 2310F in association with ambulance claims, Medicare FFS will map all “Xs” to meet the minimum required bytes standard

Medicare Specific COB Changes

- Review of Gap-Filling Standards (cont.)
  - Medicare FFS will map the following values to satisfy the N4 segment requirements for loops 2310E and 2310F on 837 professional ambulance claims:
    - For N401—map “Cityville”;
    - For N402—map “MD”; and
    - For N403—map “96941
  - If incoming UB04 or DDE screen-entered claims do not contain minutes in association with Admission Date/Hour, the Medicare FFS will gap-fill the minutes portion of the required DTP03 segment with the value “00”

Medicare Specific COB Changes

- HIPAA 5010 Errata changes affecting COB:
  - For 837 institutional claims, the 2430 SVD becomes situational
  - The pre-Errata version of HIPAA 5010 had made the 2430 SVD required, which has greatly impacted COB testing thus far
  - For 837 institutional claims, the 2300 CL101 (“Admission Type Code”) is now required
    - If gap-filling becomes necessary, Medicare FFS will default to “9” (Information not Available) for 837 institutional COB claims
  - For both 837-I and 837-P claims, the N401, N402, and N403 elements within loop 2330A are no longer applied; thus, gap-fill logic for these elements will be discontinued
  - For both 837-I and 837-P claims, the N4 segment is no longer required; thus, gap-fill logic for this element will be discontinued

Medicare Specific COB Changes

- NCPDP D.O Batch Claim Highlights
  - Within the Transmission Insurance Segment, Medicare FFS will map the 5-byte Medigap claim-based COBA ID within 301-C1 (Group ID)
    - Medigap policy number will be mapped to the newly created 359-2A (Medigap ID) element
  - The following will not be created for COB within the Transmission Insurance Segment: 336-8c, 115-N5, 116-N6, 314-CE, 303-C3, and 306-C6
  - Medicare HICN will be mapped to 332-CY (“Patient ID”) within the Transmission Patient Segment
  - Element 325-CP within the Transmission Patient Segment may contain a base 5-byte zip code, followed by 9998. (Will happen infrequently as a gap-fill measure.)
  - The supplier’s NPI will be derived from the incoming claim and mapped to 421-DL (“Primary Care Provider ID”) within the Transaction Prescriber Segment

Medicare Specific COB Changes

- NCPDP D.O Batch Claim Highlights (cont.)
  - Within the Transaction Prescriber Segment, elements 427-DR ("Prescriber Last Name") and 364-2J ("Prescriber first Name") will be mapped from the Medicare FFS DME MAC's internal provider file
  - Within the Transaction COB/Other Payments Segment, Medicare FFS will qualify deductible or co-insurance amounts remaining within element 338-5C. (Medicare FFS is currently using 98 or 99 to qualify these amounts within NCPDP 5.1 batch COB claims.)
  - Also, within the Transaction COB/Other Payments Segment, elements 392-MU, 393-MV, and 394-MW will not be mapped out for COB
  - Medicare FFS will not create the following elements within the Transaction Claim Segment if received on incoming claims: 461-EU, 462-EV, 463-EW, 464-EX, 354-NX, 357-NV, 995-E2, 996-G1, and 147-U7

Medicare Specific COB Changes

- NCPDP D.O Batch Claim Highlights (cont.)
  - Within the Transaction Pricing Segment, the following will not be created: 482-GE, 3483-HE, and 484-JE
  - Medicare FFS will not create the “Transaction Additional Doc” segment or “Additional Documentation Type ID,” as these relate to Certificate of Medical Necessity (CMN) information, which is no longer supported

Timelines and Deadlines

- Current 5010 COB Testing Opportunities
  - Seven (7) insurers/payers began testing the pre-Errata version of HIPAA 5010 COB with the COBC on September 27, 2010
  - The number of testers has grown to 43, representing 87 lines of business
  - Current COBA testers are receiving limited numbers of 837 institutional claims due to current 2430 SVD requirements that the COBC is enforcing
  - Clearinghouses whose insurer clients are interested in testing the pre-Errata version of HIPAA 5010 COB with COBC should ask their clients to contact their COBC EDI representatives

Timelines and Deadlines

- Timelines and Deadlines for HIPAA 5010 COB Implementation
  - CMS encourages insurers/payers to test in the pre-Errata 5010 COB claim formats with the COBC prior to April 2011
  - Insurers/payers and affiliated clearinghouses or vendors that are testing pre-Errata 5010 COB with the COBC must test the Errata versions of HIPAA 5010 after April 2011 before moving into production
  - All COB payers must have moved into production on the Errata 5010 COB claim formats no later than December 31, 2011, to comply with the January 1, 2012 cut-over deadline
  - Medicare FFS is targeting July 2011 as the timeframe for ensuring that all COB insurers/payers have begun, or will very soon begin, to test the 5010 Errata 837-I and 837-P claims formats with the COBC

How To Prepare

- Review the Technical Report Type 3 (TR3) Guides as well as Errata Change Documents.
- Providers and clearinghouses should be on the watch for CMS future-issued Companion Guides to assist with claims transmissions to Medicare.
- COB insurers/payers may reference the HIPAA 5010 COB/Crossover Companion Guide by referring to the March 25th COBVA broadcast.
  - The 5010 COB Companion Guide will be updated shortly to include additional changes, including HIPAA 5010 Errata modifications, and will thereafter be posted to the COBA website: http://www.cms.gov/COBAgreement/ .
- CMS is targeting December 2010 as the timeframe for making the NCPDP D.0 Batch Claims COB Companion Guide available for the benefit of insurers/payers and their affiliated agents.

Thanks for Your Attention!

Now……It's Q & A Time….