DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

REGION IV
Room 3T41
61 Forsyth Street, S.W.
Atlanta, Georgia 30303-8909

SEP 1 6 2002

CIN: A-04-01-07002

Mr. Eric Lawson
Chief Financial Officer
Orange Park Medical Center
2001 Kingsley Avenue
Orange Park, Florida 32073

Dear Mr. Lawson:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services (OAS) report entitled ***Review of Hospital Medicare Secondary Payer Issues*** for fiscal year ended June 30, 2000. A copy of this report will be forwarded to the HHS action official noted below for review of any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act, 5 United States Code 552, as amended by Public Law 104-231, OIG,OAS reports issued to the department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the department chooses to exercise. (See 45 Code of Federal Regulations Part 5). As such, within 10 business days after the final report is issued, it will be posted on the World Wide Web at http://oig.hhs.gov.

To facilitate identification, please refer to Common Identification Number (CIN) A-04-01-07002 in all correspondence relating to this report.

Sincerely yours,

Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV

Enclosure – as stated

Direct reply to HHS Action Official:
Dale Kendrick, Associate Regional Administrator
Centers for Medicare & Medicaid Services Region IV
61 Forsyth Street, S.W., Suite 4T20
Atlanta, Georgia 30303 - 8909

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF HOSPITAL MEDICARE SECONDARY PAYER ISSUES

JANET REHNQUIST
Inspector General

SEPTEMBER 2002
A-04-01-07002

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

REGION IV
Room 3T41
61 Forsyth Street, S.W.
Atlanta, Georgia 30303-8909

SEP 16 2002

CIN: A-04-01-07002

Mr. Eric Lawson
Chief Financial Officer
Orange Park Medical Center
2001 Kingsley Avenue
Orange Park, Florida 32073

Dear Mr. Lawson:

This final report provides you the results of our *Review of Hospital Medicare Secondary Payer Issues.*

EXECUTIVE SUMMARY

OBJECTIVE

The objective of this review was to determine whether Orange Park Medical Center (the hospital) complied with Medicare Secondary Payer (MSP) regulations regarding both inpatient and outpatient settings during its Fiscal Year (FY) ended June 30, 2000.

FINDINGS

Our review showed that, for 64 percent of the claims reviewed, the hospital could not provide sufficient documentation to demonstrate compliance with Medicare guidelines and it's policies and procedures regarding the completion and adequacy of MSP questionnaires. We are concerned that this condition could lead to Medicare absorbing a share of the costs applicable to other payers and to credit balances being generated and requiring unnecessary administrative expenses to resolve. In this respect, a review of 25 credit balances showed that in 7 instances, Medicare was billed in the wrong order. In reviewing these credit balances, we also found that the hospital did not always refund Medicare credit balances in a timely fashion.

We are recommending that the hospital:

- not bill Medicare unless hospital personnel have obtained and filed a completed MSP questionnaire;
- implement and provide, within 60 days, effective education and training to every staff person associated with collecting admission information;

- within 90 days of providing the above training, perform its own internal review to determine whether the conditions we found in FY 2000 are also present in subsequent periods i.e., FY 2001 through the most current up to date information at the time of review; and

- develop and implement effective administrative controls aimed at liquidating Medicare credit balances on a more timely fashion.

In response to our draft report, hospital officials generally agreed with our recommendations.

BACKGROUND

The Health Care Financing Administration (HCFA recently changed to the Centers for Medicare & Medicaid Services) Hospital Manual Section 301 states that Medicare is the secondary payer under certain circumstances and provides guidance for hospital admission staff to recognize the circumstances under which Medicare should not pay as primary and to identify the party which is responsible for primary payment. "The law mandates that Medicare is secondary payer for:

- Claims involving Medicare beneficiaries ages 65 or older who have group health plans (GHP) coverage based upon their own current employment status with an employer that has 20 or more employees, or that of their spouse of any age, or based upon coverage by a multiple employer, or multi-employer group health plan by virtue of his/her own, or a spouse's current employment status and the GHP covers at least one employer with 20 or more employees;

- Claims involving beneficiaries eligible for or entitled to Medicare on the basis of ESRD (End Stage Renal Disease) (during a period of 30 months) except where an aged or disabled beneficiary had GHP or large group health plan (LGHP) coverage which was secondary to Medicare at the time ESRD occurred;

- Claims involving automobile or non-automobile liability or no-fault insurance;

- Claims involving government programs; e.g., Workers Compensation (WC), services authorized and paid for by the Department of Veterans Affairs (DVA), or Black Lung (BL) benefits; and

- Claims involving Medicare beneficiaries under the age of 65 who are entitled to Medicare on the basis of disability and are covered by an LGHP (plans of employers, or employee organizations, with at least one participating employer that employs 100 or more employees) based upon his or her own current employment status or the current employment status of a family member."

Section 301 also states "You are required to determine whether Medicare is a primary or secondary payer for each inpatient admission of a Medicare beneficiary and outpatient encounter with a Medicare beneficiary. You must accomplish this by asking the beneficiary about other insurance coverage. Section 301.2 lists the type of questions which (hospital staff) must ask of Medicare beneficiaries for every admission, outpatient encounter, or start of care."

Section 301.2 states "failure to obtain the information listed in these sections is a violation of your provider agreement with Medicare (See 142.317.) The information you must obtain is essential to filing a proper claim with Medicare or a primary payer. Failure to file a proper claim can result in the unnecessary denial or development of claims."

Section 301.3 states "hospitals must retain a copy of completed admission questionnaires in their files for audit purposes to demonstrate that development for other primary payers coverage takes place. Hard copies and data must be kept for at least 10 years, in accordance with the Department of Justice (DOJ) record retention requirements, after the date of service, which appears on the claim."

Section 1866 (a) (1) (c) of the Social Security Act (Act) requires hospitals and other health care providers participating in the Medicare program to make adequate provisions to refund any monies incorrectly paid. In accordance with Sections 1815 (a) and 1833 (e) of the Act, the Secretary is authorized to request information from providers which is necessary to properly administer the Medicare program. In accordance with these provisions, Form HCFA-838 must be completed by all hospitals and other health care facilities participating in the Medicare program to help assure that monies owed to the Medicare program are paid in a timely manner.

The Form HCFA-838 is specifically used to monitor the identification and recovery of credit balances due the Medicare program. A credit balance is defined as an improper or excess payment made to a provider as the result of patient billing or claims processing errors. For the purpose of completing the Form HCFA-838, a Medicare credit balance is an amount determined to be refundable to the Medicare program. Generally, when a provider receives an improper or excess payment for a claim it is reflected in their accounting records (patient accounts receivable) as a credit. However, Medicare credit balances include money due the program regardless of its classification in a provider's accounting records. For example, if a provider maintains credit balances accounts for a stipulated period, e.g., 90 days, and then transfers the accounts or writes them off to a holding account, this does not relieve the provider of its liability to the program.

The MSP regulations, Code of Federal Regulations (CFR) Title 42 Section 489.20, requires providers to reimburse Medicare within 60 days from the date they receive payment from another payer (primary to Medicare) for the same service. Submission of the Form HCFA-838 and adherence to its instructions do not interfere with this rule; credit balances resulting from MSP payments must be repaid within the 60-day period.

Credit balances resulting from MSP payments must be reported on the form HCFA-838 if they have not been repaid by the last day of the reporting quarter. When an MSP credit balance is identified and repaid within a reporting quarter, in accordance with the 60-day requirement, it would not be included in the Form HCFA-838.

If an MSP credit balance occurs late in a reporting quarter, and the Form HCFA-838 is due prior to the expiration of the 60-day requirement, it would still be included in the credit balance report. However, payment of the credit balance does not have to be made at the time the Form HCFA838 is submitted, but within the 60 days allowed.

OBJECTIVE, SCOPE AND METHODOLOGY

Objective

The objective of this review was to determine whether the hospital complied with MSP regulations regarding both inpatient and outpatient settings during its FY ended June 30, 2000.

Scope and Methodology

Our audit was performed in accordance with generally accepted Government Auditing Standards.

We met with staff representing the MSP, and the Provider Reimbursement Audit Units at the Mutual of Omaha Insurance Company, Fiscal Intermediary (FI) in Omaha Nebraska. Our objective was to familiarize ourselves with MSP issues and to determine the level of audit coverage the FI affords providers regarding the MSP questionnaires and Medicare credit balances.

Our hospital selection process was based on an analysis of quarterly Medicare credit balance reports requested from the FI for the period of December 1, 2000 through May 31, 2001. The reports contained information regarding the number of claims as well as the amounts of credit balances reported by each hospital serviced by the FI. The analysis showed that Orange Park Medical Center ranked the highest in both number of claims and amounts of credit balances reported during the period.

We held an entrance conference with officials representing the hospital to discuss the objective and scope of our review. We requested a listing from the Provider Statistical and Reimbursement Report database for FY 2000 showing all Medicare beneficiaries' treated during FY 2000 regardless of whether Medicare was the primary or secondary payer.

We met individually with staff responsible for the administrative functions of the admissions and billing departments to gain first hand knowledge of the procedures in place when processing inpatient admissions or outpatient encounters. The extent of our review of the hospital internal controls was limited to functions directly related to the MSP questionnaires.

The listing of Medicare patient claims provided by the hospital was used to select a judgmental sample of 98 different beneficiaries responsible for 327 Medicare claims. We also selected 117 additional claims from the HCFA-838s. For each of the claims, we requested the corresponding MSP questionnaires.

We requested Medicare credit balance reports (Forms HCFA-838) for calendar quarters ending September 30 1999 through December 31, 2000. We reviewed the information to determine both the number of claims listed and whether the provider had reimbursed the Medicare credit balances on a timely basis.

We requested remittance advices for each of the claims identified on the 838s and verified to hospital records the date the credit balances were established. We contacted the FI's MSP unit to validate the information on the remittance advices. We then used the information to generate an aging report showing the number of outstanding days for each credit balance prior to liquidation. We counted the outstanding days beginning with the 61st day after the credit balances were established.

We reviewed 25 of the 117 claims from the HCFA-838s to determine whether: (1) the patients had multiple insurers, (2) the provider simultaneously billed multiple insurers, (3) Medicare was billed in the proper order (primary or secondary payer); and (4) credit balances were liquidated timely.

We held an exit conference with officials representing the hospital and provided them with the preliminary results of our review. They recognized that many MSP questionnaires could not be found and expressed their frustration that education and training programs put in place in the past had not been effective.

Fieldwork was performed from July through December of 2001 in the Office of Audit Services Field Offices in Miami and Tallahassee, Florida, at the Mutual of Omaha Insurance Company in Omaha, Nebraska, and at the provider place of business in Orange Park, Florida.
The hospital's response to our draft report is summarized on page nine of this report and appended in its entirety.

RESULTS OF REVIEW

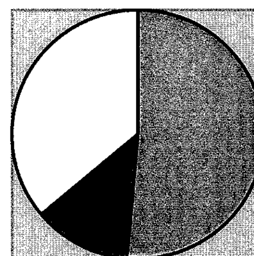
We found that for 64 percent of the claims reviewed, the hospital could not provide sufficient documentation to demonstrate compliance with MSP guidelines. Specifically, we found that the hospital could not locate questionnaires for a substantial number of claims or the questionnaires were missing information essential in identifying other potential primary payers. We are concerned that this condition could lead to Medicare absorbing a share of the costs applicable to other payers and to credit balances being generated and requiring unnecessary administrative expenses to resolve. In this respect, a review of 25 credit balances

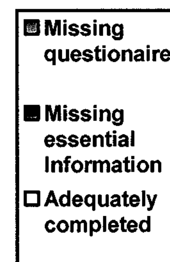
showed that in 7 instances Medicare was billed in the wrong order. In reviewing these credit balances, we also found that the hospital did not always refund Medicare credit balances in a timely fashion.

MSP questionnaires

For the 444 claims reviewed, we found that:

- 228 or 51 percent were claims for which the hospital could not locate an MSP questionnaire.
- 56 or 13 percent were claims for which the hospital failed to adequately complete sections of the questionnaires considered essential in identifying a primary payer.
- 160 or 36 percent were claims for which the hospital adequately completed the MSP questionnaires.





Section 301 of the Medicare Hospital Manual clearly delineates the hospital responsibility for determining whether Medicare is the primary or secondary payer for each inpatient admission of a Medicare beneficiary and outpatient encounter with a Medicare beneficiary. Section 301.2 of the manual lists the type of questions, which hospital staff must ask of Medicare beneficiaries for every admission, encounter, or start of care.

Section 301.2 states that the provider's failure to obtain the information listed on sections of the MSP questionnaire constitutes a violation of their provider agreement with the Medicare program. This section further states that the information the providers are required to obtain is essential to filing a proper claim with Medicare or a primary payer. According to this section, failure to file a proper claim can result in the unnecessary denial or development of claims. The provider's own policies and procedures require the admissions personnel to complete a MSP questionnaire for every inpatient admission and outpatient encounter. The staff is specifically instructed to obtain insurance information from the patient or relatives or acquaintances when the patient is unwilling or unable to communicate. The provider requirements at time of admissions and encounters include the development of hard copies or electronic versions of the MSP questionnaire. According to the provider, at the end of every admission, a pre-bill check is performed to ensure that the MSP questionnaire is obtained and properly completed to adequately capture information essential in identifying other potential payers.

As shown above, 64 percent of the time, the hospital did not provide sufficient documentation to demonstrate that it complied with Medicare guidelines and their own policies and procedures in obtaining MSP information. We do not know whether hospital staff failed to obtain the MSP information at intake or did not retain copies of information obtained. We are concerned that without obtaining adequate MSP information for Medicare beneficiaries having other insurance, the hospital limits its ability to properly identify the primary payers and may bill Medicare inappropriately as the primary payer.

Should the hospital inappropriately bill Medicare as the primary payer: (1) the Medicare program could absorb the share applicable to other unidentified payers, or (2) credit balances could arise which in turn could increase administrative costs necessary to resolve the credit balances. Medicare could absorb the share applicable to unidentified payers when the provider: fails to adequately collect MSP information, incorrectly bills Medicare as the primary payer and the correct primary payer does not make a payment to the provider. A credit balance needing resolution would arise when the correct primary payer makes a payment to the provider after the provider has incorrectly billed and received payment from Medicare. While the potential for the Medicare program absorbing the share applicable to unidentified payers exist, we did not quantify it because the information available at the provider lacked sufficiency to allow quantification. For example, if a payer does not make a payment the provider files would not always contain the information needed to identify the appropriate payer.

Our review for multiple insurers relating to 25 credit balances reported by the hospital on HCFA Forms 838 suggest that credit balances do arise because of inadequate MSP information. As a result, we believe the hospital must spend resources to investigate and resolve these credit balances. In this respect, we found that for 7 of the 25 credit balances reviewed, the hospital was unable to produce MSP questionnaires and the credit balances were for beneficiaries who had multiple insurers where the provider billed Medicare incorrectly as the primary payer. Further, the hospital needed to spend resources to record these credit balances, report the credit balances in the HCFA forms 838 and follow through to an appropriate resolution.

Timeliness of Credit Balances

In reviewing the 25 credit balances mentioned above, we determined that the hospital did not always refund Medicare credit balances in a timely fashion.

Section 1866 (a) (1) (c) of the Social Security Act (Act) requires hospitals and other health care providers participating in the Medicare program to make adequate provisions to refund any monies incorrectly paid. In accordance with Sections 1815 (a) and 1833 (e) of the Act, the Secretary is authorized to request information from providers which is necessary to properly administer the Medicare program. In accordance with these provisions, Form HCFA-838 must be completed by all hospitals and other health care facilities participating in the Medicare program to help assure that monies owed to the Medicare program are paid in a timely manner.

The MSP regulations 42 CFR 489.20 requires providers to reimburse Medicare within 60 days from the date they receive payment from another payer (primary to Medicare) for the same service. Submission of the Form HCFA-838 and adherence to its instructions do not interfere with this rule; credit balances resulting from MSP payments must be repaid within the 60-day period.

We found that for 14 of the 25 claims with credit balances, the hospital did not liquidate the credit balance in a timely manner. These claims had outstanding days prior to liquidation ranging from nine to 587 days beyond the 60 days provided in the MSP regulations. Outstanding days were calculated beginning with the 61st day from the date the credit balances were established.

Conclusions

Our review showed that in a substantial number of cases, the hospital could not provide sufficient documentation to demonstrate compliance with Medicare guidelines regarding completion of MSP questionnaires and the timely reimbursement of Medicare credit balances. We also found that some of the claims missing MSP questionnaires resulted in Medicare credit balances that were not refunded timely. We do not know whether hospital staff failed to obtain the MSP information at intake or did not retain copies of information obtained. However, we are concerned that in 64 percent of the claims reviewed the hospital could not demonstrate compliance with Medicare guidelines. Because the lack of adequate documentation related to MSP information could lead to unnecessary costs to the Medicare program, we are recommending the following.

Recommendations

We are recommending that the hospital:

- not bill Medicare unless hospital personnel have obtained and filed a completed MSP questionnaire;

- implement and provide, within 60 days, effective education and training to every staff person associated with collecting admission information;

- within 90 days of providing the above training, perform its own internal review to determine whether the conditions we found in FY 2000 are also present in subsequent periods i.e., FY 2001 through the most current up to date information at the time of review; and

- develop and implement effective administrative controls aimed at liquidating Medicare credit balances on a more timely fashion.

Hospital Comments

Hospital officials generally agreed with our recommendations and we summarize their stated actions below:

- The hospital information system was redesigned to require the completion of the MSP before the registration process can be completed.

- Education has been provided to existing staff over the last 24 months. Also, all new hires receive specific instruction on the completion of an MSP. An additional training session was conducted on 8/10/02.

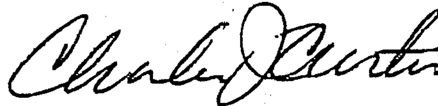
The MSP completion has been part of the Patient Access Department's quality assurance monitors. Previously, 100 charts per month were reviewed. After completion of the Office of Inspector General (OIG) review, the process was expanded to review 10 percent of all Medicare claims. Sample size increased from 100 to 1,600 claims per month. These reviews indicate that MSP compliance has improved to 99.7 percent.

- Liquidation of Medicare credit balances has been consolidated to a regional Patient Accounting Service Center. Medicare credit balances are liquidated within 30 days.

OIG Comment

We believe that the actions taken by the hospital should address the concerns presented in our findings and recommendations.

Sincerely yours,



Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV

Enclosure

APPENDIX

Orange Park
Medical Center

2001 Kingsley Avenue
Orange Park, FL 32073
Phone (904) 276-8500
www.opmedical.com

August 15, 2002

Mr. Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV
Department of Health & Human Services
Room 3T41
61 Forsyth Street, S.W.
Atlanta, Georgia 30303-8909

Re: CIN: A-01-01-07002

Dear Mr. Curtis:

We received the two copies of the U.S. Department of Health & Human Services, Office of Inspector General, Office of Audit Services' draft report entitled **Review of Hospital Medicare Secondary Payer Issues** for the fiscal year ended June 30, 2000. The following comments constitutes our response:

BACKGROUND
In April, 2001, subsequent to the review period, Orange Park Medical Center participated in a Shared Services initiative with its' parent company, HCA. This initiative consolidated the patient access and back office patient accounting functions. Part of this initiative included:

- establishing improved controls over the completion of MSP's;
- quality assurance procedures to ensure compliance
- standardized training on MSP's procedures.

Also, subsequent to the review, the hospital converted the MSP questionnaire from a paper hard copy to an electronic form maintained with patients' other medical record data (Meditech). We believe these changes have resulted in a significant improvement in MSP compliance.

ACTIONS TO RECOMMENDATIONS:

Recommendations	Actions
• Not bill Medicare unless hospital personnel have obtained and filed a completed MSP questionnaire	• Hospital information systems have been redesigned to require the completion of the MSP before the registration process can be completed.
• Implement and provide, within 60 days, effective education and training to every staff person associated with collecting admission information	• Education has been provided to existing staff over the last 24 months. Also, all new hires receive specific instruction on the completion of an MSP. An additional training session was conducted on 8/10/02. (See attached new hire orientation training manual.)
• Within 90 days of providing the above training, perform its own internal review to determine whether the conditions we found in FY 2000 are also present in subsequent periods, i.e. FY 2001 through the most current up to date information at the time of review	• MSP completion has been part of the Patient Access Department's quality assurance monitors. Previously, 100 charts per month were reviewed. After completion of the OIG review this process was expanded to review 10% of all Medicare claims, i.e. sample size increased from 100 to 1,600 per month. These reviews indicate MSP compliance has improved to 99.7%. (See attached summary.)
• Develop and implement effective administrative controls aimed at liquidating Medicare credit balances on a more timely fashion.	• As previously covered in the background/history, the liquidation of Medicare credit balances has been consolidated to a regional Patient Accounting Service Center. Medicare credit balances are liquidated within 30 days. However, during the review, the claims identified as issues were subsequently determined to not be Medicare credit balances. Therefore, there were no true delays in liquidation.

The inability to locate MSP's has been eliminated with the conversion to electronic MSP's.

In conclusion, Orange Park Medical Center's organizational changes in the past 24 months have thoroughly addressed the issues identified from this review. This response includes documentation of educational programs. The auditors were professional and we appreciated their flexibility and patience.

Sincerely,

C. Eric Lawson
Chief Financial Officer

CEL:rmm

Enclosures: New Hire Orientation Program
Quality Assurance Audit Results

QUALITY ASSURANCE AUDIT RESULTS
2002 - 2002

	Accounts Audited	Total Correct	Percentage Compliant
2000			
June	100	95	95.00%
July	100	100	100.00%
August	100	90	90.00%
September	100	95	95.00%
October	100	95	95.00%
November			
December	100	95	95.00%
2001			
January	100	95	95.00%
February	100	96	96.00%
March	100	95	95.00%
April	100	93	93.00%
May	100	93	93.00%
June	100	97	97.00%
July	100	96	96.00%
August	100	95	95.00%
September	100	95	95.00%
October			
November			
December	77	72	93.51%
2002			
January	100	97	97.00%
February	100	94	94.00%
March	1611	1608	99.81%
April	1687	1672	99.11%
May	1716	1711	99.71%
June			
July			
August			
September			
October			
November			
December			

Please note that audit methodology changed in March 2002 to include all Medicare accounts.
In early 2000, MSP forms were added online which are retained in the Abstracting system indefinitely.
MSP education is part of the new-hire process and many training sessions have been provided since the transition of the PAS.
Another MSP training session was completed 8/10/02.

Lesson 4

Collecting Insurance Information

Medicare Requirements

For Medicare programs to work effectively, patient registration staff members have a significant responsibility for the collection and permanent maintenance of patient *information.*

They must ask questions to secure employment and insurance information. They have a particular responsibility to identify primary payers other than Medicare so that incorrect billing and overpayments are minimized.

For every admission or patient encounter, admitting staff must determine if Medicare is primary or secondary payer. The beneficiary must be queried about possible other coverage that may be primary to Medicare.

Collecting Insurance Information

Information Maintenance

Earlier in this course, we learned that savings as high as $6 billion annually can be realized when claims processing includes accurate information about other insurance coverage.

In fact, failure to maintain a system of identifying other payers is viewed as a violation of the provider agreement with Medicare -- a serious breach of trust.

Maintenance of up-to-date insurance information is essential when filing a claim with Medicare or with a primary payer.

Collecting Insurance Information

Development Letter

A Medicare Development Letter is sent to a provider or patient when a claim is filed that needs additional information or documentation.

Development letters usually detail the information necessary for Medicare to resume processing on a specific claim or claims. You may be responsible for gathering and sending the information that Medicare requests.

Also note that there is usually a time limit placed on return of the requested information. If the additional information is not sent to Medicare within the timeframe specified in the Development Letter, payment of the claim will be denied by Medicare.

Collecting Insurance Information

Development Letter

With Medicare Secondary Payer claims, Medicare contractors use certain development letters to help determine the insurer responsible for the benefits and/or appropriate payment. The following list contains commonly used development letters which ensure that Medicare pays only what it is obligated to pay:

- Initial Enrollment Questionnaire
- IRS, SSA and HCFA Data Match
- First Claim Development (FCD)
- Trauma Code Development (TCD)
- Receipt of claims with other insurers' explanation of benefits

Collecting Insurance Information

Confirmation of Benefits

How does Medicare confirm its status as secondary payer?

Well, we have already established that it relies heavily on the information recorded when the patient was first interviewed.

But, in addition to your input, Medicare can refer to records maintained by:

- The Social Security Administration
- And by other insurance companies

Collecting Insurance Information

Confirmation of Benefits

Remember from the previous lesson that the patient may choose Medicare instead of an employer's group health plan as the primary payer?

If that choice is made, it must be confirmed in a letter from the employer, and the letter must include the date of disenrollment from the group plan.

In a situation where the patient retires, only the retired date is necessary.

Collecting Insurance Information

MSP Questionnaire

To help the beneficiary update the Medicare file, you should provide a questionnaire for the patient to complete before you place the call to Medicare to update his or her records.

Make sure the patient is available when you make the call because the Medicare representative will need the patient's authorization before updating the record.

Some information may not be accepted over the phone. In such cases you will be instructed to submit written documentation when needed.

Sometimes information the Social Security Administration (SSA) has on file about a patient's current insurance coverage is incorrect. To remedy this, the patient may call the SSA **1-800-772-1213** and request that the file be updated.

Collecting Insurance Information

MSP Questionnaire

Use the following MSP questionnaire to ensure that Medicare is the primary payer and to ensure that the claim is complete and accurate.

The following chart, which consists of six parts, lists questions to ask Medicare beneficiaries upon each inpatient and outpatient admission. Use this chart as a guide to help identify other payers which may be primary to Medicare.

Beginning with Part 1, ask the patient each question in sequence. Comply with any instructions which follow an answer. If the instructions direct you to go to another part, have the patient answer, in sequence, each question under the new part.

NOTE: There may be situations where more than one insurer is primary to Medicare (e.g., Black Lung and GHP). Be sure to identify all possible insurers.

Collecting Insurance Information

MSP Questionnaire - Part I

1. **Are you receiving Black Lung (BL) Benefits?**
   ___ yes; Date benefits began: *CCYY/MM/DD* BL IS PRIMARY ONLY FOR CLAIMS RELATED TO BL.
   ___ no.
2. **Are the services to be paid by a government program such as a research grant?**
   ___ yes; Government Program will pay primary benefits for these services
   ___ no.
3. **Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility?**
   ___ yes; DVA IS PRIMARY FOR THESE SERVICES.
   ___ no.

4. **Was the illness/injury due to a work related accident/condition?**
   ___ yes; Date of injury/illness: CCYY/MM/DD
   - Name and address of WC plan:
   - Policy or identification number:
   - Name and address of your employer:

   WC IS PRIMARY PAYER ONLY FOR CLAIMS RELATED TO WORK RELATED INJURIES OR ILLNESS. GO TO PART III.
   ___ no. GO TO PART II.

Collecting Insurance Information

MSP Questionnaire - Part II

1. **Was illness/injury due to a nonwork related accident?**
   ___ yes. Date of accident: CCYY/MM/DD
   ___ no. GO TO PART III.
2. **What type of accident caused the illness/injury?**
   ___ automobile
   ___ non-automobile
   - **Name and address of no-fault or liability insurer:**
   - **Insurance claim number:**

   NO-FAULT INSURER IS PRIMARY PAYER ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT. GO TO PART III.
   ___ other.
3. **Was another party responsible for this accident?**
   ___ yes;

- **Name and address of any liability insurer:**
- **Insurance claim number:**

LIABILITY INSURER IS PRIMARY ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT. GO TO PART III.
___ no. GO TO PART III.

Collecting Insurance Information

MSP Questionnaire - Part III

1. **Are you entitled to Medicare based on:**

   ___ Age. GO TO PART IV.

   ___ Disability. GO TO PART V.

   ___ ESRD. GO TO PART VI.

Collecting Insurance Information

MSP Questionnaire - Part IV - Age

1. **Are you currently employed?**
   ___ yes;
   - **Name and address of your employer:**
     ___ no. Date of retirement: CCYY/MM/DD
2. **Is your spouse currently employed?**
   ___ yes;
   - **Name and address of spouse's employer:**

   ___ no. Date of retirement: CCYY/MM/DD

   IF THE PATIENT ANSWERED NO TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II. DO NOT PROCEED ANY FURTHER.

3. **Do you have group health plan (GHP) coverage based on your own, or a spouses, current employment?**
   ___ yes;
   ___ no. STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO THE QUESTIONS IN PART I OR II.

4. **Does the employer that sponsors your GHP employ 20 or more employees?**
   ___ yes. STOP. GROUP HEALTH PLAN IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.
   - **Name and address of GHP:**
     Policy identification number:
     Group identification number:
     Name of policy holder:
     Relationship to patient:

___ no. STOP.MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II.

Collecting Insurance Information

MSP Questionnaire - Part V - Disability

1. **Are you currently employed?**
 ___ yes;

 Name and address of your employer:

 ___ no. Date of retirement: CCYY/MM/DD

2. **Is a family member currently employed?**
 ___ yes;

 Name and address of employer:

 ___ no.

 IF THE PATIENT ANSWERS NO TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II. DO NOT PROCEED ANY FURTHER.

3. **Do you have group health plan (GHP) coverage based on your own, or a family member's, current employment?**
 ___ yes;
 ___ no. STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO THE QUESTIONS IN PART I OR II.

4. **Does the employer that sponsors your GHP employ 100 or more employees?**
 ___ yes. STOP. GROUP HEALTH PLAN IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.

 Name and address of GHP:
 Policy identification number:
 Group identification number:
 Name of policy holder:
 Relationship to patient:

 ___ no. STOP.MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II.

Collecting Insurance Information

MSP Questionnaire - Part VI - ESRD

1. **Do you have group health plan (GHP) coverage?**
   ___ yes;

   Name and address of GHP:
   Policy identification number:
   Group identification number:
   Name of policy holder:
   Relationship to the patient:
   Name and address of employer, if any, from which you receive GHP coverage:

   ___ no. STOP: MEDICARE IS PRIMARY.

2. **Have you received a kidney transplant?**
   ___ yes; Date of transplant: CCYY/MM/DD
   ___ no.
3. **Have you received maintenance dialysis treatments?**
   ___ yes; Date dialysis began: CCYY/MM/DD. If you participated in a self dialysis training program, provide date training started: CCYY/MM/DD
   ___ no.
4. **Are you within the 30 month coordination period?**
   ___ yes.
   ___ no. STOP:MEDICARE IS PRIMARY.

5. **Are you entitled to Medicare on the basis of either ESRD and age or ESRD and disability?**
   ___ yes;
   ___ no. STOP.GHP IS PRIMARY DURING THE 30 MONTH COORDINATION PERIOD.

6. **Was your initial entitlement to Medicare (including simultaneous entitlement) based on ESRD?**
   ___ yes; STOP. GHP CONTINUES TO PAY PRIMARY DURING THE 30 MONTH COORDINATION PERIOD.
   ___ no. INITIAL ENTITLEMENT BASED ON AGE OR DISABILITY.

7. **Does the working aged or disability MSP provision apply (i.e., is the GHP primary based on age or disability entitlement)?**
   ___ yes; GHP CONTINUES TO PAY PRIMARY DURING THE 30 MONTH COORDINATION PERIOD.
   ___ no. MEDICARE CONTINUES TO PAY PRIMARY

FAILURE TO OBTAIN THE INFORMATION LISTED IN THESE SECTIONS IS A VIOLATION OF YOUR PROVIDER AGREEMENT WITH MEDICARE.

THE INFORMATION YOU MUST OBTAIN IS ESSENTIAL TO FILING A PROPER CLAIM WITH MEDICARE OR A PRIMARY PAYER. FAILURE TO FILE A PROPER CLAIM CAN RESULT IN THE UNNECESSARY DENIAL OR DEVELOPMENT OF CLAIMS.

Collecting Insurance Information

Summary
After completing this lesson, you should be able to:

- Identify various methods necessary to determine whether a beneficiary is covered by a primary insurer