

Attention Providers: New Medicare Crossover Process

What is the purpose of this notice?

The Centers for Medicare & Medicaid Services (CMS) is implementing a new crossover process, the **Coordination of Benefits Agreement (COBA)**. The crossover process is the method by which claims and payment information are electronically transmitted from Medicare as the primary payer to a secondary payer, such as Medicaid, thus reducing the need for the healthcare provider to submit the same claim information to Medicaid. This notice provides guidance for your participation in the new COBA crossover claims process.

Why did I receive this notice?

YOU, an enrolled Medicare and Medicaid provider, are subject to the new COBA claims process.

What is COBA?

The new COBA process is a national standard requirement between Centers for Medicare & Medicaid Services (CMS) and other health insurance organizations, including Medicaid. COBA provides an automatic claim coordination of benefits, or crossover service, from Medicare to Medicaid and other health insurance organizations, or trading partners.

Note: This notice pertains only to Alaska Medicaid as the secondary payer.

Additional information about COBA is available on the CMS Website at:
http://www.cms.hhs.gov/COBAgreement/01_overview.asp

What claims are affected by COBA?

The new COBA process affects claims that you bill to Medicare for Dual Eligibles – those who are eligible for both Medicare AND Medicaid.

What is the purpose of COBA?

CMS implemented COBA in order to better serve providers through the streamlining of the claims crossover process. COBA provides significant advantages and improvements for you, including:

- Increased accuracy of processed claims
- Increase in the number of claims which successfully crossover from Medicare to Medicaid
- Faster payment of claims
- Reduction in the number of separately submitted claims to Medicaid as the secondary payer

How will COBA work?

CMS will transfer claim crossover functions from individual Medicare contractors (intermediaries and carriers) to a single national claims crossover contractor. This **Coordination of Benefits Contractor (COBC)** is Group Health Incorporated (GHI).

When is COBA effective?

Effective July 3, 2006, claims you submit to Medicare for Dual Eligibles will electronically crossover to Medicaid via the COBC. When you correctly file a claim for a Dual Eligible, the new COBA crossover process will be largely transparent to you.

What do I need to do?

To fully realize the benefits of COBA, you will need to include your Medicaid Billing Provider ID and Medicaid Servicing (Rendering) or Attending Provider ID on claims submitted to Medicare for Dual Eligibles for claims submitted on or after July 3, 2006.

To specify your Medicaid billing and servicing or attending provider IDs on your claim to Medicare:

- Professional claims:
 - The Medicaid Billing Provider ID is entered in the 2010AA Loop
 - The Medicaid Servicing Provider ID is entered in the 2330E or 2420A Loop
- Institutional claims:
 - The Medicaid Billing Provider ID is entered in the 2010AA Loop
 - The Medicaid Attending Provider ID is entered in the 2330D or 2420A Loop

There is no change in the fields you currently use to bill Medicare. These are additional fields to identify your Medicaid provider numbers. Refer to the attached table for specific information regarding the 837 transaction and loops.

What else do I need to be aware of?

The month of July 2006 will be a transitional month; therefore you can expect to see some crossover claims that have processed through both the new COBA process and through the former process. Due to this transition, CMS has advised that the possibility of processing duplicate claims exists. For this reason, please pay particular attention to your 835 transaction or Remittance Advice statement.

Be sure to watch for additional information that will arrive soon regarding COBA. Please submit any questions or comments to FHSC via facsimile, (907) 644-8126, or by mail to:

First Health Services Corporation
Attention: Provider Inquiry
P.O. Box 240808
Anchorage, Alaska 99524-0808

NEW MEDICARE CROSSOVER PROCESS
837 Instructions: Billing Medicare for Dual Eligibles

PROFESSIONAL CLAIMS BILLED TO MEDICARE

Medicaid Provider ID	X12 Loop ID	Description	837P
The Medicaid Billing Provider ID is entered in this field:	2010AA	Billing Provider Secondary Identification	Segment: REF01
			Field Value: 1D
			Segment: REF02
			Field Value: enter your Medicaid Billing Provider ID
The Medicaid Servicing Provider ID is entered in this field:	2330E	Rendering Provider Secondary Identification	Segment: REF01
			Field Value: 1D
			Segment: REF02
			Field Value: enter your Medicaid Rendering Provider ID
When the rendering provider for this claim line is different from the other claim lines, the Medicaid Servicing Provider ID is entered in this field:	2420A	Rendering Provider Secondary Identification	Segment: REF01
			Field Value: 1D
			Segment: REF02
			Field Value: enter your Medicaid Rendering Provider ID

INSTITUTIONAL CLAIMS BILLED TO MEDICARE

Medicaid Provider ID	X12 Loop ID	Description	837I
The Medicaid Billing Provider ID is entered in this field:	2010AA	Billing Provider Secondary Identification	Segment: REF01
			Field Value: 1D
			Segment: REF02
			Field Value: enter your Medicaid Billing Provider ID
The Medicaid Provider ID for the Attending provider is entered in this field:	2330D	Attending Physician Secondary Identification	Segment: REF01
			Field Value: 1D
			Segment: REF02
			Field Value: enter your Attending Provider Medicaid ID
When the attending provider is different from the from the attending provider for the rest of the claim, the Attending Provider Medicare ID is entered in this field:	2420A	Attending Physician Secondary Identification	Segment: REF01
			Field Value: 1D
			Segment: REF02
			Field Value: enter your Attending Physician Secondary Identifier