Medicare Secondary Payer (MSP) Manual

Chapter 4 - Coordination of Benefits Contractor (COBC) Requirements

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10 - Overview and General Responsibilities

(Rev. 1, 10-01-03)

AB-00-107

The Centers for Medicare & Medicaid Services (CMS) has established a centralized Coordination of Benefits (COB) operation by consolidating under a single contractor entity, the Coordination of Benefits Contractor (COBC), the performance of all activities that support the collection, management, and reporting of other insurance coverage of Medicare beneficiaries. The CMS has a centralized COB operation that provides quality customer service to Medicare providers, suppliers and beneficiaries by streamlining the payment process while ensuring the integrity of the Medicare Trust Funds. To further that goal, CMS requires the COBC to maintain a comprehensive health care insurance profile on all Medicare beneficiaries and carry out other activities necessary to meet these objectives.

The COBC embraces all of those activities necessary to ensure that the primary payer - whether it is Medicare, employer insurance or other insurance - pays first, and then makes arrangements for transferring the claims automatically to the secondary payer for further processing. The CMS' goals in this consolidation initiative are to:

- Enhance program integrity consistent with the objectives of the Medicare Integrity Program (MIP);
- Provide beneficiaries with a more efficient, user friendly, and less intrusive Medicare COB operation by eliminating redundant inquiries from different Medicare FIs, carriers, durable medical equipment regional carriers, and other public or private parties;
- Administer the Medicare Secondary Payer (MSP) process more efficiently and effectively by using a single contractor entity to operate, coordinate, and maintain the MSP process and thus generate cost savings through a reduction in mistaken primary Medicare payments and identification of conditional primary Medicare payments; and
- Achieve other cost reductions and management efficiencies by consolidating performance of similar activities (e.g., mailroom activities, Customer Service/Help Desk activities, etc.) that are necessary to carry out each of the COB functions described in the Sections that follow.

The COBC is tasked with consolidating performance of the following functions:

- Initial Enrollment Questionnaire (IEQ);
- Data Match;
- 411.25 Notices;
- Secondary Claims Development; and

10.1 - Introduction to the Coordination of Benefits Contractor (COBC)

(Rev. 1, 10-01-03)

PMs AB-00-107, AB-01-25 (AB-02-022), AB-01-76

The Health Insurance Portability Accountability Act of 1996 (HIPAA) (Public Law 104-191) was enacted on August 21, 1996. Section 202 of HIPAA adds a new section, §1893, to the Social Security Act establishing the "Medicare Integrity Program " (MIP). This Program is funded from Medicare's Federal Hospital Insurance Trust Fund for activities related to both Medicare Parts A and B. Specifically, §1893 enables CMS to contract with an expanded pool of eligible entities to carry out the Medicare program integrity activities that are currently performed under contracts with Fiscal Intermediaries and Carriers. Section 1893 identifies MSP determinations as one of five enumerated

activities that comprise the MIP. An MSP situation generally refers to a situation where a party other than Medicare has primary responsibility to pay for the health care expenses incurred by a Medicare beneficiary. The MSP process was developed to safeguard against making mistaken Medicare primary payments and thus ensuring that the Medicare program pays only what the statute requires.

On November 1, 1999, CMS awarded the COB Contract to Group Health Inc. (GHI) Medicare. The awarding of the COB contract provides many benefits for employers, providers, suppliers, third party payers, attorneys, beneficiaries, and Federal and State insurance programs. COBC responsibilities include all MSP claims investigations being initiated from and researched at the COBC. This is no longer the function of the Medicare FI or carrier. Implementing this single-source development greatly reduces the amount of duplicate MSP investigations. This also offers a centralized, one-stop customer service approach, for all MSP-related inquiries, including those seeking general MSP information, but not those related to specific recoveries that serve to protect the Medicare Trust Funds. The COBC provides customer service to all callers, from any source, including but not limited to beneficiaries, attorneys/other beneficiary representatives, employers, insurers, provider, and suppliers.

10.2 - Scope of the COBC in Relation to FI/Carriers

(Rev. 1, 10-01-03)

PMs AB-00-107, AB-01-25, AB-01-76

In April 2000, the COBC implemented the first two phases of the COB contract that includes the Initial Enrollment Questionnaire (IEQ) and the IRS/SSA/CMS Data Match. Effective January 8, 2001, the COBC assumed responsibility for developing to determine the existence or validity of MSP for Medicare beneficiaries. The MSP development and investigation performed by the COBC occurs as a result of MSP inquiries (telephone or written) received directly by the COBC, or as a result of MSP inquiries (telephone or written) and Common Working File (CWF) assistance requests it receives from the FI or Carrier. The COBC is also charged with ensuring the accuracy and timeliness of updates to the CWF MSP auxiliary file. The COBC does not process any claims, nor will it handle any mistaken payment recoveries or claims specific inquiries (telephone or written). The COBC handles all MSP-related inquiries, including those seeking general MSP information, but not those related to specific claims or recoveries.

The COBC is primarily an information gathering entity. The COBC is dependent upon various sources to collect this information. With limited exceptions, FIs and carriers are no longer responsible for initiating MSP development and making MSP determinations. Any information received by FIs and carriers that may have MSP implications must be forwarded to the COBC in a timely and accurate fashion. Only with this timely and accurate information, can the COBC evaluate all relevant information to make the correct MSP determination and appropriately update CWF so that claims will be processed correctly. Once the COBC has established the MSP record on CWF, the FI and carrier

will continue to be responsible for all activities related to identification and recovery of MSP-related debts.

There must be a very close working relationship between the COBC and all FIs and carriers. The FI and carrier must provide the COBC with the name, private phone number, and fax number of both their primary MSP contact, and their backup MSP contact.

10.3 - Intermediary and Carrier Claim Referrals to the COBC

(Rev. 1, 10-01-03)

AB-01-25

Fiscal Intermediaries and carriers retain the responsibility to process claims for Medicare payment. The COBC is not responsible for processing any claims, nor will it handle any mistaken payment recoveries or claims specific inquiries (telephone or written).

Fiscal Intermediaries and Carriers should instruct providers not to forward claims or copies of claims to the COBC. All claims related activity (e.g., processing, adjustments) remains the FI or carrier's jurisdiction (including claims submitted with value codes, primary payer information, EOB's, copies of checks). If claims are received that do not contain enough information to create an MSP record with an "I" validation indicator, FIs and carriers should follow current claims processing guidelines and send the information through Electronic Correspondence Referral System (ECRS) (see Chapter 5, §10) as an MSP inquiry. They should send this information within one business day of processing the claim.

The COBC will return any claims received to the submitter indicating that claims should be sent to its local contractor only for claims processing and payment.

In cases of claims clarification where the FI/carrier would normally contact (telephone) the provider to complete the processing of a claim in order to avoid suspending or RTP'ing the claim back to the provider, it may continue this practice. However, if it finds that the clarification provided by the provider is still questionable or is in direct opposition to CWF, it must follow current claims processing guidelines and send the information through ECRS as an MSP inquiry (see Chapter 5, §10). It must send this information within one business day of processing the claim.

20 - CMS IEQ Responsibilities

(Rev. 1, 10-01-03)

(AB-01-076)

The CMS obtains IEQ information using questions approved by the Office of Management and Budget. The CMS provides the COBC with English and Spanish

versions of the five different versions of the OMB-approved IEQ questionnaires. These are:

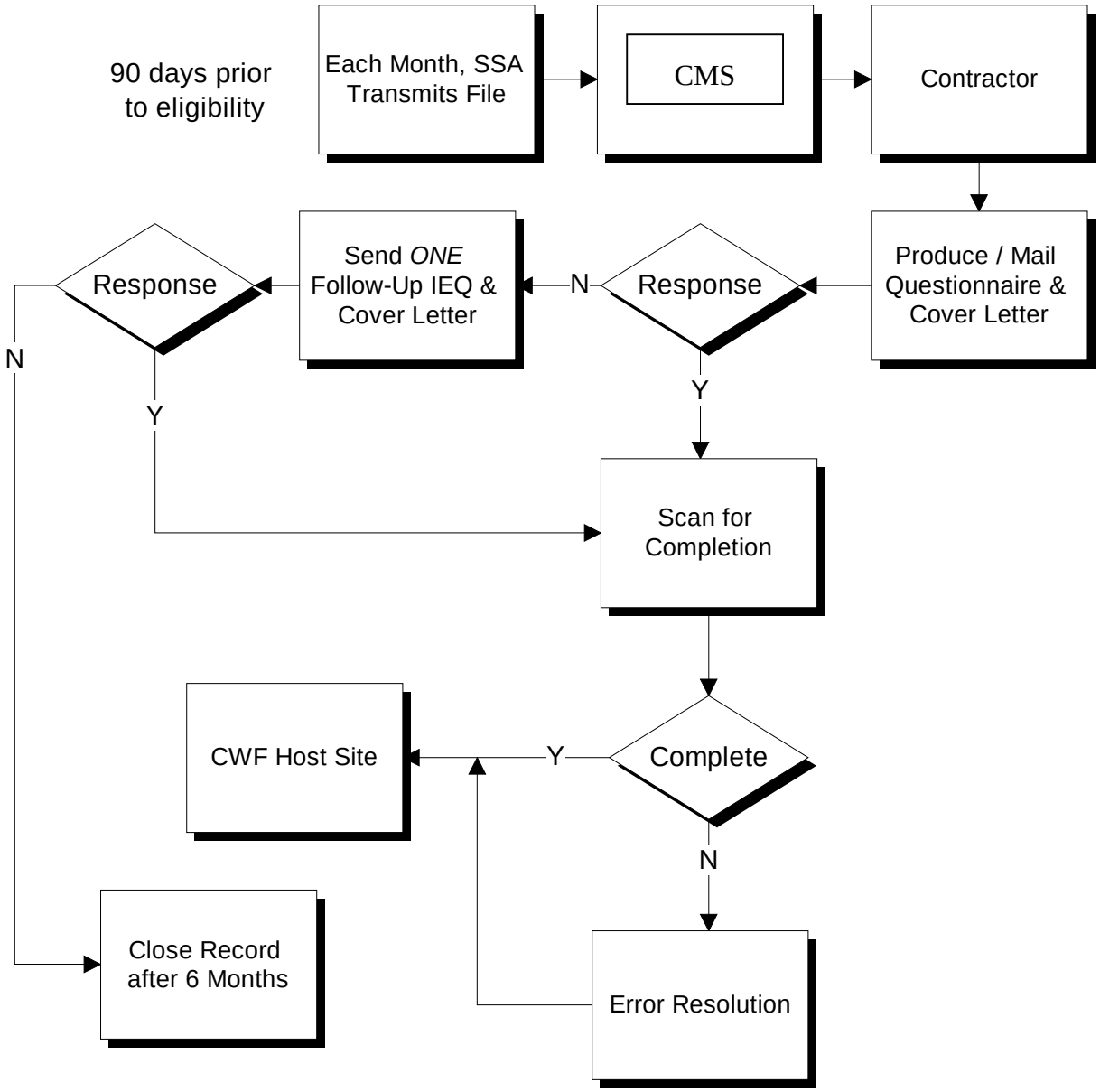
- Medicare Questionnaire for Beneficiaries 65 or Over;
- Medicare Questionnaire for Disabled Beneficiaries;
- Medicare Questionnaire for Beneficiaries with End-Stage Renal Disease;
- Medicare Questionnaire for Beneficiaries with Childhood Disabilities; and
- Medicare Questionnaire for Disabled Widow or Widower.

The CMS provides the COBC with two OMB-approved model cover letters - one for the first questionnaire sent to each newly-enrolled Medicare beneficiary, and a second for a follow-up questionnaire, if necessary. The CMS also furnishes slightly modified cover letters for COBC use with beneficiaries who attain their Medicare coverage through receipt of Railroad Retirement Board (RRB) benefits, and an information brochure about Medicare and MSP.

The return address for all non-RRB beneficiaries and the addressee on all enclosed return envelopes for all IEQs are:

Medicare - Coordination of Benefits
Initial Enrollment Questionnaire Program
PO Box 17521
Baltimore, Maryland 21203-7521

The IEQ process flow is depicted in the exhibit that follows.


90 days prior to eligibility
Each Month, SSA Transmits File
CMS
Contractor
Produce / Mail Questionnaire & Cover Letter
Response
N
Send *ONE* Follow-Up IEQ & Cover Letter
Response
N
Y
Y
Scan for Completion
Complete
Y
CWF Host Site
N
Error Resolution
Close Record after 6 Months

30 - IRS/SSA/CMS Data Match

(Rev. 1, 10-01-03)

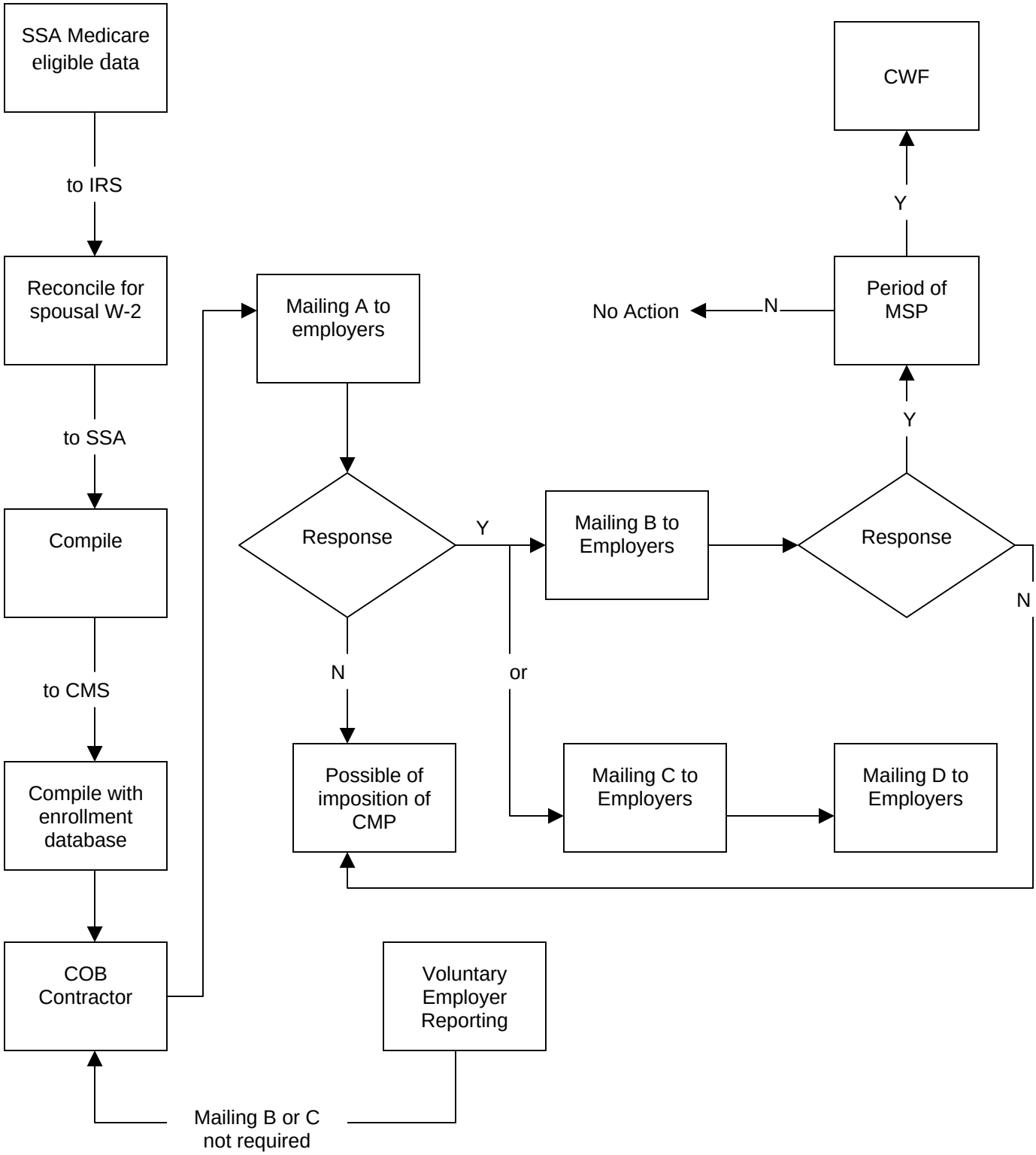
COB SOW-4.6

Section 1862(b) of the Social Security Act contains provisions intended to enhance CMS' ability to acquire complete, accurate and timely information about Medicare beneficiaries' health benefit coverage, and thus identify situations where another health care plan has the primary legal obligation for a beneficiary's health care costs.

Federal law requires the IRS, SSA, and CMS to share certain information that each agency has about Medicare beneficiaries and their spouses. The process for sharing this information is called the "Data Match." In October of each calendar year, SSA delivers a "finder file" to the IRS. The IRS has 40 business days from the date of receipt to match this finder file against its tax records. After receiving the results of the match, SSA has another 40 business days to produce the “Data Match Employer/Employee File” for CMS.

The COBC reviews and analyzes these data in preparation for use in contacting employers concerning possible periods of insurance primary to Medicare. The purpose of the Data Match is to identify those periods where Medicare is the secondary payer. The intent of the data match is twofold: to identify mistaken payments and to prevent future mistaken payments. A basic workflow diagram of the Data Match follows.

Employers are asked to complete a questionnaire requesting GHP information on identified workers who are either entitled to Medicare or married to a Medicare beneficiary. This information is used to identify the primary and secondary payers for medical services provided to a Medicare beneficiary. Fiscal Intermediaries and carriers use this information to identify claims on an ongoing basis for which Medicare should not be the primary payer.


SSA Medicare eligible data
to IRS
Reconcile for spousal W-2
to SSA
Compile
to CMS
Compile with enrollment database
COB Contractor
Mailing A to employers
Response
Y
N
Mailing B to Employers
Response
Y
N
Period of MSP
Y
N
No Action
CWF
or
Possible of imposition of CMP
Mailing C to Employers
Mailing D to Employers
Voluntary Employer Reporting
Mailing B or C not required

30.1 - Data Match Activities

(Rev. 1, 10-01-03)

COB SOW-4.6.1

Each year, the COBC receives from CMS a final output file containing approximately 350,000 employers and one million workers from matching the IRS, SSA, and CMS records. The COBC makes a comparison of the output file of the current Data Match to that of the prior Data Match, and the responses for the prior Data Matches maintained within the database. The COBC removes any employer that responded "No " to Mailing A (discussed below) in the prior Data Match from the list of employers to contact. The COBC also removes those employers that do not meet the size requirement set forth in the MSP governing statute and implementing regulations and who do not belong to multi-employer plans. After removing these employers, the COBC makes a non-duplication comparison on those employer/employee combinations that remain. The COBC does not re-contact an employer concerning a specific employee when the following data elements match between the output for the prior Data Match and the output for the current Data Match (and complete information has been processed):

- Tax Identification Number (TIN);
- Employee Social Security Number (SSN); and
- Data Match Code.

The prior Data Match would have captured these individuals via the employer questionnaire. This means that the current Data Match will encompass only those "new " Medicare beneficiaries or workers who were not in the prior Data Match and who did not have a change in status, or those that have not been included in the prior Data Match.

30.2 - Voluntary Reporting

(Rev. 1, 10-01-03)

COB SOW-4.6.1.1.2

Employers who submit EGHP/worker information voluntarily to the COBC send a reference file once a year. This file contains all of the EGHPs and associated TIN, name, and address information. (The TIN information is stored on the Voluntary Reference table by Plan Number. The Plan number is assigned when the Voluntary Reporting Agreement is executed.) This system can also receive duplicate TINs with different addresses.

30.2.1 - Employer (TFTS)

(Rev. 1, 10-01-03)

COB SOW-4.6.8

The COBC has a national toll-free telephone line to answer employer questions concerning the Data Match, in particular, and MSP, in general. This includes answering questions about the MSP governing statute and implementing regulations and how to complete the Data Match Questionnaire. Hours of the toll-free line shall be 8:00 a.m. to 8:00 p.m. Eastern Standard Time, Monday through Friday, except Federal holidays. The COBC ensures the provision and training of appropriate staffing levels for this effort so that a caller can talk to a live customer service representative during the hours of operation specified.

40 – COBC Discontinues Dissemination of the Right of Recovery Letters to Intermediaries

(Rev. 1, 10-01-03)

A-03-047

Prior to June 2003, when the COBC was notified of a non-group health plan Medicare Secondary Payer situation, it mailed the right of recovery letter to the attorney(s) representing the beneficiary or the beneficiary where no attorney is identified. A carbon copy was forwarded to the lead Medicare contractor assigned to the case. The right of recovery letter informs the recipient of his/her rights when filing a claim and/or a civil action against a third party and confirms the information related to the case that may identify Medicare as the secondary payer. As needed, the lead contractor assigned to the case may request an exact copy of the right of recovery letter through an Electronic Correspondence Referral System (ECRS) Assistance Request by selecting action code "RR".

Effective June 2003, the CMS determined that the cost and resources associated with disseminating the right of recovery letters to intermediaries are not cost effective for the few instances where they are needed. The COBC will retain the original right of recovery letter and an exact copy may be obtained through an ECRS assistance request, if necessary. Contractors are not to routinely request copies.