COB&R Coordination of Benefits and Recovery

Commercial Repayment Center (CRC)
Group Health Plan (GHP)
Valid Documented Defense Instructions

Your Guide to Submitting a Valid Documented Defense

Defense Submission Reminders

Here are a few general reminders when submitting a defense for review by the Medicare Commercial Repayment Center (CRC).

- When submitting a defense there are standard pieces of information the CRC needs to associate the defense with the appropriate case to assist in expedited processing. Generally, a cover letter containing the following documentation must be submitted by the Employer, Insurer, or TPA on letterhead:
  - Name of Beneficiary
  - Medicare Number
  - Case number
  - Name, title, and contact information of the person issuing the defense
  - A summary of the basis of the defense(s) being asserted in the submitted correspondence for CRC review

- A demand becomes delinquent on the 61st day, from the date of the demand where interest is assessed to the debt and continues to accrue in 30-day increments. It is encouraged that a defense and/or payment is submitted prior to the date of delinquency to avoid any potential interest.

- A debt is referred on the 180th day from the date of demand to the Treasury Offset Program (TOP) if an open balance remains on a case. Once a debt is referred to the TOP the defense must be submitted directly to Treasury. The CRC is unable to review any defenses received directly from an Employer, Insurer, or TPA after a debt has been referred to Treasury.

Defense Submission Reminders Cont.

- When issuing primary payment to Medicare, an explanation of payment should be included with the following key elements:
  - Beneficiary name and/or Subscriber name, if different from the Beneficiary
  - Beneficiary's HICN or MBI
  - Date the claim was paid/processed
  - Date(s) of service
  - Total amount billed
  - Allowed amount
  - Adjustments (co-pays, co-insurances, deductibles, provider discounts)
  - Name of who payment was issued to (Medicare, Commercial Repayments Center, or U.S. Department of Treasury)
- Medicare cannot be listed as the Provider on a claim and then denied. Explanation of payment should clearly demonstrate that the benefits in place for the Provider at that point in time were utilized when adjudicating the claim(s). See Non-Covered Defense, slide 6 for details.
- The CRC may need to request additional information to accept a defense on a case-by-case basis.

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Select Applicable Defense Type Below

Coverage Status

Non-Covered Services

Duplicate Primary Payment

Capitation

Timely Filing

Employer Size (Working Aged)

Employer Size (Disabled)

Long-Term Disability

Coverage Status

Situation:

This situation applies when a Medicare beneficiary did not have GHP coverage for all or some of the claims identified on Medicare's demand. This typically occurs when a beneficiary or subscriber is retired, employment terminated, or beneficiary or subscriber did not opt in for GHP coverage for all or some of the date(s) of service listed on Medicare's demand.

Documentation Needed:

- Cover letter requirements as outlined in the Defense Submission Reminders slide.
- Certification on Employer letterhead containing date of retirement, termination, or effective dates for the Medicare beneficiary on Medicare's demand.

Reminder: An Insurer or TPA may provide this information on behalf of the Employer but must be on Employer letterhead and signed by an authorized Employer representative.

Reminder: Ensure Section 111 information is correct in future submissions.

Non-Covered Services

Situation:

This situation applies when a claim(s) contained in Medicare's demand are for a date of service(s) that is not covered or payable according to the terms of the GHP.

Documentation Needed:

- Cover letter requirements as outlined in the Defense Submission Reminders slide.
- EOB(s), spreadsheet, or screen prints that include:
  - Beneficiary name/Subscriber name, if different from the Beneficiary
  - Beneficiary's HICN/MBI
  - Date(s) of service
  - Date the claim was processed
  - 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
  - Copy of plan documents or policy, specific to the year services were rendered in, clearly marked to indicate the reason why the service was not covered.

Non-Covered Services Cont.

Reminders:

For defenses pertaining to Medical Necessity, supporting documentation can typically be found in policies under the document's Utilization Management section and/or the Exclusions section for Medically Necessary or Medical Necessity.

When submitting plan documentation for the applicable plan year(s) limit to relevant documentation only and annotate the specific area(s) that apply to the defense being asserted.

If the plan documents, EOB, spreadsheet, and/or screen prints do not have the Insurer/TPA letterhead or logo, a statement on employer letterhead must be submitted certifying the document is that of the Insurer/TPA and is for each year services were rendered. The Employer may submit this correspondence directly to the CRC or a copy of the Employer's letter may be submitted by the insurer or TPA.

For situations that plan documents cannot be produced or plan documentation with plan year displayed, an attestation on employer letterhead must be provided. The Insurer may forward a copy of the employer's attestation letter certifying plan documents and/or plan year.

Duplicate Primary Payment

Situation:

- When Medicare and an Insurer both make primary payment for the same date(s) of service listed on Medicare's demand, the Insurer may provide proof of their primary payment as a defense.

Documentation Needed:

- Cover letter requirements as outlined in the Defense Submission Reminders slide.
- EOB, spreadsheet, or screenshot(s) complete with Insurer logo identifying claim(s) that were previously processed to the provider prior to Medicare's demand date. This evidence must include the following information:
  - Beneficiary name and/or Subscriber name, if different from the Beneficiary
  - Beneficiary's HICN or MBI
  - Date the claim was paid/processed
  - Date(s) of service
  - Total amount billed
  - Allowed amount
  - Adjustments (co-pays, co-insurances, deductibles, provider discounts)
  - Amounts previously paid to the provider or other supplier
  - Name of Physician, Provider, or other Supplier payment made to
- **Reminder**: If the plan documents, EOB, spreadsheet, and/or screen prints do not have the Insurer/TPA letterhead or logo, a statement on Employer letterhead must be submitted on Employer letterhead certifying the document is that of the Insurer/TPA and is for each year services were rendered.
- **Reminder:** The Insurer/TPA may not make primary payment to the Provider/Supplier/Beneficiary after receiving a Medicare demand letter in lieu of paying the Medicare demand.

Capitation

Situation:

When a GHP'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 the contracted period, when an enrollee seeks care.

Documentation Needed:

- Cover letter requirements as outlined in the Defense Submission Reminders slide.
- EOB, spreadsheet, or screenshot(s) complete with Insurer logo identifying claim(s) that were previously processed to the Provider prior to Medicare's demand date. This evidence must include the following information:
  - Beneficiary name and/or Subscriber name, if different from the Beneficiary
  - Beneficiary's HICN or MBI
  - Date the claim was paid/processed
  - Date(s) of service
  - Total amount billed
  - Allowed amount
  - Adjustments (co-pays, co-insurances, deductibles, provider discounts)
  - Amounts previously paid to the Provider or other Supplier
  - Name of Physician, Provider or other Supplier payment made to
  - Remark code or identifier that payment was made in a capitation arrangement. For situations when the EOB, spreadsheet, or screenshot(s) does not contain language around capitation the CRC may request additional documentation

Reminder: The Insurer/TPA may not make primary payment to the Provider/Supplier/Beneficiary after receiving a Medicare demand letter in lieu of paying the Medicare demand.

Reminder: If the EOB, spreadsheet, and screen prints do not have the Insurer/TPA letterhead or logo, a statement on Employer letterhead must be submitted certifying the document is that of the Insurer/TPA for each year services were rendered.

Timely Filing

Situation:

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 assert 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.

Timely Filing Cont.

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.

Please note that this presupposes that Medicare is able to 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., more than one year after 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.

Timely Filing Cont. (2)

Documentation Needed:

- Cover letter requirements as outlined in the Defense Submission Reminders slide.
- Letter from 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(s) the service(s) were rendered that establish the timely filing plan provisions and appeal rights as applicable. If the documentation does not contain the Insurer/TPA letterhead or logo, a statement on Employer letterhead must be included certifying the document is that of the Insurer/TPA and is for the year(s) service(s) were rendered.

Reminder: An Explanation of Benefits (EOB) with a claim(s) denial is not needed from an Insurer for the CRC to process this type of defense.

Reminder: For a Timely Filing defense to be considered by the CRC, the Section 111 report that established the MSP Demand must have been made by the RRE and accepted by Medicare within 1 year from the Coverage Effective Date for the case in question. For any questions or concerns related to an MSP record report or acceptance date, please contact your RRE Account Manager.

Employer Size (Working Aged)

Situation:

When a Beneficiary with GHP coverage is entitled to Medicare due to 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 20 non-consecutive weeks for the current and preceding year.

There are also situations when 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 20 non-consecutive weeks for the current or preceding year.

Documentation Needed:

- Cover letter requirements as outlined in the Defense Submission Reminders slide.
- If the Employer did not participate in a 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 on Employer letterhead:
  - Name, title, and contact information of person supplying the Defense documentation.
  - The employer did not participate in a multiple employer GHP and that the employer employed fewer than 20 employees for 20 non-consecutive weeks for each year and the preceding year that the Beneficiary received services or,
  - if the employer participate in a multi-employer GHP, that all of the employers in the plan had fewer than 20 full- and/or part-time employees for 20 non-consecutive weeks for the current or the preceding year.

Employer Size (Working Aged – Cont.)

Situation:

If an employer that has fewer than 20 full and/or part-time employees and participates in a multiple employer or multi-employer GHP and at least one participating employer has at least 20 full and/or part-time employees, these MSP rules apply to all individuals in the GHP entitled to Medicare on the basis of age, including those associated with the employer having fewer than 20 employees. However, a multi-employer GHP may be granted a **Small Employer Exception (SEE)** with respect to certain individuals in the GHP entitled to Medicare on the basis of age and who are covered through an employer in the group with fewer than 20 full and/or part-time employees.

Documentation Needed:

- Cover letter requirements as outlined in the Defense Submission Reminders slide.
- The following information must be submitted on Employer letterhead:
  - Name, title, and contact information of person supplying the Defense documentation.
  - If the Employer participated in a multiple employer GHP and one employer in the GHP employed more than 20 employees, CRC requires a copy of the approved Small Employer Exception (SEE) letter issued by the Benefits Coordination & Recovery Center (BCRC) for that specific Beneficiary.

Employer Size (Disabled)

Situation:

When a Beneficiary with GHP coverage is entitled to Medicare due to 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.

There are also situations when the GHP is a Multi-Employer Plan and all participating Employers that sponsor or contribute to that GHP 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:

- Cover letter requirements as outlined in the Defense Submission Reminders slide.
- A letter with the following information must be submitted on Employer letterhead:
  - Employer employed fewer than 100 employees for 50 percent of the year for each year and the preceding year that the Beneficiary received services from MM/DD/YYYY to MM/DD/YYYY
  - Employer did not participate in a multiple-Employer GHP.
  - Name, title, and contact information of person supplying the Defense documentation.
- If the Employer did participate in a multiple-employer GHP, CRC requires a statement 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.

Long-Term Disability

Situation:

This situation applies when an Employer asserts that Medicare is primary because the beneficiary is on long-term disability or a leave of absence and is no longer considered an active employee to qualify for GHP benefits.

Documentation needed:

- Cover letter requirements as outlined in the Defense Submission Reminders slide.
- A letter with the following information must be submitted from the Employer-on-employer letterhead:
  - Beginning and end date of the long-term disability.
  - That the employee is not actively working and has been receiving disability benefits for more than six (6) months.

Reminder: This information can be submitted by the Employer or a copy of the employer's letter from the Insurer is also acceptable.

Reminder: The first six (6) months of employee disability benefits are subject to Federal Insurance Contributions Act (FICA) taxes. After six (6) months, Medicare becomes primary.