Medicare Crossover Overview

Background

The Coordination of Benefits Agreement (COBA) program provides Cigna with the ability to receive claims electronically from Medicare through the Medicare Crossover process to help facilitate processing claims for Medicare-eligible customers.

Cigna receives electronic claims from Medicare Part A and Part B carriers for Medicare-eligible customers who have Medicare as their primary carrier and medical coverage with Cigna.

- The Medicare Crossover process is an automatic feature for clients.
- There is no cost to the client for this service.

Benefits of the Crossover Process

This process eliminates the need for the customer, health care professional, or health care facility to submit a claim twice: first to Original Medicare, and then to Cigna with the paper Medicare Summary Notice (MSN) attached. Benefits include:

- Less paperwork for the customer and health care professional/facilities.
- Savings on postage.
- Faster secondary reimbursement from Cigna.
- Improved quality of claim payment due to automated process.

How the Crossover Process Works

Medicare requires the use of a Medicare Claim Number or Health Insurance Claim (HIC) number to identify Medicare customers to the Medicare Part A and B carriers. **In order to start the Medicare Crossover process, the customer's HIC number must be populated in Cigna's eligibility system.** When both the HIC number and the Medicare Primary indicator are present, the eligibility record is extracted from Cigna systems and sent to Group Health Insurance (GHI) the centralized Coordination of Benefits Contractor (COBC). The extract occurs on a bi-weekly basis. It is important to mention that all carriers send eligibility to the COBC following the same defined schedule.

As Original Medicare Part A and B carriers process claims as primary, they provide GHI with their processed claim data. GHI uses the eligibility data received from insurance carriers like Cigna to identify the secondary payer for the date of service on the claim. GHI submits the crossover claims via the electronic claim clearinghouse to Cigna when an eligibility match is found.

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How to Obtain Medicare Claim Numbers

Cigna's preferred approach for new business and new retirees to Cigna (fastest and most hassle free approach for all parties), is to receive and load the HIC numbers during the enrollment process or on a separate spreadsheet prior to the plan's effective date with Cigna.

- A client can pass the HIC numbers to Cigna on the automated eligibility file, they can load them through the Eligibility Maintenance Tool (EMT), or they can send a separate spreadsheet to their Eligibility Analyst.
- Below is an example of the Medicare ID card showing where the Medicare claim number is located:

IMPORTANT: If the valid HIC number is not entered at the point of enrollment, then crossover claims can continue to pass to the prior carrier.

- The prior carrier will receive the claims and deny them after termination of insurance.
- This will continue until such time that Cigna receives the valid number, passes the valid number to the COBC on the bi-weekly file, and COBC sends the record to the Medicare carriers. The entire process can take up to 4 weeks.
- There is no other way to update the customer's record. Cigna has to send the accurate information on the bi-weekly file to the COBC.
- **The claims sent to the prior carrier cannot be resent by Medicare to Cigna. The claims would have to be sent to Cigna by the health care professional or customer.**
- The COBC has verified that if both Cigna and the prior carrier are showing active in their records, then claims will be sent to both carriers.
    - The customer will most likely receive a denial from the prior carrier before Cigna's processes the claim as the secondary carrier.
      NOTE: The prior carrier will need to send a termination file to the COBC to correct the issue.

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- For termed Cigna customers, the crossover process stops when a termination date is entered into Cigna's eligibility records, the term date is extracted, and sent to the COBC. The termed records are sent on a bi-weekly basis on the same file as new records.

Other Important Facts About the Crossover Process

- We receive claims from Part A and Part B Original/Traditional Medicare carriers.
- Claims are not received through crossover when the customer has elected a Medicare replacement plan (Part C).
- The crossover process applies to residents of all states including Puerto Rico and the U.S. Virgin Islands.
- Claims that are 100% denied by Medicare are not sent via the crossover process. One example would be acupuncture claims that are not covered by Medicare. If an account covers this service, then the customer or healthcare professional would need to submit the claim to Cigna.
- Claims that are adjusted by Original Medicare are not received through the crossover process.
- For termed Cigna customers, the crossover process stops when a termination date is entered into Cigna's eligibility records, the term date is extracted, and sent to the COBC. The termed records are sent on a bi-weekly basis on the same file along with the new records.