CMS Manual System

Pub 100-05 Medicare Secondary Payer

Transmittal 32

Department of Health & Human Services
Center for Medicare and &
Medicaid Services
Date: AUGUST 5, 2005
Change Request 3998

SUBJECT: Exception for Small Employers in Multi-Employer Group Health Plans (GHP)

I. SUMMARY OF CHANGES: Add sections 50 through 50.3 to Chapter 4 of the Medicare Secondary Payer Pub.100-05. Changed responsibility of granting small employer exceptions from Medicare contractors to the COBC. The IOM reference to FIs or Carriers is being changed to Contractors in light of the MAC contracting environment.

NEW/REVISED MATERIAL :
EFFECTIVE DATE : May 20, 2005
IMPLEMENTATION DATE : September 6, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R = REVISED, N = NEW, D = DELETED – *Only One Per Row.*

R/N/D	Chapter / Section / SubSection / Title
R	4/50/ Table of Contents
R	4/10/Overview and General Responsibilities
R	4/10.1/Introduction to the Coordination of Benefits Contractor (COBC)
R	4/10.2/Scope of the COBC in Relation to Contractors
R	4/10.3/Contractors Claim Referrals to the COBC
R	4/30/IRS/SSA/CMS Data Match
R	4/40/COBC Discontinues Dissemination of the Right of Recovery Letters to Contractors
N	4/50/Exception for Small Employers in Multi-Employer Group Health Plans (GHP)

N	4/50.1/Purpose
N	4/50.2/Background
N	4/50.3/Specific Information

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2005 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-05	Transmittal: 32	Date: August 5, 2005	Change Request 3998

SUBJECT: Exception for Small Employers in Multi-Employer Group Health Plans (GHPs)

I. GENERAL INFORMATION

A. Background:

A multi-employer GHP that has at least one employer with twenty (20) or more employees may prospectively request to except employees of identified employers with fewer than twenty (20) employees from the working aged provision. This transmittal is to advise all interested parties that as of May 20, 2005, the Coordination of Benefits Contractor (COBC) assumed the sole responsibility for reviewing and approving all requests for working aged Small Employer Exceptions.

B. Policy:

The small employer provision of the MSP statute can be found at 42U.S.C.1395y(b)(1)(A)(iii) and 42 CFR 411.172(b). Under this provision, multi-employer GHPs may elect Medicare as the primary payer for services provided to working aged Medicare beneficiaries covered through qualified employers participating in the plan that have fewer than twenty (20) employees. Such employees and their spouses are not subject to the working aged provision once an exception has been approved as long as the employer continues to meet the requirements for the exception.

As a result of the passage of the Medicare Modernization Act (MMA), creation of Medicare Administrative Contractors (MAC) was enacted. Changes to the Medicare Secondary Payer IOM are needed to reflect that the term contractor is to be used in place of Fiscal Intermediary or Carrier.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3998.1	The COBC shall be the only entity that receives, reviews and grants/denies small employer exceptions requests from multi-employer plan/administrator.									X

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3998.2	The COBC shall receive all requests/correspondence regarding the small employer exception at: Medicare Coordination of Benefits Attn: Small Employer Exception Request P.O. Box 125 New York, NY 10274-0125									X
3998.3	The COBC shall not make an exception for beneficiaries entitled to Medicare based on permanent kidney failure (End-Stage Renal Disease) or Disability.									X
3998.4	The COBC shall only grant requests on a prospective basis**.**									X
3998.5	The COBC shall maintain detailed information on the CMS website regarding required information regarding the Small Employer Exception									X
3998.6	The COBC shall receive all telephone inquiries from the multi-employer plan/administrator of the small employer at 1-800-999-1118									X
3998.7	Fiscal Intermediaries (FIs) and Carriers shall be referred to as contractors.									X

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)					
		FI	RHH	Car	DME	Shared System Maintainers	Other

						FISS	MCS	VMS	CWF	
	None.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: May 20, 2005 **Implementation Date:** September 6, 2005 **Pre-Implementation Contact(s):** Patricia Murphy at 410-786-8123 **Post-Implementation Contact(s):** COBC Contractor at 1-800-999-1118	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2005 operating budgets.**

***Unless otherwise specified, the effective date is the date of service.**

Medicare Secondary Payer (MSP) Manual

Chapter 4 - Coordination of Benefits Contractor (COBC) Requirements

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(Rev. 32, 08-05-05)

Crosswalk to Old Manuals

10 - Overview and General Responsibilities

(Rev. 32, Issued: 08-05-05, Effective: 05-20-05, Implementation: 09-06-05)

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 contractors 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. 32, Issued: 08-05-05, Effective: 05-20-05, Implementation: 09-06-05)

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 *were* performed under contracts with *contractors.* 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 contractor.* 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 *Contractors*

(Rev. 32, Issued: 08-05-05, Effective: 05-20-05, Implementation: 09-06-05)

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 *contractor.* 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, *contractor*s are no longer responsible for initiating MSP development and making MSP determinations. Any information received by *the contractor* 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 *contractor* 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 *contractors.* The *contractor* 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 –*Contractors* Claim Referrals to the COBC

(Rev. 32, Issued: 08-05-05, Effective: 05-20-05, Implementation: 09-06-05)

Contractors 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).

Contractors should instruct providers not to forward claims or copies of claims to the COBC. All claims related activity (e.g., processing, adjustments) remains the *contractor'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, *contractors shall* 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 *contractor* 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.

30 - IRS/SSA/CMS Data Match

(Rev. 32, Issued: 08-05-05, Effective: 05-20-05, Implementation: 09-06-05)

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. *The contractors* use this information to identify claims on an ongoing basis for which Medicare should not be the primary payer.

40 – COBC Discontinues Dissemination of the Right of Recovery Letters to *Contractors*

(Rev. 32, Issued: 08-05-05, Effective: 05-20-05, Implementation: 09-06-05)

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.

50 - Exception for Small Employers in Multi-Employer Group Health Plans (GHPs)

(Rev. 32, Issued: 08-05-05, Effective: 05-20-05, Implementation: 09-06-05)

50.1 Purpose

(Rev. 32, Issued: 08-05-05, Effective: 05-20-05, Implementation: 09-06-05)

As of May 20, 2005, the Coordination of Benefits Contractor (COBC) assumed the sole responsibility for reviewing and approving all requests for working aged Small Employer Exceptions.

50.2 Background

(Rev. 32, Issued: 08-05-05, Effective: 05-20-05, Implementation: 09-06-05)

A multi-employer GHP that has at least one employer with twenty (20) or more employees may prospectively request to except employees of identified employers with fewer than twenty (20) employees from the working aged provision. The small employer provision of the MSP statute can be found at 42U.S.C.1395y(b)(1)(A)(iii) and 42 CFR 411.172(b). Under this provision, multi-employer GHPs may elect Medicare as the primary payer for services provided to working aged Medicare beneficiaries covered through qualified employers participating in the plan that have fewer than twenty (20) employees. Such employees and their spouses are not subject to the working aged provision once an exception has been approved as long as the employer continues to meet the requirements for the exception.

50.3 Specific Information

(Rev. 32, Issued: 08-05-05, Effective: 05-20-05, Implementation: 09-06-05)

All requests for exceptions from the multi-employer plan/administrator of the small employer shall be submitted to the COBC. Medicare contractors having received a request or an update to a previous request shall forward these requests within fourteen (14) calendar days of receipt to the COBC. The COBC shall accept all requests/correspondence regarding the Small Employer Exception at:

Medicare Coordination of Benefits
Attn: Small Employer Exception Request
P.O. Box 125
New York, NY 10274-0125

The COBC shall not make an exception for beneficiaries entitled to Medicare based on permanent kidney failure (End-Stage Renal Disease) or Disability.

The COBC shall only grant requests on a prospective basis.

Detailed information regarding the Small Employer Exception and requirements for requesting an exception can be found on the CMS website at http://www.cms.hhs.gov/medicare/cob/insurers/in_home.asp.

The COBC's telephone number is 1-800-999-1118.