Anthem BlueCross BlueShield

BCBSA Initiative Helps Insure Timely and Accurate Payment for Secondary Payer Medicare Claims

We implemented new guidelines to help reduce the administrative burden of getting reimbursed for Medicare crossover claims. Please review these instructions for filing Medicare crossover claims and Medicare non-covered services to help ensure timely and accurate payment.

Duplicate Claims Handling for Medicare Crossover
Since January 1, 2006, all Blue Plans have been required to process Medicare crossover claims for services covered under Medigap and Medicare Supplemental products through Centers for Medicare & Medicaid Services (CMS). This has resulted in automatic submission of Medicare claims to the Blue secondary payer to eliminate the need for the provider's office or billing service to submit an additional claim to the secondary carrier. Additionally, this has also allowed Medicare crossover claims to be processed in the same manner nationwide.

Effective Oct. 13, 2013 when a Medicare claim has crossed over, providers are to wait 30 calendar days from the Medicare remittance date before submitting the claim to the local Plan if the charges have still not been considered by the member's Blue Plan.

If you provide members' Blue Plan ID numbers when submitting claims to the Medicare intermediary, they will be crossed over to the Blue Plan only after they have been processed by the Medicare intermediary. This process will take a minimum of 14 days to occur. This means that the Medicare intermediary will be releasing the claim to the Blue Plan for processing about the same time you receive the Medicare remittance advice. As a result, upon receipt of the remittance advice from Medicare, it may take up to 30 additional calendar days for you to receive payment or instructions from the Blue Plan.

Providers should continue to submit services that are covered by Medicare directly to Medicare. Even if Medicare may exhaust or has exhausted, continue to submit claims to Medicare to allow for the crossover process to occur and for the member's benefit policy to be applied.

Medicare primary claims, including those with Medicare exhaust services that have crossed over and are received within 30 calendar days of the Medicare remittance date or with no Medicare remittance date will be rejected by the local Plan.
Effective Oct. 13, 2013, we will reject Medicare primary provider submitted claims with the following conditions:

- Medicare remittance advice remark codes MA18 or N89 that Medicare crossover has occurred
  - MA18 Alert: The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them
  - N89 Alert: Payment information for this claim has been forwarded to more than one other payer, but format limitations permit only one of the secondary payers to be identified in this remittance advice.
- Received by provider's local plan within 30 calendar days of Medicare remittance date
- Received by provider's local plan with no Medicare remittance date
- Received with GY modifier on some lines but not all
  - A GY modifier is used by providers when billing to indicate that an item or service is statutorily excluded and is not covered by Medicare. Examples of statutorily excluded services include hearing aids and home infusion therapy.

When these types of claims are rejected, we also will remind the provider to allow 30 days for the crossover process to occur or instruct the provider to submit the claim with only GY modifier service lines indicating the claim only contains statutorily excluded services.

Commonly Asked Questions:

How do I submit Medicare primary / Blue Plan secondary claims?

- For members with Medicare primary coverage and Blue Plan secondary coverage, submit claims to your Medicare intermediary and/or Medicare carrier.
- When submitting the claim, it is essential that you enter the correct Blue Plan name as the secondary carrier. This may be different from the local Blue Plan. Check the member's ID card for additional verification.
- Be certain to include the alpha prefix as part of the member identification number. The member's ID will include the alpha prefix in the first three positions. The alpha prefix is critical for confirming membership and coverage, and key to facilitating prompt payments.

When you receive the remittance advice from the Medicare intermediary, look to see if the claim has been automatically forwarded (crossed over) to the Blue Plan:

- If the remittance indicates that the claim was crossed over, Medicare has forwarded the claim on your behalf to the appropriate Blue Plan and the claim is in process. There is no need to resubmit that claim to the local Plan.
- If the remittance indicates that the claim was not crossed over, submit the claim to the local Plan with the Medicare remittance advice.

- In some cases, the member identification card may contain a COBA (Coordination of Benefits Agreement) ID number. If so, be certain to include that number on your claim.

When should I expect to receive payment?

The claims you submit to the Medicare intermediary will be crossed over to the Blue Plan only after they have been processed by the Medicare intermediary. This process

will take a minimum of 14 days to occur. This means that the Medicare intermediary will be releasing the claim to the Blue Plan for processing about the same time you receive the Medicare remittance advice. As a result, upon receipt of the remittance advice from Medicare, it may take up to 30 additional business days for you to receive payment or instructions from the Blue Plan.

What should I do in the meantime?
If you submitted the claim to the Medicare intermediary/carrier, and haven't received a response to your initial claim submission, do not automatically submit another claim. Rather, you should:

- Review the automated resubmission cycle on your claim system.
- Wait 30 calendar days from receipt of the Medicare Remittance advice.
- Check claims status before resubmitting.

Sending another claim, or having your billing agency resubmit claims automatically, actually slows down the claim payment process and creates confusion for the member.

Whom do I contact if I have questions?
If you have any questions about where to file your claim, please contact provider customer service at the phone number on the back of the member's ID card.

Medicare statutorily excluded services – just file once to your local Blue Cross Blue Shield plan
There are certain types of services that Medicare never or seldom covers, but a secondary payer such as Anthem may cover all or a portion of those services. These are statutorily excluded services. For services that Medicare does not allow, such as home infusion, providers need only file statutorily excluded services directly to their local plan using the GY modifier and will no longer have to submit to Medicare for consideration. These services must be billed with only statutorily excluded services on the claim and will not be accepted with some lines containing the GY modifier and some lines without.

For claims submitted directly to Medicare with a crossover arrangement where Medicare makes no allowance, providers can expect the member's benefit plan to reject the claim advising the provider to submit to their local plan when the services rendered are considered eligible for benefit. These claims should be resubmitted as a fresh claim to a provider's local plan with the Explanation of Medicare Benefits (EOMB) to take advantage of provider contracts. Since the services are not statutorily excluded as defined by CMS, no GY modifier is required. However, the submission of the Medicare EOMB is required. . This will help ensure the claims process consistent with the providers contractual agreement..

Effective Oct. 13, 2013:

- Providers who render statutorily excluded services should indicate these services by using GY modifier at the service line level of the claim.

- Providers will be required to submit only statutorily excluded service lines on a claim (cannot combine with other services like Medicare exhaust services or other Medicare covered services)
- The provider's local plan will not require Medicare EOMB for statutorily excluded services submitted with a GY Modifier.

If providers submit combined line claims (some lines with GY, some without) to their local plan, the provider's local plan will deny the claims, instructing provider to split the claim and resubmit

Original Medicare -- The GY modifier *should* be used when service is being rendered to a Medicare primary member for statutorily excluded service and the member has Blue secondary coverage, such as an Anthem Medicare Supplement plan. The value in the SBR01 field should not be "P" to denote primary.

Medicare Advantage -- Please ensure SBR01 denotes "P" for primary payer within the 837 electronic claim file. This helps ensure accurate processing on claims submitted with a GY modifier.

The GY modifier *should* <u>*not*</u> be used when submitting:

- Commercial claims
- Federal Employee Program claims
- In-patient institutional claims. Please use the appropriate condition code to denote statutorily excluded services.

We appreciate your help in streamlining your claims processing.

These processes align Blue Cross Blue Shield plans with industry standards and will result in less administrative work, accurate payments and fewer rejected claims. Because the claim will process with a consistent application of pricing, our members also will see a decrease in health care costs as new crossover process eliminates or reduces balance billing to the member.

Providers can call the E-Solutions HelpDesk at 800-470-9630, or go to http://www.anthem.com/edi.html to request assistance with submitting electronic claims to us. If you have any questions about where to file your claim, please contact the provider call center at the phone number on the back of the member's ID card.

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