MEDICARE AS A SECONDARY PAYMENT SOURCE

END-STAGE RENAL DISEASE

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INSPECTOR GENERAL

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THIS REPORT

Entitled "Medicare as a Secondary Payment Source--End Stage Renal Disease," this inspection was conducted to determine if the Medicare program is improperly reimbursing for medical services which are covered under an employer group health plan as primary payer.

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EXECUTIVE SUMMARY

PURPOSE The inspection was conducted to determine whether or not:

- Medicare overpaid for services to end-stage renal disease (ESRD) beneficiaries who were covered by employer group health plans (EGHPs) and, if so, how much was overpaid;
- medical providers were identifying beneficiaries covered by EGHPs in addition to their Medicare entitlement;
- providers were correctly billing the Medicare contractors;
- Medicare contractors had appropriately adjudicated claims to ensure Medicare was the secondary payer for those claims submitted by providers that had not detected the EGHPs; and
- the Health Care Financing Administration (HCFA) had provided policies and procedures to promote identification of ESRD beneficiaries with EGHP coverage.

BACKGROUND

Several years ago, Congress recognized that a substantial number of Medicare beneficiaries had access to medical insurance through their employment. Therefore, Congress amended the Social Security Act making Medicare a secondary payer of health care expenses when a beneficiary had an employment-related medical insurance plan which would be the primary or first payer of medical claims.

Based on the Omnibus Budget Reconciliation Act of 1981, which amended Section 1862(b) of the Social Security Act, Medicare is the secondary payer for ESRD beneficiaries for up to 12 months following entitlement if the person is eligible for medical insurance under an EGHP. Coverage by an EGHP can be through the employment of the beneficiary, a spouse, or another person (usually a parent). Regulations and instructions implementing this provision have been issued by HCFA to institutional and noninstitutional renal dialysis facilities and to medical care providers.

METHODOLOGY

The Office of Inspector General (OIG) conducted a program inspection of admission and billing records of 498 ESRD patients at 36 randomly selected renal dialysis facilities in 9 States. The OIG also inspected related payment records from Medicare intermediaries and carriers, the Medicare program contractors responsible for the payment of

Medicare claims. The inspection covered beneficiaries receiving dialysis services during calendar year 1985.

MAJOR FINDINGS

- *A review of facility and payment records, and subsequent follow-up contacts, indicates that in 1985 Medicare made excess payments of $926,526 for renal dialysis services provided by sampled facilities. Projected nationally, Medicare overpaid $19,563,181 in 1985.*

- *Due to weaknesses in admission procedures, in over one-fourth of the cases the provider did not identify beneficiaries covered by an EGHP which was the primary payer.*

- *With minor modifications, the Social Security Administration (SSA) application forms represent an important document for the basic detection of beneficiaries covered by an EGHP.*

- *Due to weaknesses in the Medicare contractors' information-gathering and review processes, identification was not made of a significant number of payments for which Medicare did not have primary liability.*

- *Lack of coordination of benefit payments between Medicare intermediaries and carriers contributed to improper contractor payments in excess of $206,000. Projected national savings would be $4,360,500.*

- *In a number of cases, ESRD beneficiaries were entitled at different times under health insurance numbers with both the beneficiary identification codes (BICs) T and A. Due to a change of beneficiary status, the BIC changed but the numbers were not cross-referenced by Medicare contractors to reflect total payment amounts. Cross-referencing would aid in the identification of overpayment totals.*

RECOMMENDATIONS AND AGENCY COMMENTS

- The HCFA should require Medicare contractors to recover all identified overpayments for the 1985 review period, and ensure compliance with HCFA instructions and guidelines in order to identify and recover Medicare overpayments.

The HCFA is instructing the contractors to recover all identified overpayments. However, HCFA does not feel that the overpayment problem is as significant as projected. While we recognize the efforts of HCFA and the contractors over the last

several years, we point out that the savings were the product of a statistically valid sample as described in the footnote to Table II.

- The HCFA should revise its regulations to require the use of an admission form which fully develops Medicare secondary payer (MSP) sources, and adopt admission procedures which identify beneficiaries covered by an EGHP that is a primary payer. Likewise, HCFA should consider application of appropriate sanctions, to include civil monetary penalty where false claims have been submitted, for providers that are consistently found to ignore MSP provisions.

The HCFA generally concurs with the recommendation and is exploring more intensive bill review procedures and, if necessary, sanction of providers that do not comply with MSP provisions. The HCFA's reference to a generalized admission form pertains to areas that should be covered by all providers as part of their individualized admission forms. Further, according to HCFA policy, revisions to Federal regulations covering provider agreements are being prepared which will expand on criteria for provider performance in detection of MSP situations.

- The HCFA should develop sources of information on beneficiaries with EGHP coverage either by:

- *enlisting the cooperation of SSA in revising the HCFA-43 application form to obtain and transfer EGHP information, or*

- *requiring Medicare contractors to establish and follow a separate EGHP information-gathering process directly with the beneficiary.*

The HCFA concurs with the recommendation and has required contractors to develop MSP information after receipt of the first claim from a beneficiary. The SSA comments reflect its willingness to work with HCFA in this area.

- The HCFA should ensure that both Medicare intermediaries and carriers have a coordination of benefits capability in place to provide for proper claims processing and identification of EGHPs.

The HCFA agrees with the recommendation. The HCFA response reflects that its data exchange system, as implemented, provides leads to servicing contractors in developing claims.

- The HCFA should ensure that Medicare contractors are cross-referencing their own beneficiary suffix account records to achieve a total payment history.

The HCFA is in agreement with the recommendation. A system to extract extraneous data from the files is being developed to assure cross-referencing of beneficiary accounts.

The text of HCFA's comments to the draft inspection report are included in the Appendix.

INTRODUCTION

BACKGROUND

Title XVIII of the Social Security Act (42 USC 1395), enacted in 1965, established the Medicare program to pay for health care services for eligible beneficiaries 65 and over. As originally enacted, Medicare was made the first or primary payer for beneficiaries' health care services, with the exception of workers' compensation or services provided in Federal hospitals. The 1972 amendments to the Social Security Act extended Medicare coverage to persons of all ages on the basis of a diagnosis of end-stage renal disease (ESRD).

The Social Security Act subsequently was amended to limit Medicare payment for beneficiaries insured under an employment-related medical insurance plan. This includes employer-sponsored and self-insured programs. Throughout the report, the term employer group health plan (EGHP) will be used for such plans.

In these cases, the group health plan is the primary payer for services rendered, and Medicare is the secondary payer, to the extent that services have been paid for by the insurers. This limitation is referred to as the Medicare secondary payer (MSP) provisions. A major extension of these provisions was Section 2146 of Public Law 97-35, Omnibus Budget Reconciliation Act of 1981, which became effective October 1, 1981. This legislation amended Section 1862(b) of the Social Security Act to make Medicare the secondary payer to employer group health plans for beneficiaries with end-stage renal disease.

This section of the Act basically allows a benefit coordination period between Medicare and EGHPs. This is a 1-year span of time after dialysis starts and comprises an initial 3-month waiting period for a beneficiary to be eligible for Medicare benefits. There are exceptions to this waiting period which can provide entitlement for up to the full 12 months from initiation of dialysis. The exceptions include the qualified beneficiary having (1) begun a self-care dialysis training plan or (2) received a kidney transplant during the initial 3 months after starting dialysis.

Throughout the applicable coordination period, Medicare usually will be the secondary payer for those individuals entitled to benefits solely on the basis of ESRD. The provisions of this amendment pertain to services furnished after September 1981 to ESRD-entitled individuals for the 12-month coordination period which began on or after October 1, 1981.

Federal regulations implementing this secondary payer provision were published April 5, 1983. Based upon these regulations, the Health Care Financing Administration (HCFA) issued instructions to hospital-based and nonhospital-based renal dialysis facilities in 1983. Previous instructions covering the Medicare program as secondary payer were issued by HCFA in May 1982. The HCFA instructions called for records to be maintained

on claims showing an EGHP and for subsequent reexamination of these records when regulations were promulgated for individuals entitled to Medicare on the basis of ESRD. Regulations and HCFA instructions made implementation of provisions retroactive to October 1, 1981.

There were 103,997 beneficiaries identified as ESRD enrollees by the middle of 1985. Of these, 9,598 beneficiaries were entitled to Medicare ESRD benefits in calendar year 1985. Many of these individuals were employed prior to the onset of ESRD which required a continuous program of dialysis, and they continued to work and have coverage through their employers. Such coverage would exist regardless of the number of employees because there is no requirement under ESRD provisions that the employer must have 20 or more employees. In such cases, the EGHP would be the primary payer for medical expenses incurred up to the initial 12 months of the beneficiaries' Medicare entitlement.

The HCFA directives require Medicare intermediaries and carriers to have administrative procedures that screen all claims for the existence of other primary payers. Intermediaries and carriers (hereafter referred to as contractors) make program payments for institutional and noninstitutional provider claims respectively.

Steps taken administratively by HCFA since 1984 to enhance detection of all third-party resources include (1) a one-time effort to recover ESRD dollars incorrectly paid for claims processed, (2) the establishment in Fiscal Year 1985 of Medicare secondary payer (MSP) goals for contractors (a specific MSP-ESRD goal was established in Fiscal Year 1986), (3) periodic on-site MSP reviews of providers by contractors to analyze the effectiveness of MSP outreach program. Other activities being pursued by HCFA included a one-time questionnaire mailing to elicit MSP information for beneficiaries and establishment of a State or regional depository for MSP information to which Medicare contractors could query claims.

PURPOSE

The Office of Analysis and Inspections (OAI), Office of Inspector General (OIG), had conducted a number of regional inspections from 1983-1985 to determine if ESRD facilities were identifying EGHP coverage for ESRD Medicare beneficiaries and billing appropriately, and the propriety of payment made by Medicare contractors. These reviews identified substantial Medicare payments where an EGHP existed but was not identified by the provider or Medicare contractors.

The Office of Audit (OA), Office of Inspector General, has also been involved in activities related to MSP/ESRD. In a recent report, OA found in reviewing an earlier period that Medicare contractors in the State of Washington had been improperly reimbursing facilities for medical services where an EGHP was primary.

A joint Region IX OA and OAI study focused on how accurately claims were processed

by Medicare intermediaries when there was a prior indication of a primary payer other than Medicare and a no-payment claim was submitted. When a beneficiary was found in both samples, the beneficiary was dropped from this sample for overpayment calculation.

Considering the findings of these regional inspections and the administrative initiatives of HCFA, the OIG undertook this inspection to determine the national prevalence of undetected MSP situations for ESRD beneficiaries and to estimate the cost of improper Medicare payments.

METHODOLOGY

The program inspection methodology included the identification of 36 ESRD facilities in 9 States which were picked at random using a 2-stage sample design. The States and the facilities were selected with probability proportional to size using the number of ESRD beneficiaries as an indicator of size. The 36 facilities included 20 hospitals and 16 non-hospital-based or free-standing facilities. The facilities within each State were selected using a method which reflected the relative distribution of hospital and nonhospital facilities in that State.

Beneficiaries whose ESRD Medicare entitlement began in calendar year 1985, and who were treated at these facilities, were included in the study. Admission and patient billing records for these ESRD beneficiaries were reviewed in order to validate the ESRD onset date and to determine whether the facility had correctly identified and billed Medicare on behalf of beneficiaries where an EGHP would have been primary payer. A total of 498 records were reviewed for all facilities. At each of these facilities, the teams conducted personal interviews with the providers' admissions and business office staff responsible for patient admission and billing functions. Payment records were obtained from 21 Medicare contractors for the beneficiaries in the sampled facilities. These documents were used to verify whether Medicare made primary payments for the ESRD beneficiaries during the period in which EGHPs had liability as primary payers.

A review was conducted of these records to identify whether an EGHP existed. Where provider records reflected an employed spouse or relative, the inspection then ascertained whether the spouse or relative was a member of an EGHP, and whether the beneficiary was covered as part of that plan. Where an EGHP existed, but had not been identified by the provider and/or Medicare contractor for primary payment, the inspection team referred to the contractor's payment records to determine the overpayment by the intermediary and/or carrier. The amount of national savings was obtained by projecting the total overpayment from the sample to the ESRD providers for calendar year 1985.

FINDINGS AND RECOMMENDATIONS

The primary purpose of the inspection was to determine, for a 12-month period, the extent of overpayments made by Medicare contractors for services to ESRD beneficiaries provided by a randomly selected sample of 36 hospital and nonhospital providers, and to calculate projected savings if the results are applied to the universe of ESRD providers. While on-site visits were not made to Medicare contractors, nor were contractor systems tested, the extent of the overpayments identified can indicate a lack of operational effectiveness. Weaknesses or problem areas are reported in the specific findings and recommendations of this report.

A. MEDICARE OVERPAYMENTS

Finding

Out of the 498 ESRD beneficiaries entitled to Medicare in the sample, 282 (56.6 percent) were identified as having coverage under an EGHP. Of this number, 135 beneficiaries were found to be covered by an EGHP which should have been the primary payer for ESRD services during the coordination period but was not. The total overpayment of $926,526 was calculated for services reimbursed by the Medicare intermediary and/or carrier for the beneficiaries in the sample. The overpayment calculation does not include overpayments for beneficiaries with onsets prior to 1985 nor onsets in 1985 with payments in 1986. A breakdown of the overpayment is shown on the following chart.

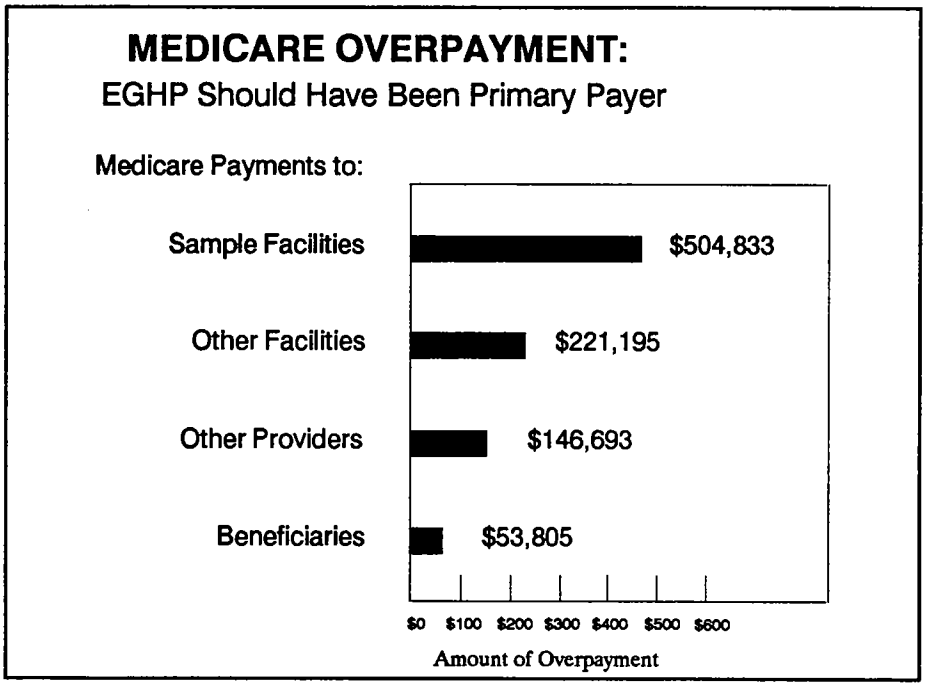

Table I in the appendix identifies the source of overpayment by intermediary, by category of sampled facilities and other facilities, and by carrier for assigned and nonassigned claims.

Projecting the sample overpayment results to all ESRD providers for the period of the review, the inspection team estimates potential national savings of $19,563,181 for the Medicare program (Table II). This calculation takes into consideration only entitlement in 1985 and is limited to payments made for services in 1985.

Recommendation

The HCFA should instruct Medicare contractors to recover overpayments and, if applicable, to pursue subrogation to recover identified overpayments from third-party payers. Because of the substantial size of the projected overpayment, consideration should also be given to a special review of services on or after January 1, 1985.

B. ADMISSION PROCEDURES

Finding

Thirty-four percent of the sampled beneficiaries had EGHP coverage based upon another household member's (primarily the spouse's) EGHP. In the overpayment cases, the provider had not pursued or fully developed information on employment of the spouse and/or coverage under the spouse's or other person's EGHP for correct billing to Medicare. Because of the study design, this percentage does not reflect "potential coverage" where beneficiaries with an EGHP also have working spouses with an EGHP.

In order to improve the identification of such EGHP payment sources, HCFA developed a supplemental decision document which proceeds through various steps that cover MSP factors. The document includes a step for determining whether: (1) the spouse or other person is employed, (2) an EGHP exists in these cases, and (3) the beneficiary is covered under its provisions. The capability to detect these MSP situations appeared to be enhanced where the providers' admission forms required this information, or when the providers used a decision document or their admission procedures called for a systematic review process.

Recommendation

The HCFA should reemphasize the importance of providers' use of systematic admission procedures which query all factors, including a working spouse, that relate to MSP. The HCFA can do this through instructions to contractors, who should then produce newsletters, conferences, or other communications to providers, and

by revision of its regulations to require the use of an admission form which fully develops MSP sources.

Providers that consistently are found to ignore the MSP provisions should be considered for application of appropriate sanctions, to include civil monetary penalty where false claims have been submitted.

C. DEVELOPMENT OF INFORMATION SOURCES TO IDENTIFY EGHP COVERAGE

Finding

The extent of the Medicare overpayment, which averaged $6,863 for each identified ESRD beneficiary covered under an EGHP, indicates a substantial weakness in the identification of EGHPs which would make Medicare the secondary payer.

If the institution, physician, or other provider does not identify Medicare as secondary payer to an EGHP, the Medicare contractor must detect EGHP coverage as part of the Medicare claims adjudication process. The contractor, in turn, must rely upon a screening process whereby the beneficiary is targeted for MSP review because he or she is working or has previously been identified for MSP. It is important that the Medicare contractors have the ability to screen individual claims and take action to recover any overpayments from the payees or to subrogate, as applicable, from the insurance companies.

Two factors in ESRD reimbursement should be considered in such detection and recovery processes.

a. *Institutional and noninstitutional providers may file for conditional Medicare payments. However, in discussions with facilities, the inspection team found that facilities do not routinely bill Medicare unless the EGHP payment is less than the amount payable for Medicare-covered services or a denial is received from the particular employer's plan.*

b. *As reflected in the finding on admission procedures, over one-third of the beneficiaries were covered under an EGHP as a function of the spouse's employment or the employment of one or both parents.*

An effective contractor detection process should also include the capability to reference and analyze all coverage factors pertinent to that beneficiary. Factors include the application for ESRD benefits and any direct contact with the beneficiary prior to processing claims.

The application form for end-stage renal disease is the HCFA-43. While the form asks for information about the claimant's work status, it does not require information about the claimant's EGHP benefits. Likewise, the HCFA-43 does not request information concerning coverage under a spouse's or other person's (parent's) EGHP. Presently, the information provided in HCFA-43, as with Social Security Administration (SSA) application forms, is confidential and is not discloseable for MSP reference.

A pilot project is being conducted by HCFA and SSA to obtain additional MSP related information at the time the SSA application is taken. The pilot involves a sample of States and SSA District Offices. The information is obtained on an additional form and forwarded to the servicing Medicare carrier. The HCFA is presently evaluating the results of the project.

Presently, HCFA does not require the Medicare contractors to routinely follow a separate process to obtain information directly from beneficiaries on whether they are employed and covered by their own EGHP, or are covered under another person's EGHP.

Recommendation

The HCFA-43 is a valuable "lead document" to assist in identifying where MSP provisions apply to Medicare entitlement based upon ESRD. The HCFA should coordinate with SSA to develop the necessary agreements and mechanisms for information or computer edit transfer. Further, HCFA should expand the information obtained in the HCFA-43 to include whether the claimant is a member of the employer's EGHP and whether the spouse or other person is a member of an EGHP. If such coordination can be worked out, the SSA would provide HCFA-43 information to HCFA for claimants who have been approved for ESRD benefits.

If HCFA determines that expansion of the HCFA-43 is not possible, then HCFA should develop procedures to require that contractors obtain potential MSP information from all newly entitled ESRD beneficiaries. The newly entitled beneficiaries average approximately 10,000 per year, and MSP workups would amount to an annual average work load for each contractor of less than 210 beneficiary contacts.

D. COORDINATION BETWEEN INTERMEDIARIES AND CARRIERS

Finding

In the analysis of overpayments made by the Medicare contractors, the inspection team found instances in which the intermediary or the carrier, but not both, had identified the existence of EGHP coverage and correctly processed the claims as

secondary. An indication of the extent of the lack of coordination for services reimbursed is noted as follows:

Situation	Overpayment Amount	Projected National Savings Amount
EGHP identified by intermediary but payment made by carrier	$158,990	$3,355,000
EGHP identified by carrier but payment made by intermediary	47,630	1,005,500
TOTALS	**$206,620**	**$4,360,500**

Lack of a system for coordinating MSP information between intermediaries and carriers is a contributory cause of improper contractor payment of ESRD claims totalling $206,620.

Recommendation

The HCFA should ensure that a "crossover" capability is in place to provide coordination of benefits/claims processing to and from Medicare intermediaries and carriers.

E. CROSS-REFERENCING BENEFICIARY ACCOUNTS

Finding

There are cases where the individual may be entitled as an ESRD currently insured beneficiary (T suffix) and subsequently be issued a fully insured health insurance number (A suffix). In such cases, the contractors must cross-reference the numbers to ensure correlation of a total payment history profile for the beneficiary.

The inspection team found that in a number of cases beneficiaries have been entitled under both an ESRD T-suffix and ESRD A-suffix without these being cross-referenced to reflect the total Medicare payment amounts for both accounts. When the team requested a payment history, only one of the accounts was provided. If an overpayment would apply because Medicare improperly paid as primary when EGHP coverage existed, the total overpayment might not be determined since both accounts had not been cross-referenced.

Recommendation

The HCFA should ensure that Medicare contractors are properly cross-referencing all accounts.

APPENDIX

TABLE 1
MEDICARE SECONDARY PAYER PROVISION
ESRD OVERPAYMENT

MEDICARE CONTRACTORS	OVERPAYMENT	
Type of Contractor	**Amount**	**Total**
Intermediaries		
Sample Facilities	$504,833	
Other Facilities	221,195	
Intermediaries		$726,028
Carriers		
Assigned Payments	$146,693	
Nonassigned Payments	53,805	
CARRIERS		$200,498
ALL CONTRACTORS		$926,526

TABLE 2
MEDICARE SECONDARY PAYER PROVISION
ESRD PROJECTION OF SAVINGS
FOR 1985 SERVICES[1]

MEDICARE CONTRACTORS	PROJECTED SAVINGS	
Type of Contractor	**Amount**	**Total**
Intermediaries		
Sample Facilities	$105,00,625	
Other Facilities	5,294,230	
Intermediaries		$15,794,855
Carriers		
Assigned Payments	$ 2,913,365	
Nonassigned Payments	854,961	
CARRIERS		$ 3,768,326
ALL CONTRACTORS		$19,563,181

[1]The projections for this inspection, which represent only overpayments for beneficiaries with onset and services in 1985, were arrived at by multiplying the findings for each facility by the inverse of the sampling probalilities associated with the facility. The States were selected with probability proportional to size, size being determined by the number of ESRD beneficiaries within each State. Facilities within each State were selected in the same fashion except that the sample was picked to reflect the proportion of hospital-based and nonhospital-based facilities found in each State.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date AUG 6 1987

From William L. Roper, M.D.
Administrator

Glenn M. Hackson for

Subject OIG Draft Report: "Medicare as a Secondary Payment Source - End Stage Renal Disease," OAI-07-86-00092

To The Inspector General
Office of the Secretary

We have reviewed the OIG's draft report detailing the results of the national inspection of program reimbursement to end stage renal disease facilities. We concur with the findings in the report, and our comments on the specific recommendations are attached for your consideration.

Thank you for the opportunity to comment on this report.

Attachment

Comments of the Health Care Financing Administration on the OIG Draft Report "Medicare as a Secondary Payment Source -- End Stage Renal Disease" - OAI-07-86-00092

OIG Recommendation

Require Medicare contractors to recover all identified overpayments for the 1985 review period, and ensure compliance with HCFA instructions and guidelines in order to identify and recover Medicare overpayments.

HCFA Comments

We will instruct contractors to recover those overpayments identified as a result of the study. This will require that the OIG furnish us with a listing of identified overpayments for each contractor reviewed. However, we would note that with respect to services on or after January 1, 1985, we do not believe the overpayment problem was as significant as projected by the OIG. Initially, contractors could not identify end stage renal disease (ESRD) claims on a prepayment basis, thus while overpayments have been made, many were subsequently recovered upon post-payment review. Contractors have since developed the capability to identify ESRD claims before payment.

OIG Recommendation

Revise regulations to require use of an admission form which fully develops Medicare Secondary Payer (MSP) sources, and adopt admission procedures which identify beneficiaries covered by an employee group health plan (EGHP) that is a primary payer. Providers that consistently are found to ignore the MSP provisions should be considered for application of appropriate sanctions, to include civil monetary penalty where false claims have been submitted.

HCFA Comments

HCFA began an "outreach" program in FY 1987 to educate providers, beneficiaries, employers, and insurers about Medicare as a secondary payer. We have had particular success with the ESRD providers, probably because they are, as a group, an easily identified population. Contractors that have discussed ESRD claims procedures with providers have advised them that claims should be sent directly to insurers rather than being submitted to Medicare contractors. In addition, we routinely sample provider admission procedures to identify and correct inappropriate practices.

There is a generalized admission form that is used currently by all providers. To supplement that form, we have included in both the provider manual and the intermediary manual a series of questions that develop MSP information. Therefore, we do not believe a regulatory revision is necessary at this time.

We currently are considering more intensive bill review procedures and, if necessary, sanctions against providers that do not comply with MSP provisions.

OIG Recommendation

Develop sources of information on beneficiaries with EGHP coverage either by:

- enlisting the cooperation of SSA in revising the HCFA-43 application form to obtain and transfer EGHP information, or

- require Medicare contractors to establish and follow separate EGHP information-gathering process directly with the beneficiary.

HCFA Comments

We concur with your alternate recommendation. We are now requiring contractors to develop the first claim received from any beneficiary. The development letter requests data on the beneficiary's or spouse's employment, insurance coverage, and other information that would provide leads for MSP situations. The information is entered into a data base to be shared with other contractors.

OIG Recommendation

Ensure that both Medicare intermediaries and carriers have a coordination of benefits capability in place to provide for proper claims processing and identification of EGHPs.

HCFA Comment

We have recently implemented a data exchange system among contractors which permits quarterly exchanges of MSP data. This system provides leads to the receiving contractor and limits the duplication in effort among contractors in developing claims.

OIG Recommendation

Ensure Medicare contractors are cross-referencing their own beneficiary suffix account records to achieve a total payment history.

HCFA Comments

From an MSP aspect, as contractors improve their data bases as a result of the data exchange system described above, we expect that cross-referencing of accounts will be less of a problem. We are now developing a purge system which will remove extraneous data from the data base. Once this is installed, we will be better able to review the information and assure that cross-referencing is being used.