

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE SECONDARY PAYER:
EFFECTIVENESS OF FIRST CLAIM
DEVELOPMENT**

MANAGEMENT ADVISORY REPORT



**Richard P. Kusserow
INSPECTOR GENERAL**

NOVEMBER 1991

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This report was prepared under the direction of Don McLaughlin, Regional Inspector General and James H. Wolf, Deputy Regional Inspector General, Office of Evaluation and Inspections, Region VII. Participating in this project were the following people:

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OEI-07-90-00763

EXECUTIVE SUMMARY

PURPOSE

To evaluate the effectiveness of developing the first claim submitted by or on behalf of a beneficiary to help identify other insurance coverage.

BACKGROUND

In June 1987, Health Care Financing Administration (HCFA) required the carriers to contact each beneficiary who is age 65 or 66 when the first Medicare claim is submitted on his/her behalf. This procedure entails sending a form letter to the beneficiary asking for current employment and insurance information. If there is an indication of a primary payment source, the claim is developed to establish primary payment liability. If not, the claim is processed and paid as usual. To assess the effectiveness of this procedure, we obtained data from 30 carriers.

FINDINGS

Approximately 6.4 percent of the first claims developed by carriers successfully identified primary payment sources other than Medicare.

Although some concerns were expressed, carrier representatives believe first claim development effectively identifies primary payment sources.

Carriers vary greatly in the number of MSP situations identified by the first claim development process.

The HCFA does not require carriers to suspend payment on the first claim submitted by or on behalf of a disabled beneficiary until the development letter is returned.

RECOMMENDATIONS

The HCFA should obtain data to evaluate each carrier's reporting of first claim development activities and assure compliance with all first claim development procedures.

The HCFA should collect health insurance information for disabled beneficiaries during the required disability benefit waiting period.

COMMENTS

The HCFA concurred with both recommendations presented in the draft report. The HCFA's verbatim comments are included in Appendix A.

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INTRODUCTION

PURPOSE

To evaluate the effectiveness of developing the first claim submitted by or on behalf of a beneficiary to help identify other insurance coverage.

BACKGROUND

The Health Care Financing Administration (HCFA) is responsible for administering the Medicare program and for ensuring compliance with Medicare legislation and regulations. Private insurance companies contract with HCFA to process and pay Medicare claims. These contractors are known as fiscal intermediaries (Part A) and carriers (Part B).

The contractors are responsible for ensuring that Medicare pays for covered care only after reimbursement from other primary insurers has been made. Contractors are required to administer the program in a manner that achieves maximum savings and cost avoidance to the Medicare trust funds. Medicare secondary payer (MSP) provisions affect claims involving the working aged, spousal working aged, beneficiaries with end-stage renal disease, beneficiaries eligible for payment under automobile, medical liability, and no-fault insurance; individuals eligible for or receiving workers compensation; and the disabled.

Despite current procedures and HCFA initiatives to help identify MSP situations, contractors continue to have difficulties identifying all beneficiaries who have a primary payment source(s) other than Medicare. Previous studies and audits conducted by the Office of Inspector General have reported that Medicare is losing at least \$637 million annually due to the contractor's inability to identify primary payment sources.

In a previous OIG inspection "Extent of Unrecovered Medicare Secondary Payer Funds" (OEI-07-90-00760), we conducted MSP development on a random sample of Medicare beneficiaries. We tracked our development costs to determine a cost-benefit ratio. For every dollar spent to develop an MSP source, we identified \$5.40 that should have been paid by insurance other than Medicare.

In June 1987, HCFA required the carriers to contact each beneficiary who is age 65 or 66 when the first Medicare claim is submitted on his/her behalf. This procedure entails sending a form letter to the beneficiary asking for current employment and insurance information. Section 4307 of the Medicare Carriers Manual (MCM) requires all claims be suspended until the questionnaire is completed by the beneficiary and returned to the carrier.

If there is an indication of a primary payment source, the claim is developed to establish primary payment liability. If not, the claim is processed and paid as usual. If no response is received after 30 days, a second letter is sent and if no response is received after another 15 days, the claim is denied for insufficient information. Carriers are instructed to flag the beneficiary's file and develop any subsequent claims in the same manner. The HCFA's instructions require that no claims be paid until complete information is received.

METHODOLOGY

We mailed questionnaires to all Medicare carriers and the Blue Cross Association to obtain data concerning current first claim development procedures and their effectiveness. We surveyed the carriers concerning their methods of development, the percentage of claims that were verified MSP situations, and their suggestions to improve the first claim development process. We also collected information relating to the possibility of expanding the current first claim development requirement to develop the first claim submitted for a beneficiary each year.

In addition, we analyzed information collected during onsite visits to carrier MSP units. These visits were conducted to collect data for a previous OIG study entitled "Medicare Prepayment Review: MSP Procedures at Carriers" (OEI-07-89-01683). During this study we examined the carriers' methods and interpretation of first claim development activities. The findings and recommendations presented in this report are based on the information collected during these visits and an analysis of the questionnaires. This report presents a summary of the questions that address significant issues.

FINDINGS

Approximately 6.4 percent of the first claims developed by carriers successfully identified primary payment sources other than Medicare.

Twenty-four of the thirty carriers that responded to our survey developed a total of 1,971,881 first claims during FY 1989. The HCFA does not require formal reporting of first claim development activities. Due to the limited scope of this MAR, we did not verify the responses to the questionnaire because it would have required extensive onsite work.

Six carriers indicated that they did not track this information so it was not readily available for analysis. Of the remaining 24 carriers, one carrier reported 70 percent and a second reported that 50 percent of the first claims developed successfully identified a primary payment source other than Medicare. These two carriers were not included in our analysis because we considered them to be "outliers."

We calculated the weighted average for the carriers. This method placed more "weight" on those carriers who developed a greater volume of first claims. Approximately 6.4 percent (126,200) of the first claims developed by the carriers identified a primary payment source.

We also calculated the median of the percentages reported by the carriers. The median number of first claims with a positive indication of a primary payment source is 8 percent or a total of 157,750 claims.

According to HCFA, Medicare carriers processed 407,700,000 claims in FY 1989. These claims totaled \$27,171,022,826 in Medicare payment for an average of \$66.64 per claim. Using this average, the 24 carriers saved from \$8,409,968 to \$10,512,460 by identifying primary payment sources other than Medicare.

Although some concerns were expressed, carrier representatives believe first claim development effectively identifies primary payment sources.

The carriers responded that first claim development is an effective method of identifying MSP situations. When asked whether the current method of "first claim" development process effectively identifies MSP situations, all thirty carriers responded positively. According to the carriers, first claim development is an important part of their development process.

Respondents from the carriers provided the following positive comments.

- o "First claim development gives Medicare the opportunity to gather the needed information pertaining to MSP before we make payment on the claim. This reduces the number of incorrect payments."

- o "We identify cases on a prepayment basis. By doing so, we avoid costly, time consuming overpayment recovery."
- o "Most of the working aged and working disabled are identified from this procedure."

Despite these and many similar comments, the respondents also expressed some concerns with the procedure.

- o "The majority of responses received indicate that there is no MSP involvement. Therefore, payment for a new beneficiary's claim is often delayed unnecessarily. First claim development has generated many negative professional relations issues."
- o "The information received from the majority of beneficiaries is incorrect regarding EGHP/LGHP coverage."
- o "The number of positive MSP leads identified through first claim development is a very small volume in comparison to the number of letters sent out by the MSP department."

Carriers vary greatly in the number MSP situations identified by the first claim development process.

Each carrier is required to conduct first claim development according to the procedures outlined in Section 4307 of the MCM.

We asked the carriers to provide the percentage of first claims that successfully identified MSP situations. The percentages provided ranged from two percent to seventy percent. This is a large range for a process that should be consistent from carrier to carrier.

A combination of two factors may be contributing to this variance. Carriers are not required to track or report information concerning their first claim development procedures. Therefore, some carriers may have reported more accurate figures than others. Secondly, the variance may be due to different levels of compliance with the first claim development procedures. Some carriers may be more aggressive in their development.

In a prior onsite review of seven carriers, we also questioned carrier representatives about their first claim development procedures. We found a great variance in how the process is conducted and how the instructions are interpreted.

The HCFA does not require carriers to suspend payment on the first claim submitted by or on behalf of a disabled beneficiary until the development letter is returned.

The HCFA has modified its instructions to the carriers concerning the first claim development process. The procedures no longer require first claim development for disabled beneficiaries. Unless the carrier receives information from another source that a primary payer exists, all claims for disabled beneficiaries are processed and paid without delay. Carriers continue to send development letters, however, claims continue to be processed and paid before the letters are returned.

The HCFA made this modification for two reasons. Firstly, disabled individuals typically file many claims within the first few months of Medicare eligibility. Suspending all of these claims would create a backlog and beneficiary relations would suffer. Secondly, disabled beneficiaries often need assistance in responding to the development letters. Therefore, responses to the letters would not be timely. This also slows the payment process.

This modification creates an inefficient "pay and chase" situation for the carriers. When the carrier receives a development letter with a positive indication of a primary payment source, the contractor must conduct a postpayment recovery.

RECOMMENDATIONS

The HCFA should obtain data to evaluate each carrier's reporting of first claim development activities and assure compliance with all first claim development procedures.

Currently, carriers are not required to keep statistics or submit reports about their first claim development activities. To monitor compliance with the first claim development requirements, HCFA should require the carriers to track and report information relating to first claim development. The following list includes examples of the type of information that would help monitor first claim development procedures.

- o The number of development letters sent.
- o The total cost of first claim development procedures.
- o The number of development letters returned within 30 days.
- o The number of claims denied because a development letter was not returned.
- o The number of MSP situations identified due to first claim development.

The HCFA should collect health insurance information for disabled beneficiaries during the required disability benefit waiting period.

We recognize that HCFA's policy of not suspending the first claims of the disabled until the development letters are returned is based on valid concerns. We believe that an alternate solution is possible.

The Social Security Act provides entitlement to disabled beneficiaries following a two year waiting period. During this period, HCFA could be advised of these disability beneficiaries and begin the development process. When the disabled beneficiary is eligible for Medicare, his/her health insurance situation will have been determined prior to submission of the first claim. This would reduce the number of post-payment recoveries by eliminating "pay and chase" situations for disabled beneficiaries and be a more cost effective method of MSP development. At the same time, it would avoid the obstacles during the first few months of eligibility.

COMMENTS

The HCFA concurred with both recommendations presented in the draft report. They are arranging to utilize the Common Working File (CWF) to generate a report to monitor first claim development activity and track contractor compliance.

Also, the HCFA is considering a pre-claim development process to replace first claim development. This process would include the disabled. It would collect complete health insurance information at the time of Medicare enrollment and Medicare beneficiaries would complete this form prior to filing their first claim. While this is not exactly what we recommended regarding the disabled, we do agree it is responsive to the problem that we raised.

The HCFA's verbatim comments are included in Appendix A.

APPENDIX A

AGENCY COMMENTS

**Memorandum**

SEP 30 1991

Date Gail R. Wilensky, Ph.D. *grw*
From Administrator

Subject OIG Draft Management Advisory Report: "Medicare Secondary Payer:
Effectiveness of First Claim Development," OEI-07-90-00763

To Inspector General
Office of the Secretary

We have reviewed the subject draft management advisory report which evaluates the effectiveness of first claim development to identify primary insurers of Medicare beneficiaries. OIG found that, for the most part, first claim development is efficient.

OIG recommends that HCFA obtain data to evaluate each carrier's reporting of first claim development activities and assure compliance with all first claim development procedures. They also recommend that HCFA should collect health insurance information for disabled beneficiaries during the required disability benefit waiting period. HCFA concurs with these recommendations. Our specific comments are attached for your consideration.

Thank you for the opportunity to review and comment on this draft management advisory report. Please advise us whether you agree with our position on the report's recommendations at your earliest convenience.

Attachment

Comments of the Health Care Financing Administration
(HCFA) on the OIG Draft Management Advisory
Report - "Medicare Secondary Payer: Effectiveness
of First Claim Development." OEI-07-90-00763

Recommendation 1

HCFA should obtain data to evaluate each carrier's reporting of first claim development activities and assure compliance with all first claim development procedures.

HCFA Response

HCFA concurs with this recommendation. We are arranging for the establishment of a Common Working File report by contractors on first claim development activities. This report will be used to monitor the activity and track contractor compliance.

Recommendation 2

HCFA should collect health insurance information for disabled beneficiaries during the required disability benefit waiting period.

HCFA Response

HCFA concurs with this recommendation. We are considering the establishment of a pre-claim development process which would replace first claim development. For that process, we would develop a questionnaire to solicit the information currently provided by first claim development. The questionnaire would be distributed at the time of the initial Medicare enrollment, and would be completed by all Medicare beneficiaries, including the disabled, prior to filing their first Medicare claim.