MEDICARE PART A BULLETIN

May 15, 1998 General Medicare Bulletin G-330

TO: All Medicare Providers

FROM: Provider Relations

SUBJECT: **PROVIDER REQUIREMENTS FOR THE COLLECTION OF INSURANCE INFORMATION AND RESPONDING TO FIRST CLAIM DEVELOPMENT LETTERS**

ATTENTION MEDICARE BUSINESS OFFICE MANAGER: Please distribute to all appropriate health care personnel.

The purpose of this bulletin is to publish Provider requirements for collection of insurance information and responding to first claim development letters sent from the Intermediary.

PROVIDER REQUIREMENTS FOR THE COLLECTION OF INSURANCE INFORMATION

In many instances, Medicare patients have private health insurance that takes precedence over their Medicare coverage. In these instances, Medicare is the secondary payer and is billed only after the primary payer is billed and processes the patient's claim. The Medicare Secondary Payer (MSP) program pays any Medicare benefits that are not covered by the primary insurer.

The provider plays a major role in ensuring that the proper primary insurer is billed first. To make this determination, the provider must determine all possible insurance coverage during the initial point of contact with the patient by:

- •Interviewing the patient,
- •Completing a patient questionnaire,
- •Contacting family members or employers.

During the admission process, the Patient Registration Area or Admitting Department is responsible for asking particular questions and securing all pertinent employment and insurance information. For further clarification, please refer to Hospital Manual, HCFA Publication 10, Section 301.

To reduce incorrect billing and overpayments, Medicare regulations (42 CFR 489.20(f)) require all Medicare Providers (as a condition of participation to the Medicare Program) to identify in the admission process any primary payers other than Medicare. Therefore, at the time of admission the appropriate staff must determine if Medicare is a primary or secondary payer for each admission. The beneficiary must be asked about possible other coverage that may be primary to Medicare. Failure to maintain a system of identifying other payers will be viewed as a violation of the provider agreement with Medicare. This information is essential to file a proper claim with Medicare or a primary payer.

Under no circumstances are providers allowed to bill Medicare and the primary insurer at the same time, nor can a provider bill for the difference between their charges and the Medicare primary payment. This is considered “double billing” and is a violation of the law.

PROVIDER REQUIREMENT FOR RESPONDING TO FIRST CLAIM DEVELOPMENT LETTERS

First claim development for MSP is the process where the Medicare Contractor must develop all first time claims identified by the Common Working File (CWF). The CWF is a national database all Medicare Contractors are required to access for verification of beneficiary status. If the first claim for a beneficiary is a Part A claim, it will process. However, the Fiscal Intermediary will generate a development letter to the provider. The provider has up to (30) days to respond to the Intermediary with this information. It is imperative that the providers respond to this questionnaire (and not the beneficiary) as the provider should already have all of this information in their files based on the MSP admission’s development process requirements.

In responding to this questionnaire, the provider can respond based on information in the admission file or submit a copy of their admission data sheet if all of the questions asked in the development letter are also included and completely answered in the data sheet.

Questions regarding this bulletin may be addressed to the Medicare Part A Customer Service Department by calling (904) 355-8899.