CMS
CENTERS for MEDICARE & MEDICAID SERVICES

# Fact Sheet
## FOR CLINICAL LABORATORIES

COLLECTING, SUBMITTING, AND UPDATING BENEFICIARY INSURANCE INFORMATION TO MEDICARE

## Background

As the Medicare program matures and the "baby boomer" generation moves towards retirement, it becomes critical to maintain the viability and integrity of the Medicare Trust Fund. Clinical laboratories can contribute towards the appropriate use of Medicare by complying with all Medicare requirements, including those applicable to Medicare Secondary Payer (MSP).

Clinical laboratories operate in a distinctly different environment from other Medicare providers. Unlike physicians and hospitals, a clinical laboratory often furnishes covered services without actually seeing the patient. This lack of patient interaction may create a special challenge when obtaining and maintaining accurate insurance information needed for claim submission. Without accurate insurance information, clinical laboratories may receive unnecessary payment denials or delays in Medicare payments. The purpose of this Fact Sheet is to introduce the MSP Program to clinical laboratory service providers, with particular emphasis on how to maintain and submit updated beneficiary insurance information.

## What Is Medicare Secondary Payer (MSP)?

Since 1980, the Medicare Secondary Payer (MSP) Program has protected Medicare funds by ensuring that Medicare does not pay for services that private health insurance plans or Government plans have primary responsibilities for paying. The MSP Program applies to claim situations when Medicare is not the beneficiary's primary insurance. It provides the following benefits for both the Medicare program and the provider:

***What Constitutes a Clinical Laboratory?***

A clinical laboratory is any facility that tests specimens derived from humans for the purpose of diagnosis, prevention, treatment of disease, or impairment and assessment of health. This includes laboratories that provide onsite simple testing such as physician office laboratories, skilled nursing facilities, rural health clinics, and pharmacies.

- National program savings – Medicare saves over $4.5 billion annually from claims processed by insurers that are primary to Medicare.
- Increased provider revenue – Providers that bill a liability insurer *before* billing Medicare may receive more favorable payment rates. Providers can also reduce adminis-

trative costs when health insurance is properly coordinated.

To realize these benefits, providers must have access to accurate, up-to-date information about all health insurance coverage that Medicare beneficiaries may have. Current law requires all entities seeking payment for any item or service furnished under Medicare Part B to complete the portion of the claim form relating to the availability of other health insurance, based on information obtained from the individual to whom the item or service is furnished.

## How Does the Centers for Medicare & Medicaid Services (CMS) Support the MSP Program?

The Centers for Medicare & Medicaid Services (CMS) established the Coordination of Benefits (COB) Contractor to collect, manage, and maintain information on Medicare's Common Working File (CWF) regarding other health insurance coverage for Medicare beneficiaries.

## What Is the Clinical Laboratory's Role in the MSP Program?

All providers must submit accurate beneficiary health insurance information to assist CMS in maintaining accurate beneficiary records. Specifically, clinical laboratories have two primary responsibilities for the collection and coordination of beneficiary insurance information:

- **Updating insurance profiles prior to submitting laboratory claims.** For laboratories with direct patient interaction, this process may be as simple as asking to see a beneficiary's insurance card(s) and asking several MSP-related questions. (Please see the text box for example questions that laboratory staff may ask patients.) Exception: When there is no face-to-face encounter with the Medicare beneficiary, laboratories are no longer required to obtain health insurance information from the beneficiary in order to bill Medicare for reference laboratory services (as described in subsection (b) of Section 943 of the Medicare Modernization Act). The Health Insurance Portability and Accountability Act (HIPAA) permits communication of beneficiary insurance information between a referring/ordering provider and a clinical laboratory for the purpose of submitting claims for individual beneficiaries. However, CMS does not authorize nor does it approve of requesting or obtaining insurance information from anyone other than the beneficiary.

- **Billing the primary payer before billing Medicare for laboratory services.** Clinical laboratories that submit Electronic Media Claims (EMCs) may acquire access to beneficiary eligibility files through their software vendor. EMCs permit billers to instantly determine if a beneficiary is eligible for Medicare benefits, has met his or her deductible, or is enrolled in a Medicare managed care (Medicare Advantage) plan. In addition, clinical laboratories can verify if the beneficiary has other health insurance coverage registered in the MSP database [referred to as the Common Working File (CWF)] that should be billed before Medicare. If a beneficiary has other insurance identified in the CWF, the laboratory should confirm with the beneficiary if the information is current and correct. Section 1862(b)(6) of the Social Security Act (42 USC 1395y(b)(6)) requires all entities seeking payment for any item or service furnished under Medicare Part B to complete the portion of the claim form relating to the availability of other health insurance, based on information obtained from the individual to whom the item or service is furnished. If a clinical laboratory has updated information, but is not sure if Medicare is the primary or secondary payer, the clinical laboratory may also contact the Medicare COB Contractor. When contacting the COB Contractor the clinical laboratory must have its provider number readily available.

***What Questions Should a Clinical Laboratory Ask to Gather Accurate Data from the Beneficiary?***

Laboratories can save time and money by collecting patient insurance information prior to billing for services. When gathering insurance information, the following questions should be addressed:

- Is the patient covered by any GHP through his or her current or former employment? How many employees work for the employer providing coverage?
- Is the patient covered by any GHP through his or her spouse or other family member's current or former employment? How many employees work for the employer providing coverage?
- Is the patient receiving Federal Black Lung Program benefits?
- Is the patient receiving Workers' Compensation (WC) benefits?
- Is the illness or injury covered under automobile insurance, no-fault insurance, medical payments coverage, personal injury insurance, liability insurance, or a medical "set aside" account from a legal settlement?
- Is the patient being treated for an injury or illness for which another party could be held liable?

If the clinical laboratory does not provide Medicare with a record of other health insurance that may be secondary to Medicare on any claim and there is an indication of possible MSP, the COB Contractor may request that the provider complete a Development Questionnaire.

## Why Gather Additional Beneficiary Insurance Information?

The goal of MSP information-gathering activities is to quickly identify possible MSP situations, thus ensuring correct primary and secondary payments by the responsible parties. This effort may require providers to complete Development Questionnaires to collect accurate beneficiary insurance information. Many of the questions on the Development Questionnaires are similar to the coverage questions that providers might ask a beneficiary during a routine visit. This similarity provides another good reason to routinely ask patients about their insurance coverage. If a provider gathers information about a beneficiary's other insurance and uses that information to complete the claim properly, a Development Questionnaire may not be necessary. Accurate submittal of claims may accelerate the processing of the provider's claim.

The types of questionnaires the COB Contractor may send to providers include:

- Secondary Claim Development (SCD) Questionnaire; and
- Trauma Development (TD) Questionnaire.

Each questionnaire addresses different potential MSP situations.

## What Is an SCD Questionnaire?

An SCD Questionnaire may be sent to the provider when a claim is submitted with an Explanation of Benefits (EOB) attached from an insurer other than Medicare, and pertinent information was not submitted to properly adjudicate the submitted claim. The COB Contractor provides the name and Health Insurance Claim Number (HICN) of each beneficiary for which the provider is requested to complete an SCD Questionnaire. The provider should complete and return the SCD Questionnaire to the COB Contractor.

## What Is a TD Questionnaire?

A TD Questionnaire may be sent when information regarding an accident, illness, or injury is received and/or a diagnosis appears on a claim that indicates an accident, illness, or injury has occurred. This incident may be related to a Workers' Compensation (WC), automobile accident, or other liability situation. The TD Questionnaire may be sent to the beneficiary, the provider, the attorney, or the insurer to collect information on the existence of other insurance that may be primary to Medicare. If an MSP situation is identified after Medicare pays the claim, Medicare has the right to recover any conditional payments made on behalf of the beneficiary.

## What Happens if a Laboratory Bills Another Insurance First and It Does Not Pay in a Timely Manner?

Sometimes claims properly submitted to automobile, no-fault, liability, or WC insurers as primary payers, are not paid in a timely manner (within 120 days). This situation may occur when there are delays in settlements. To offset this problem, Medicare may make conditional payments in situations when the primary claims are not expected to be paid in a timely manner. If a provider has not received payment within 120 days, Medicare may be billed for any Medicare covered services provided and Medicare may make a conditional payment on the claim. However, once a settlement has been reached, the primary payer is still responsible for its portion of the claim. Medicare has the right to recover any conditional payments made on behalf of the beneficiary.

## What Happens If the Laboratory Submits a Claim to Medicare Without Providing the Other Insurer's Information?

The claim will be paid if it meets Medicare coverage and medical necessity guidelines. However, if the beneficiary's Medicare record indicates that another insurer should have paid primary to Medicare, the claim will be denied. If the provider has information that contradicts Medicare's files, this information should be reported to the COB Contractor. If necessary and MSP Development Questionnaire will be sent to the beneficiary or other entity. The COB Contractor will review the information on the returned questionnaire and determine whether there is MSP. If necessary, Medicare's records will be updated and the affected claims will be reprocessed.

## What Happens if the Laboratory Fails to File Correct and Accurate Claims with Medicare?

Federal law permits Medicare to recover its conditional payments. Providers can be fined up to $2,000 for knowingly, willfully, and repeatedly providing inaccurate information relating to the existence of other benefit plans.

## How Does a Clinical Laboratory Contact the COB Contractor?

Clinical laboratories can contact the COB Contractor at 1-800-999-1118 (TTY/TDD: 1-800-318-8782), Monday - Friday, 8 a.m. to 8 p.m. Eastern Time (excluding holidays). Laboratories may contact the COB Contractor to:

- Report potential MSP situations;
- Report incorrect insurance information; or
- Address general MSP questions/concerns.

Specific claim-based issues (including claim processing) should still be addressed to the clinical laboratory's Carriers.

## Where Can I Find More Information on the Clinical Laboratory's Role in MSP and COB?

CMS offers several online references for information about MSP, COB, and the Medicare program:

- **The Medicare Learning Network Home Page**

  www.cms.hhs.gov/medlearn/

  The Medlearn Home Page features CMS provider education materials for COB and MSP issues, including a link to the Physicians Information Resource for Medicare Home Page.

- **The Medicare Coordination of Benefits Home Page**

  www.cms.hhs.gov/medicare/cob

  The Medicare Coordination of Benefits Home Page features provider materials for the MSP Program, such as the *COB Contractor MSP Claims Investigation Fact Sheet for Providers* and quarterly newsletters.

- **The Medicare Secondary Payer and You Home Page**

  www.cms.hhs.gov/medicare/cob/msp/msp_home.asp

  The Medicare Secondary Payer and You Home Page contains many useful resources for the MSP Program, including information on data gathering for providers, claims investigations, and contact information for the COB Contractor.

- **The Quarterly Provider Update Page for Clinical Diagnostic Laboratories**

  www.cms.hhs.gov/providerupdate/clia.asp

  The Quarterly Provider Update Page includes regulations, manuals, and Program Memoranda for clinical diagnostic laboratories.

Written inquiries or requests for hardcopy COB newsletters can be sent to:

**Medicare – COB**
**P.O. Box 125**
**New York, NY 10274-0125**