COORDINATING WITH MEDICARE

Fact Sheet

MASSACHUSETTS

This document explains how to submit claims when a member has both Medicare and a Blue Cross Blue Shield of Massachusetts health plan.

Refer to CMS.gov for more information about Medicare Secondary Payer (MSP) rules.

CONTENTS

KEY TERMS

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)	The law that provides continuing coverage of group health benefits to employees and their families when such coverage would otherwise be terminated.
Crossover	The process in which Centers for Medicare and Medicaid Services (CMS) adjudicates and then forwards Medicare primary claims to private health plans or Medicaid for secondary adjucation.
Group Health Plan (GHP)	In general, a health plan offered by an employer or employee organization that provides health coverage to employees and their families.
Medicare Secondary Payer (MSP)	The rules establishing when the Medicare program does not have primary payment responsibility - that is, when another entity has the responsibility for paying before Medicare.

IMPORTANT REMINDERS

- If the member is dual eligible with Medicare and Medicaid, you must bill Medicaid – and not the member – for any remaining balance.
- For coordination of benefits claims:
  - All paper claims must be accompanied by the corresponding Medicare explanation of benefits (EOB).
  - We must receive your paper claim within one year of the Medicare EOB's processed date.
  - You must wait 30 calendar days after receiving the Medicare payment before submitting the secondary claim to Blue Cross. This is because it may take up to 30 calendar days after you receive Medicare's payment for you to receive our payment or instructions.

Medicare primary claims submitted to us within 30 calendar days of the Medicare payment date, or with no Medicare payment date, will be rejected.

CLAIM CROSSOVER

Once a month, Blue Cross forwards eligibility information (the member's Medicare Beneficiary Identification (MBI) number and effective dates of coverage) to the Centers for Medicare & Medicaid Services. Medicare uses this information when determining which claims should be forwarded to Blue Cross.

Problems that can occur with eligibility files

If	Then
The Medicare MBI number is missing from our eligibility file	• We will not send any member information to Medicare and claims will not automatically cross over to us from Medicare. • Ask the member to call our Coordination of Benefits Department at **1-800-839-8991** and give the representative their Medicare number. • Please bill us directly.
The Medicare MBI number we have on file is invalid	• Claims for this member won't cross over. • Ask the member to call our Coordination of Benefits Department at **1-800-839-8991** to revalidate the Medicare number. • Please bill us directly.

GROUP HEALTH PLANS (GHP) & MEDICARE COORDINATION OF BENEFITS

This section describes certain conditions in which Blue Cross is the primary payer.

Working aged
The member is age 65 or older and is covered by a GHP through current employment or the spouse's current employment.

What to do: If the patient's employer has at least 20 employees, bill Blue Cross first.

Disability
The member's Medicare eligibility is based on a disability. They are covered by a GHP through their own current employment (or through a family member's current employment).

What to do: If the subscriber's employer has at least 100 employees, bill Blue Cross first.

End Stage Renal Disease (ESRD)
The member is entitled to Medicare based on kidney failure and is covered by a GHP (or COBRA).

What to do: If the member is within the first 30 months of their ESRD Medicare coverage effective date, bill Blue Cross first.

The ESRD law applies to all members enrolled in a GHP of an employer of any size.

Dual entitlement to Medicare
The dual entitlement law applies when a member is entitled to Medicare based on:

- Both ESRD and disability, or
- Both ESRD and age.

When a member has dual entitlement to Medicare, the chart below will help you determine who to bill first.

If the primary payer is	When the member becomes dual entitled to Medicare based on	Then
The GHP, based on aged or disability MSP law	ESRD	Continue to bill the GHP first for the first 30 months of the member's ESRD Medicare coverage. Then, bill Medicare first for as long as the member remains dually entitled.
Medicare, based on aged or disability MSP law	ESRD	Continue to bill Medicare first for as long as the member remains dual entitled.
The GHP, based on ESRD MSP law	Age or disability	Continue to bill the GHP first for the remaining of the 30-month ESRD Medicare coverage. Then, bill Medicare first for as long as member remains dually entitled.
Medicare, based on ESRD MSP law	Age or disability	Continue to bill Medicare first for as long as the member remains dually entitled.

BILLING FOR OUTPATIENT CARE

If the member has	And you are	Then
Medicare A and B, Medicare A only or Medicare B only	Billing for outpatient services, and Medicare's payment equals $0 due to a rejection or denial of service. Note: You may submit electronically any claims that have a Medicare payment equal to zero due to Medicare-approved dollars that are deductible-applied.	• Submit to us a paper UB-04. • Attach a Medicare explanation of benefits (EOB) statement showing the denied/rejected services to a completed ***Request for Claim Review Form*** send to Provider Services.

BILLING FOR INPATIENT CARE WHEN THE MEMBER HAS BOTH MEDICARE A AND B

For Federal Employee Program members, click here.

If the member has	And	Then
Medicare A and B	The inpatient lifetime reserve days are being used	Medicare is primary, and as secondary, we pay deductible, co-insurance and life-time reserve days.
Medicare A and B	Medicare A benefits were exhausted before admission and the use of lifetime reserve days is being waived by the member.	• Plan pre-certification is required. • Bill us as primary. • Bill on UB-04 and attach a lifetime reserve day waiver letter signed by the member.
Medicare A and B	Medicare A benefits are exhausted during the inpatient stay. (For example, the member is admitted 9/1/19 and discharged 9/30/19, but Medicare A benefits are exhausted 9/15/19.)	• Split the claim. • Pre-certification is required. • Bill us as the primary payer (for services from 9/16-9/30) • In Form Locator 31 of the UB-04, enter Occurrence Code A3 and the date Medicare benefits exhausted. (In this case you'd enter 9/15/19.) We will deduct any Medicare Part B payment from our payment.

BILLING FOR INPATIENT CARE WHEN THE MEMBER HAS EITHER MEDICARE A OR B

For Federal Employee Program members, click here.

If the member has	And you are	Then
Medicare A only (member doesn't have Part B)	Billing for an inpatient stay	• Bill Medicare as primary for all facility services. • Bill us as the secondary payer for facility deductible and co-insurance.
Medicare Part B only (member doesn't have Part A)	Billing for an inpatient stay	• Plan pre-certification is required. • Bill us as primary for all services, including hospital-salaried physician services. • We will retract any payments that may have previously processed as Part B charges. We may deduct any Medicare Part B payment from our diagnosis related group (DRG) payment.

BILLING FOR INPATIENT CARE WHEN THE MEMBER IS MEDICARE-ELIGIBLE & HAS FEDERAL EMPLOYEE PROGRAM BENEFITS

If the member is	And you are	Then
Actively working	Billing for an inpatient stay	• We will pay the claim according to our All Patient Refined Diagnosis Related Groups (APR-DRGs) rate or charges, whichever is less.
• Retired, • over age 65, and • has neither Medicare A nor B	Billing for an inpatient stay	• We will reimburse the claim using Medicare's DRG rates or charges, whichever is less.
• Retired, • over age 65, and • has Medicare A only (member doesn't have Part B)	Billing for an inpatient stay	• Bill Medicare as primary for all facility services. • Bill us as the secondary payer for facility deductible and co-insurance. • Plan pre-certification is required if Medicare benefits are exhausted

If the member is	And you are	Then
• Retired, • over age 65, and • has Medicare B only (member doesn't have Part A)	Billing for inpatient services	• Plan pre-certification is required. • Bill all ancillary charges to Medicare B. • Submit one claim to us for all services including Part A and Part B charges, along with a copy of the Medicare B explanation of benefits (EOB). • We will deduct Medicare B payment from the Medicare DRG. • We will retract any payment that may have previously processed as Part B charges.

COMPLETING THE UB-04 WHEN WE ARE SECONDARY

Be sure to complete these fields. Claims can be submitted electronically.

The four items below, which are required on inpatient claims when we are secondary to Medicare, are reported as value code. If there is overflow, please use Form Locator 81 to code.

- **Covered days** (total number of days covered by Medicare) Form Locator 39-41 a-c with value code 80 and days entered as whole numbers (no decimal points – no 00 suffix.)
- **Non-covered days** (days not covered by Medicare) Form Locator 39-41 a-c with value code 81 and days entered as whole numbers (no decimal points – no 00 suffix.)
- **Co-insurance days** (number of co-insurance days used, if applicable) Form Locator 39-41 a-c with value code 82 and days entered as whole numbers (no decimal points – no 00 suffix.)
- **Lifetime reserve days** (number of lifetime days used, if applicable) Form Locator 39-41 a-c with value code 83 and days entered as whole numbers (no decimal points – no 00 suffix.)

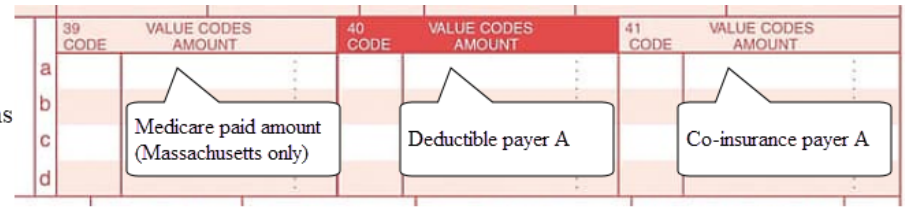
In addition, be sure to provide:

- **Claim Adjustment Reason Code,** for Medicare-rejected services.
- **Occurrence code and date**, indicating the reason benefits were not available under Medicare. Form Locator 31, i.e., benefits exhausted (A3) and the date benefits were exhausted.
- **Claim control number** (the claim number the other payer processed this claim under). Form Locator 64 A, B or C is optional.
- **Value code (enter 88) and amount** (Form Locator 39, line A) showing the amount Medicare paid.
- **Value code(s) and amount(s)** for Medicare deductible, co-insurance and/or lifetime reserve days to show the amount you are billing us. Begin at Form Locator 40, line A and move to the right, Form Locator 41, line A; Form Locator 39, line B, etc.
- **Revenue code and description** to indicate the accommodation and ancillaries included in your bill (Form Locator 42 and 43).
- **Non-covered charges**, showing the amount Medicare did not cover (Form Locator 48).
- **Insured's name** (Form Locator 58, line A).
- **Member's Medicare Identification number** (Form Locator 60, line A).

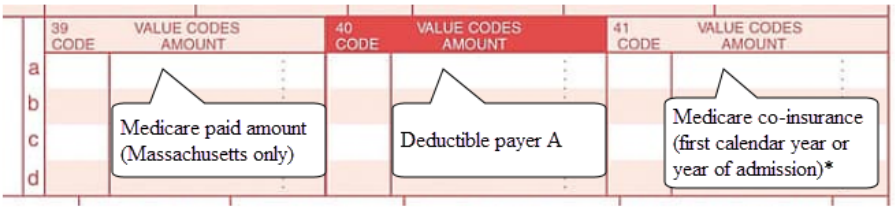
A NOTE ABOUT VALUE CODES

To ensure the accurate processing of claims when Medicare is primary and we are secondary, it is important to report the appropriate value codes and their corresponding dollar amounts.

Outpatient claims



Inpatient claims



Medicare **must be reported as the primary payer so this value code will appropriately identify the balance you are requesting. If the Plan is reported as Payer A with co-insurance value code A2, your claim will reject for "no Medicare dollars reported."*