Group Health Plan (GHP) Defense Reference Guide

Version 1.3

October 7, 2024

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1.0 Summary of Version 1.3 Updates

The following updates have been made in Version 1.3 of the Group Health Plan (GHP) Defense Reference Guide:

The guide has been updated to elaborate on required contact information, revise the description of the Duplicate Primary Payment (DPP) process, and add an attestation example (Section 3.1 and 4.0Appendix A).

2.0 Introduction

This guide is intended to assist Group Health Plans (GHP) in appropriately utilizing various defense types when the Commercial Repayment Center (CRC) identifies a Medicare Secondary Payer (MSP)-related debt owed to Medicare.

The term "GHP" refers to any arrangement by employers or employee organizations to provide health benefits or medical care to employees, family members, and others associated with the employer or employee group. The GHP may provide such coverage through an agreement with a health insurer or a claims-processing Third Party Administrator (TPA). The MSP provisions of the Social Security Act (also found at 42 U.S.C. § 1395y(b)) require GHPs to pay for items and services for covered Medicare beneficiaries before the Medicare program ("primary payment responsibility"). If Medicare mistakenly paid primary when a GHP had primary payment responsibility, Medicare has the right to recover its payment(s).

The CRC utilizes information reported through the Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) ("Section 111") process (see Section 4.0: Additional GHP Resources) to identify payments to recover. Medicare is expressly authorized to recover its mistaken primary payment(s) from any party responsible for the GHP arrangement or who received payment from the GHP. In most cases, the employer or other plan sponsor is identified as the debtor, but courtesy copies of recovery correspondence are sent to the insurer or TPA. These letters provided detailed information about the debt, including how to remit payment, dispute the amount owed, and consequences for failure to resolve the matter.

3.0 Disputing Medicare's Demands

When a debtor wishes to dispute the amount owed as stated in a demand letter, the debtor generally needs to explain why they believe the amount owed is incorrect and submit supporting evidence to the CRC for review. This dispute is called a "defense." When a defense is accepted, it is called a "valid documented defense." The following sections describe specific defense types and the general documentation needed to support that type of defense. Defenses may be sent by either mail, fax, or through the Commercial Repayment Center Portal (CRCP) application.

Debtors must repay Medicare in full. If a debtor does not pay within the given timeframe, interest will accrue on the debt. Details on timing and interest are included in the demand letter. A Sample GHP Demand Letter is available on CMS.gov at https://www.cms.gov/files/document/sample-ghp-demand-letter-2023.pdf.

Defenses Submitted by Mail or Fax

Defense documents on paper can be mailed or faxed to the CRC. To expedite processing and ensure an accurate review of the defense, documentation must include:

- *GHP Correspondence Cover Sheet,*
  Note: This sheet is only required for mailed or faxed defenses.
- A cover letter that explains the defense, and
- Other supporting documentation.

See Section 4.0: Additional GHP Resources for a link to the *GHP Correspondence Cover Sheet*, and the appendices for samples of letters and supporting evidence.

Mail or fax paper defense documents to:

Medicare Commercial Repayment Center – GHP
PO Box 680
Lathrop, CA 95330
Fax: 1-844-315-4313

Defenses Submitted Through the CRCP

Defenses may also be submitted through the CRCP application. Defenses submitted through the CRCP must include:

- A cover letter that explains the defense, and
- Other supporting documentation.

Please refer to the *CRCP User Guide* for more information regarding how to submit defenses through the CRCP (see Section 4.0: Additional GHP Resources).

See the appendices for a sample of a cover letter that can be used for both methods of submitting defenses (mailed/faxed or CRCP), as well as for examples of supporting evidence. Note that the CRC may request additional information to accept a defense on a case-by-case basis.

If any information differs from what is on file with Medicare, for fastest resolution please contact the Benefits Coordination & Recovery Center's (BCRC) Customer Service Department at 855-798-2627 (TTY/TDD: 1-855-797-2627 for the hearing and speech impaired) and ensure that mandatory quarterly S111 reporting aligns with coverage being reported.

3.1. Defense Types and Requirements

The following is a list of the most common defense types, including the defense type code to be used when submitting a defense through the CRCP, and the typical required supporting documentation:

- Coverage (COV)
- Payment Applied to Deductible/Coinsurance/Copay (DCC)
- Disability (DIS) – Short- and Long-Term Disability
- Duplicate Primary Payment / Capitation (DPP)

- Duplicate Demand (DUP)
- Eligibility Status (ELG)
  - Cancelation of Policy Due to Non-Payment of Premium
  - Employment Status and Retirement
  - COBRA Defense
- Employer Size – Working Aged and Small Employer Exception (EMP)
- Employer Size – Disabled (EMP)
- Medicare Primary Due to End of ESRD Coordination of Benefits Period (ESR)
- Identity Theft Suspected (IDT)
- Indian Health Services/Tribal Exclusion (IND)
- Patient Entitled to GHP Institutional Services Only (INO)
- Service/Amount Maximum Per Year Has Been Met (MAX)
- Not A Group Health Plan or COBRA (NGH)
- Other (OTH) which includes:
  - Bankruptcy
  - Payment Made to Another Entity
  - Records Destroyed
  - Type A Indemnity Coverage Plans
  - Vow of Poverty
  - Workers' Compensation or No-Fault
  - Other Defense
- Patient Is Eligible for Medicare Part B Only (PBO)
- Precertification/Preauthorization Not Filed (PRE)
- Timely Filing (TIM)

3.1.1. Coverage (COV)

This defense type applies when one or more claims contained in Medicare's demand are not for covered items or services according to the terms of the policy, or when the amount payable under the coverage was less than Medicare's primary payment amount.

For situations where a claim(s) is processed and amounts are applied to disallowed/not covered/member savings/discount (etc.) after Medicare's demand date, the CRC can accept an Explanation of Benefits (EOB), a spreadsheet, screenshots, or a combination of the three as standalone documentation identifying that the claim could not be paid due to a contractual agreement with the provider (sometimes the term "excluded from provider contract" is used).

Documentation Needed:

1. EOB, spreadsheet, or screenshots that include:
   - Beneficiary name and/or subscriber name, if different from the beneficiary
   - Beneficiary's Medicare number (Health Insurance Claim Number (HICN) or Medicare Beneficiary Identifier (MBI))
   - Date(s) of service
   - Date the claim was processed (EOB date)
   - Total amount billed
   - Adjustments (co-pays, deductibles, provider discounts)
   - Proof of the denial of reimbursement for services not covered, including the specific reason for the denial
   - Provider name
2. Copy of dated plan documentation or policy (screenshots are acceptable), for the year(s) of service, with applicable limitations and exclusions annotated, for the non-covered date of service/item. If the specific plan documents are not dated, an attestation on employer letterhead, certifying the validity of the submitted plan documents for the year(s) services rendered is acceptable.
3. Any additional explanatory notes to assist in the review of the documentation.

Notes:

The provider contract is not required to be provided.

The source of supporting evidence should be easily identifiable. If submission on letterhead or the like is not possible, an accompanying statement on debtor letterhead must certify the documents are from the appropriate source.

Please refer to the appendices for examples of the most common supporting documentation.

When submitting plan documentation for the applicable plan year(s), limit the submission to relevant documentation only and annotate the specific area(s) that apply to the defense being asserted. If plan documentation for the applicable plan year is not available, an attestation is acceptable, provided it is on employer letterhead submitted by the employer. Alternatively, a copy of the employer's attestation may be submitted by the insurer/TPA.

3.1.2. Payment Applied to Deductible/Coinsurance/Copay (DCC)

This defense type applies when the costs associated with claims included in the Medicare demand were applied to the deductible, coinsurance, copay, or other cost sharing under the terms of the GHP policy.

Documentation Needed:

1. EOB, spreadsheet, or screenshots that include:
   - Beneficiary name and/or subscriber name, if different from the beneficiary
   - Beneficiary's Medicare number (HICN or MBI)

- Date(s) of service
- Date the claim was processed
- Total amount billed
- Adjustments (co-pays, deductibles, provider discounts)
- Provider name

2. Copy of plan documents and accumulators.
3. Any additional explanatory notes to assist in the review of the documentation.

Notes:

The source of supporting evidence should be easily identifiable. If submission on letterhead or the like is not possible, an accompanying statement on debtor letterhead must certify the documents are from the appropriate source.

Please refer to the appendices for examples of the most common supporting documentation.

When submitting plan documentation for the applicable plan year(s), limit the submission to relevant documentation only and annotate the specific area(s) that apply to the defense being asserted. If plan documentation for the applicable plan year is not available, an attestation is acceptable, provided it is on employer letterhead submitted by the employer. Alternatively, a copy of the employer's attestation may be submitted by the insurer/TPA.

For claims that are processed post demand, an EOB, screenshot, spreadsheet, or combination of the three will be accepted as stand-alone documents when amounts are applied to the deductible, copay, coinsurance, or combination of the three.

3.1.3. Disability (DIS) – Short- and Long-Term Disability

This defense type applies if Medicare should have paid as primary because the beneficiary is not actively working and is receiving disability benefits (for three to six months for short-term disability or for more than six months for long-term disability), from the employer or from Social Security. When a Medicare beneficiary, or the subscriber through whom the beneficiary was covered, does not retain current employment status/rights, a defense that Medicare is primary to the insurer applies.

The beneficiary must be on long-term disability for more than six (6) months for Medicare to assume primary payment responsibility. Medicare becomes the primary payer as the disability payments are no longer considered wages under the Federal Insurance Contributions Act (FICA).

Documentation Needed:

1. Certification from the employer that the employee is not actively working and has been receiving disability benefits for three to six months for short term disability or for more than six months for long-term disability.
2. Beginning and end date (if applicable) of the disability benefits.
3. Name, title, and contact information (address and telephone number) of the person issuing the correspondence from the employer, if not clear from letterhead or GHP Correspondence Cover Sheet.

Notes:

Whether or not the individual is receiving pay during the period of nonwork is not a factor.

This information can be submitted on employer letterhead by the employer or by the insurer/TPA on behalf of the employer.

When submitting this defense, you must also update the MSP record so that you don't overwrite it with your next quarterly submission. You can do this by calling the BCRC or submitting an update to the Section 111 report. If you call the BCRC, they will ask you a number of questions, including the Responsible Reporting Entity (RRE) number. Be sure to follow up with an updated Section 111 submittal.

3.1.4. Duplicate Primary Payment (DPP)/Capitation

This defense type applies when Medicare and an insurer both make primary payment for the same item or service (from the same provider, on the same date) listed on Medicare's demand. The identified debtor may provide proof of its primary payment as a defense. Payment made under capitation arrangements also meets this definition.

The debtor may not make primary payments to the provider, supplier, or beneficiary after receiving a Medicare demand letter in lieu of paying Medicare's demand. Defenses that include payments made after the presumed receipt of the demand letter will be denied. Note that if the related coverage records submitted to Medicare were subsequently deleted, a Duplicate Primary Payment defense will be denied.

In the event a duplicate primary payment defense is validated, the claim(s) will be referred to the applicable Medicare Administrative Contractor (MAC) for review and re-adjudication, where appropriate.

Duplicate Primary Payment Automation Requirements

The CRC no longer accepts spreadsheets with bundled amounts or date spans for DPP.

If the GHP must submit a spreadsheet due to information that is missing on an EOB/EOP, or if an EOB/EOP is not available, the required elements listed below apply. Additionally, any spreadsheet submitted shall contain each claim line and date of service listed on the CRC's Claim Summary Form (attached to the demand).

Charged amounts, allowed amounts, cost shares, and paid amounts must be present on all EOBs/EOPs and spreadsheets submitted for each line defended. If any of the required information is missing on an EOB/EOP, a spreadsheet must be submitted with the information provided. If a spreadsheet is submitted, charged amounts, allowed amounts, cost shares, and paid amounts must balance to zero.

Documentation Needed:

1. EOB or remittance advice, spreadsheet, or screenshot(s) that includes:
   - Beneficiary name and/or subscriber name, if different from the beneficiary
   - Beneficiary's Medicare number (HICN or MBI)
   - Date the claim was paid or processed

- Date(s) of service
- Total amount billed
- Allowed amount
- Adjustments with associated Claims Adjustment Reason Codes (CARCs) (co-pays, co-insurances, deductibles, provider discounts)
- Amounts previously paid to the provider or other supplier
- Provider name
- Capitation EOB/Explanation of Payment (EOP) Requirements: Evidence that a capitation payment agreement exists.

2. Any additional explanatory notes or documentation to assist in the review of the defense, such as evidence of a capitation arrangement.

Notes:

The source of supporting evidence should be easily identifiable. If submission on letterhead or the like is not possible, an accompanying statement on debtor letterhead must certify the documents are from the appropriate source.

Please refer to the appendix for examples of the most common supporting documentation.

Please note that claim lines processed as secondary are not acceptable. CRC requires proof of primary payment to the provider prior to the MSP demand date.

Payments made to the beneficiary are acceptable as long as they were paid as primary prior to the MSP demand date.

CMS requirements prohibit bundling of services on lines of a spreadsheet. Each service must be reflected on its individual line. The following are examples of invalid and valid spreadsheets.

Figure 1: Invalid Spreadsheet Example

Plan Logo/Letterhead													
Beneficiary Name:	John Doe												
HICN/MBI	11111111A												
Case ID:	2023XXX-XX-XXXXXX												
Date of Service	**Provider of Service**	**Billed Amount**	**Allowed Amount**	**Disallowed (CARC 45)**	**Deductible**	**Copay**	**Coinsurance**	**Paid Amount**	**Paid Date**	**Paid To**	**Check# (Optional if paid to CRC/CMS)**	**Defense Type**	**Medicare Req Amt (Optional)**
1/30 - 1/31/2021	ABC Hospital	$1,000.00	$500.00	$500.00	$0.00	$0.00	$0.00	$500.00	3/1/2021	ABC Hospital	1111111	DPP	
1/24/2021	ABC Provider	$389.00	$240.31	$148.69	$0.00	$0.00	$48.06	$192.25	4/1/2021	ABC Provider	1111112	DPP	
1/24 - 1/25/2021	ABC Provider	$401.00	$248.00	$153.00	$0.00	$0.00	$49.60	$198.40	3/2/2021	ABC Provider	1111113	DPP	
1/24 - 1/25/2021	ABC Provider	$40.00	$16.42	$23.58	$0.00	$0.00	$4.72	$18.86	5/3/2021	ABC Provider	1111114	DPP	
1/24/2021	ABC Provider	$389.00	$240.31	$148.69	$0.00	$0.00	$48.06	$192.25	2/4/2021	ABC Provider	1111115	DPP	
1/24 – 1/25/2021	ABC Provider	$175.00	$54.18	$120.82	$54.18	$0.00	$0.00	$0.00	4/5/2021	ABC Provider		DCC	

Figure 2: Valid Spreadsheet Example

Plan Logo/Letterhead													
Beneficiary Name:	John Doe												
HICN/MBI	11111111A												
Case ID:	2023XXX-XX-XXXXXX												
Date of Service	**Provider of Service**	**Billed Amount**	**Allowed Amount**	**Disallowed (CARC 45)**	**Deductible**	**Copay**	**Coinsurance**	**Paid Amount**	**Paid Date**	**Paid To**	**Check# (Optional if paid to CRC/CMS)**	**Defense Type**	**Medicare Req Amt (Optional)**
1/30-1/31/2021	ABC Hospital	$1,000.00	$500.00	$500.00	$0.00	$0.00	$0.00	$500.00	3/1/2021	ABC Hospital	1111111	DPP	
1/24/2021	ABC Provider	$389.00	$240.31	$148.69	$0.00	$0.00	$48.06	$192.25	4/1/2021	ABC Provider	1111112	DPP	
1/24/2021	ABC Provider	$148.00	$35.00	$113.00	$35.00	$0.00	$0.00	$0.00	4/5/2021	ABC Provider		DCC	
1/25/2021	ABC Provider	$27.00	$27.09	$7.82	$7.82	$0.00	$0.00	$0.00	4/5/2021	ABC Provider		DCC	
1/24/2021	ABC Provider	$389.00	$240.31	$148.69	$0.00	$0.00	$48.06	$192.25	2/4/2021	ABC Provider	1111115	DPP	
1/24/2021	ABC Provider	$20.00	$18.86	$1.14	$0.00	$0.00	$0.00	$18.86	5/3/2021	ABC Provider	1111114	DPP	
1/25/2021	ABC Provider	$20.00	$4.72	$15.28	$0.00	$0.00	$4.72	$0.00	5/3/2021	ABC Provider	1111114	DCC	
1/24/2021	ABC Provider	$262.00	$198.40	$63.60	$0.00	$0.00	$0.00	$198.40	3/2/2021	ABC Provider	1111113	DPP	
1/25/2021	ABC Provider	$139.00	$49.60	89.40	$0.00	$0.00	$49.60	$0.00	3/2/2021	ABC Provider	1111113	DCC	

3.1.5. Duplicate Demand (DUP)

Duplicative demand efforts may be encountered when an insurer or TPA erroneously deletes and resubmits coverage records through the Section 111 reporting process while a recovery case is in process. They may also be asserted when Medicare recovers its primary payment amount from the provider/supplier soon before or concurrent with the issuance of the demand by the CRC.

Documentation Needed:

1. An explanatory note identifying the claims for which Medicare was previously reimbursed, or which were successfully disputed and removed from a previous demand.
2. Evidence that Medicare was reimbursed for the claim or that the claim was removed from the recovery case, such as a copy of the Medicare Remittance Advice (RA) from the provider.

3.1.6. Eligibility Status (ELG)

These defense types apply when a Medicare beneficiary was not eligible for coverage under a GHP for some portion of the time period when the items or services identified on Medicare's demand were provided. The following defense scenarios all require certification on employer letterhead except ELG-Cancelation of Policy Due to Non-Payment of Premium Defense.

When submitting this defense, you must also update the MSP record so that you don't overwrite it with your next quarterly submission. You can do this by calling the BCRC or submitting an update to the Section 111 report. If you call the BCRC, they will ask you a number of questions, including the Responsible Reporting Entity (RRE) number. Be sure to follow up with an updated Section 111 submittal.

Notes:

An insurer or TPA may provide this information on behalf of the employer, but the documentation must be on employer letterhead and signed by an authorized employer representative.

If the beneficiary's eligibility for coverage has changed due to long-term disability, please see the Disability (DIS) defense type (Section 3.1.3).

3.1.6.1. Cancelation of Policy Due to Non-Payment of Premium

There may be rare instances where an insurer has canceled a policy due to employer's non-payment of premiums.

For a cancelation of policy due to non-payment of premium defense to be considered valid, the CRC must receive a statement on insurer letterhead along with identifying information that associates the defense to the demand (beneficiary/subscriber name, Case ID, etc.).

Documentation Needed:

1. Copy of correspondence on insurer letterhead notifying the employer of the cancelation of coverage due to non-payment of premium.
2. Date termination is effective.

3. Name, title, and contact information (address and telephone number) of the person issuing the correspondence, if not clear from letterhead or GHP Correspondence Cover Sheet.

3.1.6.2. Employment Status and Retirement

Medicare is the secondary payer to a GHP when a beneficiary entitled to Medicare receives health insurance coverage through a GHP or a spouse's GHP based on current employment status. Employers must offer the same coverage to a Medicare beneficiary that they offer to all employees and their spouses. An employer may indicate that a beneficiary that is entitled to Medicare based on working age or disability did not have coverage under the employer's GHP because:

- The beneficiary (or the subscriber, as applicable) retired.
- The beneficiary (or the subscriber, as applicable) left employment, voluntarily or involuntarily.
- The individual (or the subscriber, as applicable) was not eligible for or otherwise enrolled in GHP coverage at the time services were rendered.
- The individual was not enrolled in GHP coverage at the time of services and was on a Leave of Absence (LOA).

For LOA defenses: When a Medicare beneficiary, or the subscriber through whom the beneficiary was covered, does not retain current employment status/rights, a defense that Medicare is primary to the insurer applies.

Documentation Needed:

For an Eligibility Status and Retirement defense to be considered valid, the CRC must receive a statement on employer letterhead along with identifying information that associates the defense to the demand (beneficiary/subscriber name, Case ID, etc.). This includes:

1. Correspondence on employer letterhead demonstrating that the beneficiary or subscriber did not have coverage under the employer's GHP when services were rendered. This includes if a beneficiary or subscriber is unknown to the GHP.
2. Effective and term dates of coverage.
3. Last day of active employment.
4. Date of retirement if different from last date of active employment.
5. Name, title, and contact information (address and telephone number) of the person issuing the correspondence from the employer, if not clear from letterhead or GHP Correspondence Cover Sheet.

3.1.6.3. COBRA Defense

This defense type may be asserted when the information reported through the Section 111 process was incorrect because the type of coverage did not meet Medicare's definition of GHP coverage. For situations where a Medicare beneficiary is entitled to Medicare based on COBRA, Medicare is primary according to the Consolidated Omnibus Budget Reconciliation Act (COBRA).

Documentation Needed:

For a COBRA defense to be considered valid, the CRC must receive a statement on employer letterhead from the employer or insurer certifying:

1. That the beneficiary or subscriber did not have GHP coverage when services were rendered and that coverage a COBRA policy.
2. The dates COBRA coverage began and ended.
3. Name, title, and contact information (address and telephone number) of the person issuing the correspondence from the employer, if not clear from letterhead or GHP Correspondence Cover Sheet.

3.1.7. Employer Size – Working Aged and Small Employer Exception (EMP)

This defense type may be asserted if a beneficiary with GHP coverage is entitled to Medicare on the basis of age (65 years old or older) and Medicare is primary to that GHP because the employer that sponsors or contributes to that GHP has fewer than 20 full- and/or part-time employees for at least 20 weeks during the current and preceding year (the 20 weeks do not have to be consecutive).

This defense type may also be asserted where the GHP is a multi-employer plan and all participating employers that sponsor or contribute to that GHP have fewer than 20 full- and/or part-time employees for at least 20 weeks during the current and preceding year.

Documentation Needed:

If the employer did not participate in a multi-employer GHP or multiple-employer GHP, or the employer participated in a multiple-employer GHP and all employers in the group employed fewer than 20 employees, the following information must be submitted:

1. Certification or other evidence that the employer did not participate in a multiple-employer GHP, and that the employer employed fewer than 20 employees for 20 weeks for each year and the preceding year that the beneficiary received services, OR,
2. If the employer participates in a multi-employer GHP, certification or other evidence that all employers in the plan had fewer than 20 full- and/or part-time employees for 20 weeks for the current or the preceding year.
3. Name, title, and contact information (address and telephone number) of the person issuing the correspondence from the employer, if not clear from letterhead or GHP Correspondence Cover Sheet.

Small Employer Exception (SEE)

When an employer has fewer than 20 employees but participates in a multi-employer GHP where at least one other employer has more than 20 employees, the MSP rules apply to all individuals in the GHP who are entitled to Medicare based on age, including those associated with any employers that have fewer than 20 employees. However, a multi-employer GHP may request an exception to the Working Aged MSP rules ("Small Employer Exception," or SEE). If such an exception was requested and granted, please see below.

Documentation Needed:

- If the employer participated in a multiple-employer GHP and one employer in the GHP employed more than 20 employees, provide a copy of the approved SEE letter issued by the BCRC for that specific beneficiary.

Notes:

SEEs are only applicable to individual beneficiaries and are prospective in nature, and so may only be used to dispute claims with dates of service after the SEE is granted. For more information regarding SEEs, please visit https://www.cms.gov/medicare/coordination-benefits-recovery/employer-services/small-employer-exception.

There cannot be a SEE exception when a beneficiary's eligibility is due to ESRD.

3.1.8. Employer Size – Disabled (EMP)

This defense type may be asserted when a beneficiary with GHP coverage is entitled to Medicare on the basis of disability and Medicare is primary to the GHP because the employer that sponsors or contributes to that GHP has fewer than 100 full- and/or part-time employees for 50 percent or more of its business days for the preceding year.

Documentation Needed:

For an employer size – disabled defense to be considered valid, the CRC must receive a statement from the employer or insurer, on employer letterhead, along with identifying information that associates the defense to the demand (beneficiary/subscriber name, Case ID, etc.) and certifying:

1. That there were fewer than 100 employees for 50 percent or more of the employer's business days in the year(s) services were rendered and in the year prior to the year services were rendered.
2. That either the employer does not participate in a multi/multiple employer plan, or certification from the GHP verifying all participating employers in the multi/multiple employer plan have fewer than 100 employees for 50 percent or more of their business days in the year(s) services were rendered and in the year preceding the date(s) of service.
3. The name, title, and contact information (address and telephone number) of the person issuing the correspondence from the employer, if not clear from letterhead or GHP Correspondence Cover Sheet.

Note: An insurer or TPA may provide this information on behalf of the employer, but the documentation must be on employer letterhead and signed by an authorized employer representative.

3.1.9. Medicare Primary Due to End of ESRD Coordination of Benefits Period (ESR)

This defense applies when a beneficiary is eligible for or entitled to Medicare due to End-Stage Renal Disease (ESRD) and the 30-month Coordination of Benefits (COB) period has elapsed. Medicare is the secondary payer for individuals eligible for or entitled to Medicare based on

ESRD for the first 30 months of Medicare eligibility or entitlement, regardless of the number of employees and whether the coverage is based on current employment status. For more information regarding ESRD, please visit https://www.cms.gov/medicare/coordination-benefits-recovery/overview/end-stage-renal-disease-esrd.

Documentation Needed:

1. A clear explanation of why Medicare is primary for the claim(s) in question, based on the beneficiary's ESRD diagnosis/treatment and dates of Medicare eligibility/entitlement
2. Date of renal dialysis at a dialysis facility or of home/self-dialysis
3. Name, title, and contact information (address and telephone number) of the person issuing the correspondence, if not clear from letterhead or GHP Correspondence Cover Sheet.

Note: When or if a beneficiary becomes entitled to Medicare on the basis of age and/or disability in addition to ESRD, the Working Aged and/or disability MSP rules apply from the date of entitlement on the basis of age and/ or disability.

3.1.10. Identity Theft Suspected (IDT)

This defense type applies when the beneficiary did not receive the services on the claim(s) in question due to identity theft (also known as fraud and abuse).

Documentation Needed:

1. The name of the beneficiary and/or the name of the subscriber (the individual through whom the beneficiary had coverage) and either the MBI or HICN.
2. An assertion that service(s) rendered were not received by the beneficiary (additional explanations may be provided).
3. The dates of service, provider name, and charged amounts that are being asserted to have not been received.
4. Evidence supporting the assertion of identity theft including, but not limited to:
    - A police report;
    - Evidence that the beneficiary was elsewhere at the time services were rendered, or otherwise unable to use the services (such as a timecard, or clear geographic distance); or
    - A letter from the beneficiary stating that the services were never rendered.
5. Name, title, and contact information (address and telephone number) of the person issuing the correspondence from the employer, if not clear from letterhead or GHP Correspondence Cover Sheet.

3.1.11. Indian Health Services/Tribal Exclusion (IND)

This defense type may be asserted when a Medicare beneficiary has health coverage by merit of membership in a tribal organization (generally through tribal self-insurance). This defense type may also apply if claims included in the demand are for services the beneficiary received through an Indian Health Service provider.

Indian Health Service

The Indian Health Service (IHS) is the health care service delivery system for federally recognized American Indian Tribes and Alaska Natives (AI/AN) in the United States. The IHS is not an entitlement program like Medicare nor is it an insurance program. The IHS provides two types of services:

- Direct health care services—provided by an IHS facility.
- Contract Health Services—provided by non-IHS facilities or providers under contract with IHS.

Documentation Needed:

1. Statement that services rendered were provided by an IHS facility or a contracted health services facility or provider.
2. Name, title, and contact information (address and telephone number) of the person issuing the correspondence from the employer, if not clear from letterhead or GHP Correspondence Cover Sheet. An insurer or TPA may provide this information on behalf of the employer, but the documentation must be on employer letterhead and signed by an authorized employer representative.

Note:

If a member of a tribal organization has GHP health coverage through their own, their spouse's, or their family member's employment rather than membership in that tribal organization, then that employment-based health coverage is generally primary to Medicare and this defense type would not be appropriate.

Tribal Exclusion

When a tribe submits a defense stating they are exempt from recovery solely based on the fact they are a tribal entity, the Federal Register for Indian Entities Recognized by and Eligible to Receive Services will be reviewed to confirm.

Documentation Needed:

1. Statement certifying that tribe/nation/band is federally recognized and is excluded from recovery.
2. Name, title, and contact information (address and telephone number) of the person issuing the correspondence from the employer, if not clear from letterhead or GHP Correspondence Cover Sheet. An insurer or TPA may provide this information on behalf of the employer, but the documentation must be on employer letterhead and signed by an authorized employer representative.

Note: If a member of a tribal organization has GHP health coverage through their own, their spouse's, or their family member's employment rather than membership in that tribal organization, then that employment-based health coverage is generally primary to Medicare and this defense type would not be appropriate.

3.1.12. Patient Entitled to GHP Institutional Services Only (INO)

This defense type applies when a beneficiary was covered by a limited-coverage plan that offers GHP Institutional services only. In this case, Medicare needs to verify that the beneficiary is covered by this plan type and services, as well as validate the Medicare coverage for the beneficiary to determine eligibility and enrollment.

Documentation Needed:

- Certification that the beneficiary was covered by a limited-coverage plan, which offers limited benefits for institutional services only.

3.1.13. Service/Amount Maximum Per Year Has Been Met (MAX)

This defense type applies when the benefit maximum for the year(s) of service was met for all or some of the claims on Medicare's demand. A maximum benefit reached defense is appropriate when the payment for service(s) in question reaches an annual or lifetime benefit limit, as established within the plan or policy.

Documentation Needed:

Evidence in the form of an EOB, Remittance Advice (RA), or spreadsheet, with insurer logo, that the benefit maximum for the year(s) of service was met for all or some of the claims in Medicare's demand. This evidence must include all the following information:

1. EOB, spreadsheet, or screenshot(s) that include:
   - Beneficiary name and/or subscriber name, if different from the beneficiary
   - Beneficiary's Medicare number (HICN or MBI)
   - Date(s) of service
   - Date the claim was processed
   - Total amount billed
   - Allowed amount
   - Adjustments (co-pays, deductibles, provider discounts)
   - Provider name
2. Copy of dated plan documentation or policy for the year(s) of service establishing the benefit maximum for the services under the plan with applicable terms annotated. If the specific plan documents are not dated, an attestation on employer company letterhead, certifying the validity of the submitted plan documents for the year(s) services rendered, is acceptable.
3. An accumulator must be provided as evidence for the proof that maximum benefits have been met.
4. Any additional explanatory notes to assist in the review of the documentation.

Notes:

The source of supporting evidence should be easily identifiable. If submission on letterhead or the like is not possible, an accompanying statement on debtor letterhead must certify the documents are from the appropriate source.

Please refer to the appendices for examples of the most common supporting documentation.

When submitting plan documentation for the applicable plan year(s), limit the submission to relevant documentation only and annotate the specific area(s) that apply to the defense being asserted. If plan documentation for the applicable plan year is not available, an attestation is acceptable, provided it is on employer letterhead submitted by the employer. Alternatively, a copy of the employer's attestation may be submitted by the insurer/TPA.

3.1.14. Not A Group Health Plan (NGH)

This defense type applies when the information reported through the Section 111 process was incorrect because the type of coverage did not meet Medicare's definition of GHP coverage. If the coverage was reported in error, then the record must be deleted through the Section 111 reporting process. If the record is re-reported, additional recovery efforts may occur.

Documentation Needed:

1. Evidence that the coverage was not GHP coverage as defined by Medicare when services were rendered (for example, coverage was an individual type of coverage such as a college student health coverage, short term/gap coverage paid for by beneficiary, life insurance, etc.).
2. The effective and termination dates of this coverage.
3. Name, title, and contact information (address and telephone number) of the person issuing the correspondence, if not clear from letterhead or GHP Correspondence Cover Sheet.

3.1.15. Other Defenses (OTH)

3.1.15.1. Bankruptcy

This defense type applies when an employer or insurer enters bankruptcy (voluntary, involuntary, or a State-Ordered Liquidation (SOL)) that has been petitioned and/or is in post-petition or received final adjudication.

There are five phases of a bankruptcy and/or SOL:

- **Petition**: Paperwork has been filed requesting that the Federal Court hear a bankruptcy proceeding.
- **Post-Petition**: Timeframe between the petition and the final adjudication.
- **Adjudication**: A court's determination of the proceedings. Adjudication has two forms:
  - **Dismissal**: Court dismissed the petition for bankruptcy or SOL; and all debt is due in full.
  - **Discharge**: Court determined the debt is to be resolved in a court-ordered manner and amount.

Documentation Needed:

1. Letter of explanation with:
   - Beneficiary name and/or subscriber name, if different from the beneficiary
   - Beneficiary's Medicare number (HICN or MBI)
2. Date(s) of service

3. Copy of bankruptcy documentation issued by a court or state.
4. Any additional explanatory notes to assist in the review of the documentation.

3.1.15.2. Payment Made to Another Entity

This defense type applies when payment has been issued to, but not received by, the CRC. The payment may have been misdirected to another entity, such as the BCRC or the U.S. Department of the Treasury.

Documentation Needed:

1. Evidence of where payment was sent by the employer or insurer (name, address, etc.).
2. Payment information found on check (check date, amount, number, etc.).
3. Copy of the front and back of the check, if available.

3.1.15.3. Records Destroyed

A Records Destroyed defense applies if an employer indicates that a disaster (e.g., hurricane, fire, winter storm, or flood) destroyed the employer's records and disaster recovery efforts failed to recover all records. It is important to note that employers are required to have disaster recovery plans in place when Protected Health Information (PHI) is at risk.

Documentation Needed:

- A letter from the employer that explains what disaster recovery plans were in place prior to the alleged disaster, how those plans were implemented, and why they failed to recover the necessary records.
- Name, title, and contact information (address and telephone number) of the person issuing the correspondence, if not clear from letterhead or GHP Correspondence Cover Sheet.

Note: This information may be submitted by the employer or a copy of the letter may be provided by the insurer.

3.1.15.4. Type A Indemnity Coverage Plans

This defense type applies if the beneficiary is covered by a Type A Indemnity plan. A Type A Indemnity plan covers both Part A and Part B services. This is not to be confused with a Part A Medicare plan which only covers Part A services.

Documentation Needed:

- Plan documentation to demonstrate what specific types of service are covered by the plan. The plan documentation or policy must be dated for the year(s) of service. If the specific plan documents are not dated, an attestation on employer company letterhead, certifying the validity of the submitted plan documents for the year(s) services rendered, is acceptable.

3.1.15.5. Vow of Poverty

This defense type applies when a beneficiary has taken a vow of poverty. A beneficiary in a religious order whose members are required to take a vow of poverty is not considered to have current employment status with the religious order if the services performed are considered

employment for Social Security purposes only. A religious order that has elected Social Security coverage for its members under the Internal Revenue Service Member of Religious Order Code has eligibility and entitlement to Medicare. Under this circumstance, Medicare is considered the primary payer to any GHP coverage provided by the religious Order for a Medicare-entitled member.

Documentation Needed:

1. The name of the beneficiary and other information such as Case ID or Medicare number (HICN/MBI) to associate the defense to the demand.
2. Evidence that the beneficiary is enrolled in Medicare due to age or disability.
3. Evidence that the beneficiary has taken a vow of poverty.
4. Evidence that the beneficiary is enrolled in Social Security coverage under the Internal Revenue Service Member of Religious Order Code.
5. Confirmation that the beneficiary has performed, or is performing, services for the order, or at the direction of the order, for employer(s) outside of the order and the employer(s) does/do not provide insurance coverage.

3.1.15.6. Workers' Compensation or No-Fault

When Medicare-covered items or services are provided as a result of a Worker's Compensation- or No-Fault-related illness or injury, the GHP will not assume primary payment responsibility. A Non-Group Health Plan (NGHP), rather than Medicare, is the proper primary payer for these services.

When a NGHP is determined to have primary payment responsibility, and the NGHP information has been provided in the defense, the CRC will take steps to verify the accuracy of that information.

Documentation Needed:

1. A letter from the insurer or employer on letterhead, identifying the name of the Medicare beneficiary and/or subscriber's name, Case ID (any other information to help associate the correspondence with a demand) certifying that all or part of Medicare's demand is related to a Worker's Compensation or No-Fault incident/policy. The documentation must include specific dates of service, or other means to identify specific claims.
2. Name, title, and contact information (address and telephone number) of the person issuing the correspondence from the employer, if not clear from letterhead or GHP Correspondence Cover Sheet.

3.1.15.7. Wrong Employer

An insurer, employer, or TPA may submit a defense advising the CRC that a demand was issued to a wrong employer due to incorrect Section 111 reporting for a beneficiary. This is an acceptable defense when this information is furnished on employer letterhead and the Section 111 reporting is corrected by the insurer.

Documentation Needed:

1. The employer's statement that:
    - They have never employed or covered the employee or beneficiary in an employer-sponsored plan for the dates of service in question; or,
    - There was coverage for a specified period, but it does not include the dates of service in question.
2. Name, title, and contact information (address and telephone number) of the person issuing the correspondence from the employer, if not clear from letterhead or GHP Correspondence Cover Sheet

Note: An insurer or TPA may provide this information on behalf of the employer, but the documentation must be on employer letterhead and signed by an authorized employer representative.

3.1.15.8. Wrong Insurance Company

A wrong insurance company defense applies if the insurer is no longer the employer's insurer of record. In situations where the insurer is incorrectly listed, a valid defense may be filed once the insurer has updated the Section 111 reporting.

Documentation Needed:

For a wrong insurance company defense to be considered valid, the CRC must receive a statement on employer letterhead along with identifying information that associates the defense to the demand (beneficiary/subscriber name, Case ID, etc.) and includes:

1. Evidence from the employer that the insurer listed is incorrect.

    List the correct insurer, if known, with effective dates, or provide a statement that neither the employer nor listed insurer have knowledge of the correct insurer.
2. Name, title, and contact information (address and telephone number) of the person issuing the correspondence from the employer, if not clear from letterhead or GHP Correspondence Cover Sheet.

3.1.15.9. Other Defense

This defense type applies for any other reasons that the GHP is submitting a defense that does not match any of the previous definitions.

Documentation Needed:

1. EOB, spreadsheet, or screenshots that include:
    - Beneficiary name and/or subscriber name, if different from the beneficiary
    - Beneficiary's Medicare number (HICN or MBI)
    - Date(s) of service
    - Date the claim was processed
    - Total amount billed

- Allowed amount
- Adjustments (co-pays, deductibles, provider discounts)
- Provider name

2. Copy of dated plan documentation or policy for the year(s) of service establishing the benefit maximum for the services under the plan with applicable terms annotated. If the specific plan documents are not dated, an attestation on employer company letterhead, certifying the validity of the submitted plan documents for the year(s) services rendered, is acceptable.
3. Any additional explanatory notes to assist in the review of the documentation.

Notes:

The source of supporting evidence should be easily identifiable. If submission on letterhead or the like is not possible, an accompanying statement on debtor letterhead must certify the documents are from the appropriate source.

Please refer to the appendix for examples of the most common supporting documentation.

When submitting plan documentation for the applicable plan year(s), limit the submission to relevant documentation only and annotate the specific area(s) that apply to the defense being asserted. If plan documentation for the applicable plan year is not available, an attestation is acceptable, provided it is on employer letterhead submitted by the employer. Alternatively, a copy of the employer's attestation may be submitted by the insurer/TPA.

3.1.16. Patient Is Eligible for Medicare Part B Only (PBO)

This very rare defense type only applies when a demand was erroneously generated. The GHP MSP rules do not apply where Medicare beneficiaries are eligible for Medicare Part B only. In this case, Medicare needs to be informed of the situation and validate the coverage for the beneficiary.

Documentation Needed:

1. Explanation of the situation, including all relevant eligibility and coverage effective and termination dates.
2. Plan documents indicating patient coverage only covers Part B outpatient hospital services and/or provider services.

3.1.17. Precertification/Preauthorization Not Filed (PRE)

This defense type applies when the services were not covered due to failure by the beneficiary or subscriber to obtain prior authorization or pre-certification.

Documentation Needed:

1. EOB, spreadsheet, or screenshots that include:
    - Beneficiary name and/or subscriber name, if different from the beneficiary
    - Beneficiary's Medicare number (HICN or MBI)
    - Date(s) of service
    - Date the claim was processed and check date

- Total amount billed
- Adjustments (co-pays, deductibles, provider discounts)
- Proof of the denial of reimbursement for services not covered including the specific reason for the denial
- Provider name

2. Copy of dated plan documentation or policy (screenshots are acceptable), for the year(s) of service, with applicable limitations and exclusions annotated, for the non-covered date of service/item. If the specific plan documents are not dated, an attestation on employer company letterhead, certifying the validity of the submitted plan documents for the year(s) services rendered, is acceptable.
3. Any additional explanatory notes to assist in the review of the documentation.

Notes:

The source of supporting evidence should be easily identifiable. If submission on letterhead or the like is not possible, an accompanying statement on debtor letterhead must certify the documents are from the appropriate source.

Please refer to the appendices for examples of the most common supporting documentation.

When submitting plan documentation for the applicable plan year(s), limit the submission to relevant documentation only and annotate the specific area(s) that apply to the defense being asserted. If plan documentation for the applicable plan year is not available, an attestation is acceptable, provided it is on employer letterhead submitted by the employer. Alternatively, a copy of the employer's attestation may be submitted by the insurer/TPA.

3.1.18. Timely Filing (TIM)

When Medicare's demand is issued more than three (3) years from a date of service, an employer, insurer, or TPA may assert a Timely Filing defense when certain criteria are met. To submit a possible Timely Filing defense, there must first be certification that the GHP has no knowledge of the claim. "No knowledge" means that records do exist for the beneficiary but that no claim for services, whether primary, secondary, or tertiary, was ever presented. If a claim was ever presented by the provider, supplier, or beneficiary, whether or not it was paid or denied, then this defense type is inapplicable, and Medicare's demand must be resolved.

A Timely Filing defense is appropriate only when the date(s) of service are more than three (3) years prior to the date of Medicare's demand. All dates of service(s) before the 3-year deadline are not acceptable as a timely filing defense even if the plan's provision is less than 3 years. An insurer may assert a Timely Filing defense when records exist for the period in question, and no claim for services was ever presented for the beneficiary through direct submission or Medicare cross-over processing. If a claim was ever presented, regardless of whether the claim was denied or paid as secondary or tertiary, then there is no opportunity for a Timely Filing defense. Dates of service within three (3) years of the date of Medicare's original demand will not constitute a valid Timely Filing defense and will be automatically denied.

When records do exist for the beneficiary but no record of a claim for the services may be located, then Medicare's demand must be treated as a request for an appeal, or waiver, under the

plan's appeal or waiver rights. Under the plan's appeal or waiver rights, the plan must treat Medicare's demand with the same considerations as it would if the beneficiary had filed the appeal or request for waiver. A denial of an appeal or request for waiver must be justified by the plan's established conditions for the year in which the services were provided. If a plan consistently rules in the beneficiary's favor for timely filing appeals or waivers under subrogation rights, the plan also must rule in favor of Medicare's demand.

A GHP is generally prohibited from asserting this defense type if the GHP in any way prevented Medicare from asserting its recovery claim within a reasonable amount of time relative to the date of service. Failure on the part of the GHP to report coverage to Medicare on time (i.e., within one year of the coverage effective date) prevents Medicare from asserting its recovery claim in a timely manner and would likely result in this defense being rejected.

Notes:

The Balanced Budget Act of 1997 eliminated timely filing defenses for *at least* three (3) years from the date of service. For services on, or after, August 5, 1997, a Timely Filing defense will not be accepted if Medicare's original demand letter is dated within three (3) years of the date of service. This rule applies even if the plan's timely filing period is less than three (3) years.

This presupposes that Medicare can assert its recovery claim within a reasonable amount of time relative to the date of service. Failure on the part of the GHP to report coverage to Medicare timely (i.e., within one year from the coverage effective date) prevents Medicare from asserting its recovery claim in a timely manner and shows that records do in fact exist for the time period in question, thus generally nullifying the GHP's ability to successfully assert a Timely Filing defense.

See Appendix A for a sample Timely Filing letter.

Documentation Needed:

1. Evidence that the beneficiary was a member of the GHP.
2. An attestation that all records for the beneficiary were searched and no record of the services being provided was located.
3. An attestation that:
    - Medicare's demand was treated as a request for an appeal, based on the defense of Timely Filing and the appeal was denied, OR,
    - Medicare's demand was treated as a request for waiver, based on the defense of Timely Filing and the waiver was denied, OR,
    - Appeal and/or waiver rights do not exist within the plan.
4. Evidence that plan documents for the year(s) the services were rendered that establish the timely filing plan provisions and appeal rights are applicable.

Notes:

The source and year(s) of supporting evidence should be easily identifiable. If submission on letterhead or the like is not possible, an accompanying statement on debtor letterhead must certify the documents are from the appropriate source and the year(s) in effect.

For any questions or concerns related to an MSP record report or acceptance date, please contact the BCRC EDI Department at 1-646-458-6740 or email the CRC at: crcoutreachteam@performantcorp.com.

4.0 Additional GHP Resources

CRCP Application

- CRCP application: https://www.cob.cms.hhs.gov/CRCP/

CRCP Information:

- CRCP Overview: https://www.cms.gov/medicare/coordination-benefits-recovery/overview/commerical-repayment-center-portal.
- For help with CRCP account setup, login, or password issues, or other technical problems please contact an EDI Representative at the BCRC at: 1-646-458-6740.
- For questions about cases on the CRCP, the CRC can be reached at 1-855-798-2627 (TTY/TDD: 1-855-797-2627 for the hearing and speech impaired).

Other Resources:

- Group Health Plan Recovery: https://www.cms.gov/medicare/coordination-benefits-recovery/overview/group-health-plan-recovery.
  - GHP Correspondence Cover Sheet (.PDF) (see Downloads, end of page).
- Section 111 GHP User Guide: https://www.cms.gov/medicare/coordination-benefits-recovery/mandatory-insurer-reporting-group-health-plans/user-guide.
- Section 111 mandatory insurer reporting details and requirements: https://go.cms.gov/mirghp.
- Internet-Only Manuals: https://www.cms.gov/medicare/regulations-guidance/manuals/internet-only-manuals-ioms.
- For CRC outreach inquiries, please email: crcoutreachteam@performantcorp.com.

Appendix A: Sample Letters

When creating a defense cover letter, the following identifiers must be submitted by the identified debtor (i.e., employer, insurer, other plan sponsor, or third-party administrator (TPA):

- Beneficiary name and/or subscriber name, if different from the beneficiary
- Medicare number (HICN or MBI)
- Case ID
- A summary of the basis of the defense(s) being asserted
- Name, title, and contact information of the person issuing the defense

Defense Cover Letter (Sample)

[Written on corporate letterhead of the identified debtor]

[Date]

To: Commercial Repayment Center (CRC)
Medicare Commercial Repayment Center – GHP
PO Box 680
Lathrop, CA 95330

Re: Beneficiary Name:
Medicare ID (MBI/HICN):
Case ID:

We have reviewed the demand issued by the CRC and we dispute **[this debt / part of this debt]** due to the following reason:

Defense reason and explanation of why the debtor does not agree with the debt.

The requested documentation is included with this letter.

Closing,

[Name]
[Title]
[Contact information of the person issuing the defense]

Enclosure: EOB, spreadsheet, screenshots, or plan documentation

Timely Filing (Sample)

[Written on corporate letterhead of identified debtor]

[Date]

To: Medicare Commercial Repayment Center – GHP
PO Box 680
Lathrop, CA 95330

Re: Beneficiary Name:
Medicare ID (MBI/HICN):
Case ID Number:

Based on the member and MSP match information, we have concluded that we have not received the following claim(s) for **[Member's Name]** for the dates(s) of service [**list date(s) of service**] within the timely filing period with the Medicare Secondary Payer debt dated [**date of GHP demand**] and, therefore, the CMS claim is untimely, and we do not owe the demand.

In addition to this letter, which serves as the necessary written statement that all claims' records of all responsible entities have been searched and no record was found for the services in question during the timely filing period, please find enclosed the following documentation to establish a Timely Filing Defense:

- A copy of the individual Medicare claim or claim detail supplied with the demand letter with the services
- A copy of our documents that establish the timely filing period with the applicable provisions annotated

Please note that in the copy of the documents attached under this plan **[there is a / there is no]** waiver or appeal right for not filing claims timely unless the member lacks legal capacity. We find that there has not been a showing of lack of legal capacity for the period of time in question, and therefore such appeal or waiver request is denied.

Closing,

[Name]
[Title]
[Contact information of the person issuing the defense]

Enclosure: EOB, spreadsheet, screenshots, or plan documentation

Attestation (Sample)

[Written on corporate letterhead of the identified debtor]

[Date]

To: Medicare – Commercial Repayment Center
PO Box 680
Lathrop, CA 95330

Re: Eligibility and Coverage Letter
Beneficiary Name:
Medicare ID:
Case ID:
Beneficiary Policy Number:
Letter ID:
FedDebt#:

This Attestation Letter enclosed is to notify the Centers for Medicare and Medicaid Services (CMS), that I {Employer Name/Entity Name} have officially reviewed and confirm the validity of the submitted plan documents, screenshots of plan benefits or a combination of the two provided by {GHP insurer Name} for the {date range of plan year(s)} services and claims in question. Included with this letter is a copy of the demand letter and plan documentation provided by the insurer for Case {xxxxx-xxxxx-xxxxx}. Please contact {Point of Contact from GHP Insurer Name/Entity} at {phone number and email address} if there are any questions or any additional information is needed.

I hereby certify that the foregoing information is true and accurate.

Sincerely,

[Name]
[Title]
[Contact information of the person issuing the correspondence]

GHP Demand Letter (Sample)

[Written on CMS corporate letterhead]

[Print Date]

[Debtor Name]
[ATTN: HUMAN RESOURCES DEPARTMENT or COORDINATION OF BENEFITS]
[Debtor Address 1]
[Debtor Address 2]
[City], [State] [Zip]

Letter ID: [Letter ID#]
Account TIN: [Masked TIN# (*****0000)][1]
Total Debt Due: [Amount Due]
Response Due Date: [Date]

Subject: GHP Demand

Dear [Debtor Name]:

We are writing to advise you that your organization has either sole or shared liability for a debt to the Medicare program. We have determined that you are required to repay the Medicare program for mistakenly made primary payments for services furnished to the identified Medicare beneficiary(ies) below for which the actual primary payment responsibility lies with a group health plan (GHP). The total amount due is [Amount Due]. The Claim Summary Status Report with this letter list the total amount due for each beneficiary. Please note that individual beneficiary claim facsimiles are routinely included only with the courtesy copy sent to the insurer/Third Party Administrator (TPA). You may request a copy of the individual beneficiary claim facsimiles.

NOTE: "Responsible Entities" for this debt include the employer, insurer, claims processing third party administrator ("TPA"), GHP, or other plan sponsor. If you are not a responsible entity with respect to this debt or are not authorized to act on behalf of a responsible entity, please notify us immediately.

The following explains how this happened, what you must do to resolve this matter, and the penalties for failing to act in a timely manner. If you fail to pay Medicare in full or otherwise fully resolve this matter within sixty (60) days, you may be subject to interest as well as additional recovery activities by Medicare, the Department of Treasury, or the Department of Justice.

How This Happened

This recovery claim arose because Medicare mistakenly made primary payments for services furnished to the identified Medicare beneficiary(ies) below for which the actual primary payment

[1] This is the account TIN associated to this Demand letter. Required for CRCP.

responsibility lies with a group health plan (GHP). You have been identified as the GHP itself, or you either sponsor, contribute to, insure the GHP or serve as the claims processing/paying TPA of the GHP (Responsible Entities). A Health Reimbursement Arrangement (HRA) is considered to be a GHP under applicable Federal law. Although the identified individuals may be entitled to Medicare, when certain conditions delineated within the Medicare laws (42 U.S.C. § 1395y(b)) and regulations (42 C.F.R. § 411.20, et seq.) are satisfied, the Medicare Secondary Payer (MSP) statute requires GHPs to make primary payment for services furnished to Medicare beneficiaries who are also covered by a GHP. Medicare was not aware that these conditions were satisfied at the time it made primary payment for certain services, but information now available indicates that these conditions were satisfied when the services were furnished.

The MSP statute and regulations require Medicare to recover primary payments it mistakenly made for which a GHP is the proper primary payer. Medicare's Commercial Repayment Center (CRC) may recover from any of the identified responsible entities. You are receiving this letter because you are a responsible entity under the Medicare law, and Medicare's CRC wants to afford you the opportunity to resolve this matter. We encourage you to contact other responsible entities for assistance in resolving this matter. However, you may not transfer responsibility to resolve this matter to any other entity. Please also be aware that you may be subject to an excise tax under the Internal Revenue Code if any GHP to which you contribute fails to comply with the MSP requirements.

Detailed information about the beneficiary(ies) for which Medicare mistakenly paid primary are provided in the Claim Summary Status Report sent with this letter. These enclosures also identify the subscriber associated with each beneficiary. Please note that the Medicare beneficiary may be an employee, retiree, individual associated in a business relationship with an employer that sponsors or contributes to the GHP, and the associated spouse or other family member of any of these.

How to Resolve this Recovery Demand

You or someone acting on your behalf (e.g., your insurer or plan administrator) must respond within sixty (60) days of the date of this letter. The amount due Medicare is the lesser of the GHP's total primary payment obligation or the amount that Medicare paid. You may not reduce the amount due Medicare by the amount of any payments your GHP may have made other than full primary payments to any entity prior to the date of this Demand Letter. If your GHP had not previously made full primary payment, you must refund Medicare. The GHP may not now make proper primary payment to the provider or supplier.

1. If you pay the entire amount demanded with respect to any Medicare beneficiary, you must indicate the payment amount associated with that particular beneficiary either on the check or via an attachment.
2. If you are paying less than the amount demanded with respect to any Medicare beneficiary because the GHP's total primary payment obligation was less than the amount Medicare paid, you must document how the lesser payment was determined as well as link the payment amount to the beneficiary in question.
3. You may assert and document a valid defense against all or a portion of the demand. Valid defenses include (but are not limited to):

a) The beneficiary received services not covered by the GHP: For this defense to be accepted, you must document that the services were not covered. You may not merely assert that the "services were not covered for primary payment."
b) The GHP already made full primary payment for certain specified services, either by direct payment or by inclusion in a capitation payment: You must provide proof of payment by documentation evidencing either direct payment or payment made by virtue of inclusion in a capitated payment system.
c) Medicare's Demand Letter claim was not presented timely.
    i) Medicare has a minimum of 3 years from the date of service to present a demand. You may not assert a timely filing defense if the date of this Demand Letter is less than 3 years from the date of service.
    ii) If more than 3 years from the date of service, a timely filing defense may still not be asserted if:
        1) Medicare's demand has been presented within a GHP's longer timely filing period; or
        2) Irrespective of when Medicare makes its demand, during the period either 3 years from the date of service (or, if applicable, the GHP's longer timely filing period), any responsible entity (including the GHP, insurer, or TPA) had knowledge that services had been furnished to a Medicare beneficiary. Knowledge can come from any source (e.g., a claim for secondary payment, inquiry, report, etc.). For example, if the GHP's insurer or TPA had a cross-over agreement with Medicare (i.e., Medicare forwards its primary payment data to the insurer/TPA) for the period when the services were provided, notice would have routinely been provided as a result of that cross-over agreement.
d) The beneficiary was either not covered by any GHP for which you are a responsible entity or cannot be identified. A responsible officer must certify on company letterhead that GHP enrollment records for the period when services were provided exist; the records identify all covered individuals (not just the principal named insured, e.g., the employee); the records have been searched; and no record of the beneficiary's being covered under any GHP, for which you are a responsible entity, was found. An insurer, TPA, or other responsible entity may not make this certification for the employer or the plan.

Please make checks payable to Medicare and send to the address below. Please include a copy of the first page of this letter with your payment.

Please include the beneficiaries Medicare ID, noted on the Claim Summary Status Report, on all correspondence and payment. This enables Medicare to reconcile its records.

If you do not repay Medicare in full by [Due Date], you will be required to pay interest on any remaining balance, from the date of this letter, at a rate of [Interest Rate] per year as determined by federal regulation. If the debt is not fully resolved within sixty (60) days of the date of this letter, interest is due and payable for each full 30-day period the debt remains unresolved. By law, all payments are applied to interest first, principal second. You can find the regulation that explains interest charges at 42 C.F.R., sub-section 411.24(m).

Aside from the assessment of interest, your failure to respond within sixty (60) days of the date of this letter may also result in the initiation of additional recovery procedures by Medicare, the Department of Treasury, or the Department of Justice. The Debt Collection Improvement Act of 1996 requires Federal agencies to refer delinquent debts to the Department of Treasury for cross-servicing action, including offset by the U.S. against any monies (including tax refunds) otherwise payable to the debtor.

Medicare may also determine that a GHP that fails to appropriately refund Medicare payments is nonconforming. The basis upon which CMS will make a determination of nonconformance is explained at 42 C.F.R. § 411.110, et seq. If a GHP is determined to be nonconforming, the Internal Revenue Service may impose a 25 percent excise tax on all health plan expenditures of employers and employee organizations that contribute to the health plan for each year (or portion thereof) that the GHP is found to be non-conforming.

For further information regarding the Medicare program's rights of recovery and potential penalties for noncompliance, see 42 U.S.C. § 1395y (b) and 42 C.F.R. §§ 411.20 through 411.37, 411.100 through 411.206.

If you have any questions concerning this matter, please contact the Commercial Repayment Center (CRC) by phone at 1-855-798-2627 (TTY/TDD: 1-855-797-2627 for the hearing and speech impaired) or in writing at the address below, or by fax to 844-315-4313. When sending correspondence, please include the Beneficiary Name, Medicare ID, and the Case Identification Number.

Sincerely,

CRC Case Analyst

cc: [Insurer/TPA]

Enclosure: Claim Summary Status Report

Appendix B: Sample Explanation of Benefits

Figure 3: Sample EOB

Sample Explanation of Benefits EOB

Ja ne Doe
1234 Main Street
Your Town, USA 56789

DATE: 10/12/21

EXPLANATION OF BENEFITS

EMPLOYEE:
SSN: XXX-XX-XXXX
GROUP:
GROUP ID:

CLAIM:
INCURRED:
PATIENT:

TREATMENT DATES	SERV CODE	CHARGE AMOUNT	NOT COVERED	REASON CODE	PPO/EPO DISCOUNT	COVERED AMOUNT	DEDUCTIBLE AMOUNT	CO-PAY AMOUNT	PCT	PAYMENT AMOUNT
03/30/-03/30/06	411	92.25	.00	C7	38.42	53.83	.00	.00	100	53.83
		92.25	.00		38.42	53.83	.00	.00		53.83

YOU HAVE SATISFIED $ 250.00 OF YOUR STANDARD DEDUCTIBLE
YOU HAVE SATISFIED $ 500.00 OF YOUR STANDARD FAMILY DEDUCTIBLE
YOU HAVE SATISFIED $ 250.00 OF YOUR PPO DEDUCTIBLE
YOU HAVE SATISFIED $ 500.00 OF YOUR PPO FAMILY DEDUCTIBLE

OTHER INSURANCE CREDITS	.00
TOTAL PAYMENT AMOUNT	53.83
PATIENT RESPONSIBILITY	.00

PAYMENT DISTRIBUTION

CODE **PAYEE**	**AMOUNT**	**CHECK NUMBER**	**ACCOUNT**
A)	$ 53.83		
EMP)	$ 0.00		

SERVICE CODE	**REASON CODE**
411 PHYSICIAN XRAY / LAB SERVICE	C7 Insurer Discount

MESSAGES

THIS IS YOUR ONLY COPY. PLEASE RETAIN FOR YOUR RECORDS.

Figure 4: Sample EOB Spreadsheet

	PLAN LOGO / LETTERHEAD													
	Beneficiary Name:													
	HIC#/MBI#:													
	Case ID:													
1	Date of Service	Provider Name	Billed Amount	Allowed Amount	Disallowed (CARC 45)	Deductible	Copay	Coins	Paid Amount	Date Paid	Paid To	Check# (Optional If paid to CRC/CMS)	Defense Type	Medicare Req Amt (Optional)
	Reason for Denial:													
2	Date of Service	Provider Name	Billed Amount	Allowed Amount	Disallowed (CARC 45)	Deductible	Copay	Coins	Paid Amount	Date Paid	Paid To	Check# (Optional If paid to CRC/CMS)	Defense Type	Medicare Req Amt (Optional)
	Reason for Denial:													

Appendix C: Authorizations

When a debtor wishes an entity that is not listed on a case to submit information, request information, receive copies of all related mail, and receive identifiable health information to resolve a debt, the debtor must provide an authorization that explains the relationship between the debtor and the entity, and that is signed and dated by the debtor's authorized representative.

An authorization is required any time that an entity that is not a named debtor requests to receive or provide information to address MSP recovery claims on behalf of any entity listed on a demand.

Authorization Requirements Checklist:

- Must be in writing, on letterhead of the authorizing party.
- Must include at least one of the following:
  - Beneficiary name
  - Beneficiary's Medicare Number (HICN/MBI)
  - Case ID
- Must be signed and dated by the party granting authorization (this may be an employer or an insurer depending on scenario).
- Must state that one entity authorizes the other entity to receive and provide information on its behalf and include the following:
  - Name of entity being authorized.
  - Address of the entity being authorized.
  - Phone number of the entity being authorized.
- Must include purpose and scope (reason for the authorization).
- Must identify the relationship between the entities (insurer, employer, third party administrator (TPA), etc.).
- Must include the Case ID, or otherwise provide information that allows CRC to associate the authorization to a particular beneficiary.
- Must include a timeframe for authorization. If not included, timeframe will default to one calendar year from receipt date.

Authorization Letter (Sample)

[Written on corporate letterhead of the identified debtor]

[Date]

To: Medicare – Commercial Repayment Center
PO Box 680
Lathrop, CA 95330

Re: Eligibility and Coverage Letter
Beneficiary Name:
Medicare ID:
Case ID:
Beneficiary Policy Number:
Letter ID:
FedDebt#:

Dear CRC:

This Authorization Letter is to notify the Centers for Medicare and Medicaid Services (CMS), that I {GHP Insurer Name/Entity Name} have officially designated and authorized {Representative Name} to act on my behalf in the matter of the Medicare Secondary Payer (MSP) recovery case {Case ID} as of the date of this letter. {Representative Name} is hereby granted the authority to take any actions or make any decisions it determines necessary to resolve Medicare's recovery claim, including but not limited to requesting a redetermination of the debt. CMS and its agents and/ or contractors are hereby authorized to share any information regarding this matter with them. Included with this letter is {a copy of a contract, chain of authorization, or similar demonstration of authority}. Please provide {Representative Name} with copies of all future correspondence. Correspondence may be sent to {Representative address}. Please contact {Point of Contact from GHP Insurer Name/Entity} at {phone number or email address} if there are any questions or any additional information is needed.

Closing,

[Name]
[Title]
[Contact information of the person issuing the correspondence]

Appendix D: GHP Recovery Process

Figure 5: Overview of the GHP Recovery Process

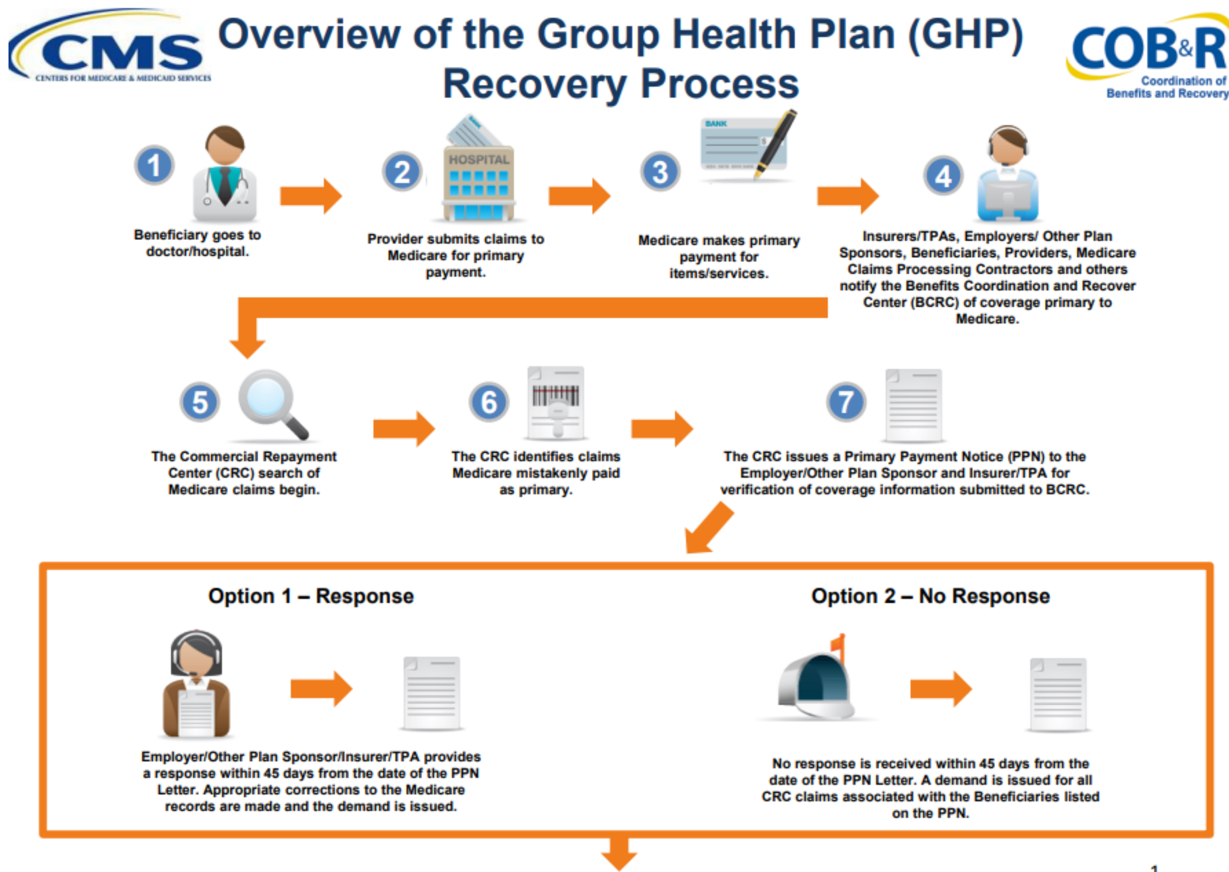
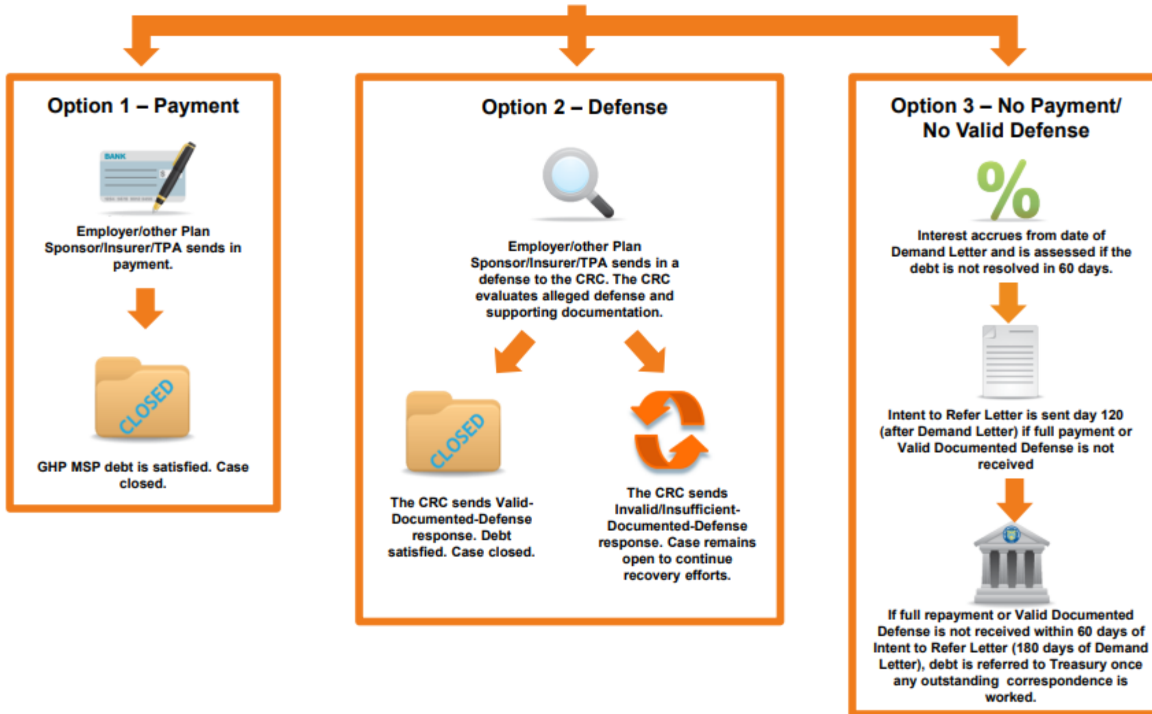


Figure 6: Overview of GHP Recovery Process (cont.)

Overview of GHP Recovery Process (cont.)

The Demand Letter is issued to the Employer/other Plan Sponsor and a copy is supplied to the insurer/ TPA.

Three situations arise from the Demand Letter.



Appendix E: Acronyms

Table E-1: Acronyms

Term	Definition
BCRC	Benefits Coordination & Recovery Center
CARC	Claim Adjustment Reason Code
CMS	Centers for Medicare & Medicaid Services
COB	Coordination of Benefits
COBRA	Consolidated Omnibus Budget Reconciliation Act
CRC	Commercial Repayment Center
EOB	Explanation of Benefits
EOP	Explanation of Payment/Explanation of Processing
ESRD	End-Stage Renal Disease
FICA	Federal Insurance Contributions Act
GHP	Group Health Plan
HICN	Health Insurance Claim Number
IHS	Indian Health Service
MAC	Medicare Administrative Contractor
MBI	Medicare Beneficiary Identifier
MSP	Medicare Secondary Payer
RA	Remittance Advice
RRE	Responsible Reporting Entity
SEE	Small Employer Exception
SOL	State-Ordered Liquidation
TPA	Third-Party Administrator

Appendix F: Previous Version Changes

Version 1.2

The list of defense types has been expanded to include sub-types, and requirements have been clarified for all types. In addition, appendices have been added for authorizations and for an overview of the GHP recovery process (Chapter 3.0, Appendix D, and Appendix E).

Version 1.1

The Commercial Repayment Center (CRC) mailing address has been updated (Section 3.0 and Appendix A).

Version 1.0

Initial version.