CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

COB&R
Coordination of Benefits and Recovery

MSP GHP Valid Documented Defense Instructions

Your Guide to Submitting a Valid Documented Defense

V.03_20140401

Select Applicable Defense Below

- Coverage Status
- Non-Covered Services
- Duplicate Primary Payment
- Capitation
- Timely Filing
- Employer Size (Working Aged)
- Employer Size (Disabled)
- Long Term Disability

Coverage Based on Employment Status

Explanation of Defense:

If a Beneficiary did not have Group Health Coverage (GHP) due to coverage ending, retirement, termination, etc., during the time frame of the date of service(s) listed on the Demand, an Employer should provide documentation confirming the Beneficiary's end of coverage as a Valid Documented Defense.

Documentation Needed:

- To dispute a Demand on the basis of employment status, the following information must be submitted on Employer letterhead:
  - Name of Beneficiary and identification of the individual through whom the Beneficiary had coverage.
  - Certification of the date of retirement or termination of that individual or their coverage.
  - Name, title, and contact information of the person issuing the correspondence on the Employer's behalf.
  - Letter identification number, case number, or lead number.
- Copy of Medicare's original Demand Letter.

Reminder: An Insurer, Third Party Administrator (TPA), or other entity may provide this information on behalf of the Employer, but must include the attestation from the Employer on Employer letterhead.

Non-Covered Services Documentation

Explanation of Defense:

When services are listed in the Demand, a GHP can provide certain documentation as proof that these services are not covered by the plan. In the event that the Demand includes claims for services that are not covered according to the terms of the plan, an Insurer/TPA should provide plan documentation.

Documentation Needed:

- Proper documentation must clearly demonstrate that the services were not covered. To dispute a Demand on the basis of non-covered services, the following information must be submitted by the Insurer and may take the form of the Explanation of Benefits (EOB), a spreadsheet, or screen prints of EOB(s) with the Insurer/TPA letterhead, and should include:
  - Date(s) of Service
  - Total amount of claim(s)
  - Allowed amount
  - Co-Pays
  - Deductibles
  - Copy of the EOB including the denial code and reason must be present
  - Copy of plan documents or policy, specific to the year services were rendered in, indicating the reason why the service was not covered
  - Name, title, and contact information of person supplying the Defense documentation
- Copy of Medicare's original Demand Letter

Reminder: The EOB, spreadsheet, and screen prints must be submitted with Insurer/TPA letterhead or logo. If the item does not have the letterhead or logo, include a statement on Insurer/TPA letterhead certifying the documents are that of the Insurer/TPA.

Duplicate Primary Payment

Explanation of Defense:
When Medicare and a GHP both make primary payment for the same date of service(s) listed on a Demand, the GHP may provide proof of their primary payment as a Defense.

Documentation Needed:

- To dispute a Demand on the basis of duplicate primary payment, the following information must be submitted on Employer's letterhead to include:
  - Beneficiary name
  - HICN
  - Explanation of the Defense
- Proper submission of an EOB concerning a paid claim, or a spreadsheet or screen prints of any EOBs concerning paid claims, as a Defense for claims previously paid by the Insurer/TPA, as a primary payer, to a Provider or to the Beneficiary. The documentation must contain:
  - Date(s) of service
  - Total amount of claim(s) (billed amount)
  - Allowed amount
  - Amount previously paid to Provider or Beneficiary
  - Date processed/payment was made
  - Name of recipient of processed claim or payment
  - Name, title, and contact information of person supplying the Defense documentation
- Copy of Medicare's original Demand Letter

Reminder: The EOB, spreadsheet, and screen prints must be submitted with the Insurer/TPA letterhead or logo. If the item does not have the letterhead or logo, include a statement on letterhead certifying the documents are that of the Insurer/TPA.

Reminder: The Insurer/TPA may not make primary Payment to the Provider/Supplier/Beneficiary after receiving a Demand Letter in lieu of paying the Demand.

Capitation

Explanation of Defense:

When a Group Health Plan's full primary payment responsibility was resolved by payment to a Provider, physician, or supplier of a contractually set amount for each enrolled person, per period of time, whether or not an enrollee seeks care. The following documentation is needed for a Valid Documented Defense.

Documentation Needed:

- To dispute a Demand on the basis of Capitation, the following information must be submitted by an Insurer, on Insurer letterhead, to include:
  - Name of Beneficiary and/or the name of the Subscriber, if applicable
  - Information to identify the claim(s) to which the Defense applies
  - Name, title, and contact information of the person supplying the Defense documentation
- Explanation of benefits, spreadsheet, or computer print-out that identifies the payment made was a Capitated amount
- Copy of Medicare's original Demand Letter

Timely Filing

Explanation of Defense:

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, there is no valid Timely Filing Defense, 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.

When a date of service is greater than three (3) years from the date of Medicare's Demand, an Employer, Insurer, or Third Party Administrator (TPA) may establish a Timely Filing Defense when certain criteria is met. To submit a possible Timely Filing Defense, there must first be certification that there is no knowledge of the claim. "No knowledge" means that records do exist for the Beneficiary and that no claim for services was ever presented, whether for primary, secondary, or tertiary payment. If a claim was ever presented by the Provider, supplier, or Beneficiary, whether paid or denied, then there is no valid Timely Filing Defense and Medicare's Demand must be resolved.

When records do exist for the Beneficiary and 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 plans appeal or waiver rights. Under the plans 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 plans 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.

To submit a possible Timely Filing Defense, click here for the documentation needed to support this Defense.

Timely Filing - Continued

Documentation Needed:

- Statement on Insurer or Third Party Administrator (TPA) letterhead certifying the following:
  - Records for the Beneficiary exist
  - All records for the Beneficiary were searched
  - No record of the services being provided were located
  - Medicare's Demand was treated as a request for an appeal of Timely Filing and the appeal was denied; OR
  - Medicare's Demand was treated as a request for waiver of Timely Filing and the waiver was denied; OR
  - Appeal and/or waiver rights do not exist within the plan
- Plan documents for the year the services were rendered that establish the Timely Filing period
- Name, title, and contact information of person supplying the Defense documentation
- Copy of Medicare's original Demand Letter

Employer Size (Working Aged)

Explanation of Defense:
When a Beneficiary with GHP coverage is entitled to Medicare due to age (65 years old or older), Medicare is primary to that GHP if the Employer that sponsors or contributes to that GHP has fewer than 20 full- and/or part-time employees for 20 non-consecutive weeks for the preceding year.

If the GHP is a Multi-Employer Plan, all participating Employers that sponsor or contribute to that GHP must have fewer than 20 full- and/or part-time employees for 20 non-consecutive weeks for the preceding year.

Documentation Needed:

- To dispute a Demand on the basis of Employer size, the following information must be submitted from the Employer on Employer letterhead:
  - You employed fewer than 20 employees for 20 non-consecutive weeks for each year and the preceding year that the Beneficiary received services.
  - You did not participate in a multiple-Employer GHP.
  - Name, title, and contact information of person supplying the Defense documentation.

- If the Employer participated in a multiple-Employer GHP, CRC requires a statement from the GHP that:
  - Each participating Employer employed fewer than 20 employees for 20 non-consecutive weeks for each year and the preceding year that the Beneficiary received services.

- Copy of Medicare's original Demand Letter.

Employer Size (Disabled)

Explanation of Defense:

When a Beneficiary with GHP coverage is entitled to Medicare due to disability, Medicare is primary to that GHP if 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.

If the GHP is a Multi-Employer Plan, all participating Employers that sponsor or contribute to that GHP must have fewer than 100 full- and/or part-time employees for 50 percent or more of its business days for the preceding year.

Documentation Needed:

- To dispute a Demand on the basis of Employer size, the following information must be submitted from the Employer on Employer letterhead:
  - You employed fewer than 100 employees for 50 percent of the year for each year and the preceding year that the Beneficiary received services.
  - You did not participate in a multiple-Employer GHP.
  - Name, title, and contact information of person supplying the Defense documentation.

- If you did participate in a multiple-Employer GHP, CRC requires a statement from the GHP that:
  - Each participating group employed fewer than 100 employees for 50 percent of the year for each year and the preceding year that the Beneficiary received services

- Copy of Medicare's original Demand Letter.

Long Term Disability

Explanation of Defense:

The Employer asserts that Medicare is primary because the Beneficiary is on Long Term Disability and is no longer considered an active employee.

Documentation needed:

- To dispute a Demand on the basis of long term disability, the following information must be submitted from the Employer on Employer letterhead:
  - Beginning and end date, if applicable, of the Long Term Disability.
  - That the employee is not actively working and has been receiving disability benefits for more than six (6) months.
  - Name, title, and contact information of the person supplying the Defense documentation.
- Copy of Medicare's original Demand Letter.

Note: ***The first six (6) months of employee disability benefits are subject to FICA taxes. After six (6) months, Medicare becomes primary.***