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 Provider or Facilities or his/her/its 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 October 13, 2013 when a Medicare Claim has crossed over, Providers and Facilities 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 Covered Individual’s Blue Plan.

To avoid the submissions of duplicate Claims, use the 276/277 Health care Claims status inquiries to verify Claim and adjudication status prior to re-submission of electronic Claims.

If Provider or Facility provides Covered Individuals’ Blue Plan ID numbers (including alpha prefix) 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 Provider or Facility receives 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 Provider or Facility to receive payment or instructions from the Blue Plan.

Providers and Facilities 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 Covered Individual’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 October 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 or Facility’s local Plan within 30 calendar days of Medicare remittance date
- Received by Provider or Facility’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 and outpatient Facilities 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, Anthem will also remind the Provider or Facility to allow 30 days for the crossover process to occur or instruct the Provider or Facility to submit the Claim with only GY modifier service lines indicating the Claim only contains statutorily excluded services.

**Medicare statutorily excluded services – just file once to your local 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 and outpatient Facilities 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 and Facilities can expect the Covered Individual’s benefit plan to reject the Claim advising the Provider or Facility 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 or Facility’s local Plan with the Explanation of Medicare Benefits (EOMB) to take advantage of Provider or Facility 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 Provider’s or Facility’s contractual agreement.

Effective October 13, 2013:

- Providers or outpatient Facilities who render statutorily excluded services should indicate these services by using GY modifier at the service line level of the Claim.
- Providers or Facilities 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 or outpatient Facility’s local Plan will not require Medicare EOMB for statutorily excluded services submitted with a GY Modifier.

If Providers or outpatient Facilities submit combined line Claims (some lines with GY, some without) to their local Plan, the Provider or outpatient Facility’s local Plan will deny the Claims, instructing the Provider or outpatient Facility to split the Claim and resubmit.

**Original Medicare** – The GY modifier should be used when service is being rendered to a Medicare primary Covered Individual for statutorily excluded service and the Covered Individual 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 not be used when submitting:**
- Federal Employee Program Claims
- Inpatient institutional Claims. Please use the appropriate condition code to denote statutorily excluded services.

These processes align Blue Cross and/or 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 Covered Individuals will also see a decrease in health care costs as the new crossover process eliminates or reduces balance billing to the Covered Individual.

**Medicare Crossover Claims FAQs**

1. **How do I handle traditional Medicare-related claims?**
   - When Medicare is primary payer, submit claims to your local Medicare intermediary. All Blue claims are set up to automatically cross over (or forward) to the Covered Individual’s Blue Plan after being adjudicated by the Medicare intermediary.

2. **How do I submit Medicare primary / Blue Plan secondary claims?**
   - For Covered Individuals 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 Covered Individual’s ID card for additional verification.
   - Be certain to include the alpha prefix as part of the Covered Individual identification number. The Covered Individual’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 advice 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. **DO NOT** resubmit that claim to Anthem; duplicate claims will result in processing and payment delays.
     - If the remittance advice indicates that the claim was not crossed over, submit the claim to your local Anthem Plan with the Medicare remittance advice.
     - In some cases, the Covered Individual identification card may contain a COBA ID number. If so, be certain to include that number on your claim.
     - For claim status inquiries, please contact your local Anthem Plan.

3. **Who do I contact with claims questions?**
   - Your local Anthem Plan.
4. **How do I handle calls from Covered Individuals and others with claims questions?**
   - If Covered Individuals contact you, tell them to contact their Blue Plan. Refer them to the front or back of their ID card for a customer service number.
   - A Covered Individual’s Blue Plan should not contact you directly, unless you filed a paper claim directly with that Blue Plan. If the Covered Individual’s Blue Plan contacts you to send another copy of the Covered Individual’s claim, refer the Blue Plan to your local Anthem Plan.

5. **Where can I find more information?**
   For more information:
   - Visit Anthem’s Web site at [www.anthem.com](http://www.anthem.com).
   - Please contact your local Anthem Plan.