



Group Health Plan (GHP) Defense Reference Guide

Version 1.0

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1.0 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 3.0: 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.

2.0 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.

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 3.0: 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

P.O. Box 248909

Oklahoma City, OK 73124

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 3.0: 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 BCRC's 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.

2.1. 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 \(DIS\)](#)
- [Duplicate Primary Payment / Capitation \(DPP\)](#)
- [Duplicate Demand \(DUP\)](#)
- [Eligibility Status \(ELG\)](#)
- [Employer Size – Working Aged \(EMP\)](#)
- [Employer Size - Disabled \(EMP\)](#)
- [ESRD Medicare Primary Due to End of 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 \(NGH\)](#)
- Other (OTH) which includes:
 - [Payment Made to Another Entity](#)
 - [Vow of Poverty Defense](#)
 - [Other Defense](#)
- [Patient Is Eligible for Medicare Part B Only \(PBO\)](#)
- [Precertification/Preauthorization Not Filed \(PRE\)](#)
- [Timely Filing \(TIM\)](#)

2.1.1. 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 that the amount payable under the coverage was less than Medicare's primary payment amount.

Documentation Needed:

1. EOB, spreadsheet, or screen prints 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
 - 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 plan documents or policy specific to the year services were rendered. These should be clearly marked to indicate the reason a service was not covered.
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.

2.1.2. 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 screen prints 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 or policy specific to the year services were rendered. These should be clearly marked to indicate the reason a service was not covered.
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.

2.1.3. Disability (DIS)

This defense type applies if Medicare is primary because the beneficiary is on long-term disability, and thus is no longer considered an active employee for purposes of qualifying for GHP benefits. 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 more than six (6) months
2. Beginning and end date (if applicable) of the long-term disability.

Note:

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

2.1.4. Duplicate Primary Payment / Capitation (DPP)

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 meet this definition.

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.

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
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.

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.

2.1.5. 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 occur when Medicare recovers its Duplicate Primary Payment from a provider (through voluntary refund, for example) 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.

2.1.6. Eligibility Status (ELG)

This defense type applies when a Medicare beneficiary did not have coverage under a GHP for all or some of the claims identified on Medicare's demand. This defense is based on the beneficiary's eligibility for coverage under the GHP based on their own, their spouse's, or their family member's employment status (such as when a beneficiary or subscriber retired, was not actively employed due to a leave of absence or did not have active coverage but was covered under a Consolidated Omnibus Budget Reconciliation Act (COBRA) policy).

Documentation Needed:

1. Certification from the employer or other plan sponsor of the date the beneficiary or subscriber retired, was terminated, or otherwise became ineligible for health coverage benefits, or
2. Certification from the employer or other plan sponsor of the beginning and end date (if applicable) of either a leave of absence or COBRA coverage.

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 2.1.3).

2.1.7. Employer Size - Working Aged (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:

1. 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:
 - 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,
 - 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.

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:

1. 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.

Please note that 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-of-Benefits-and-Recovery/EmployerServices/Small-Employer-Exception>.

2.1.8. 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:

1. If employer did not participate in a multiple-employer GHP and 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, OR,
2. If the employer did participate in a multiple-employer GHP, provide 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.

Notes:

If the employer has fewer than 100 employees but participates in a multi- or multiple-employer plan and where at least one employer has 100 or more employees, this defense may not be asserted.

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

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

This defense may be asserted 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-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/End-Stage-Renal-Disease-ESRD/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. ESRD coverage start date.

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.

2.1.10. 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. An assertion that service(s) rendered were not received by the beneficiary.
2. The dates of service, provider name, and charged amounts that are being asserted to have not been received.
3. Any additional proof supporting the assertion of identity theft must be included, including but not limited to:
 - A police report;
 - Evidence 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.

2.1.11. 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 (IHS) provider.

Documentation Needed:

1. An assertion that service(s) rendered were provided by IHS.
2. Supporting documentation that the Medicare beneficiary is a member of a tribal organization.

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.

2.1.12. 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:

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

2.1.13. 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:

1. EOB, spreadsheet, or screen prints 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.

2.1.14. Not A Group Health Plan (NGH)

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. 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.

2.1.15. Payment Made to Another Entity (OTH)

This defense type applies when payment has been issued 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. To whom 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.

2.1.16. Vow of Poverty (OTH)

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. That the beneficiary is enrolled in Medicare due to age or disability.
2. The beneficiary has taken a vow of poverty.
3. The beneficiary is enrolled in the Social Security coverage under the Internal Revenue Service Member of Religious Order Code.
4. Confirmation the beneficiary has, 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.

2.1.17. Other Defense (OTH)

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 screen prints 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.

2.1.18. 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.

2.1.19. 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 screen prints 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.

2.1.20. Timely Filing (TIM)

When Medicare's demand is issued greater 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.

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.

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.

See Appendix A for a sample Timely Filing letter.

Documentation Needed:

1. The beneficiary was a member of the GHP.
2. All records for the beneficiary were searched and no record of the services being provided was located.
3. Medicare's demand was treated as a request for an appeal, based on the defense of Timely Filing and the appeal was denied, OR,
4. Medicare's demand was treated as a request for waiver, based on the defense of Timely Filing and the waiver was denied, OR,
5. Appeal and/or waiver rights do not exist within the plan.

6. Plan documents for the year(s) the services were rendered that establish the timely filing plan provisions and appeal rights as 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.

3.0 Additional GHP Resources

CRCP Application

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

CRCP information:

- CRCP Overview: <https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/CRCP/Commercial-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-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Group-Health-Plan-Recovery/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-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Group-Health-Plans/GHP-User-Guide/GHP-User-Guide>.
- Section 111 mandatory insurer reporting details and requirements: <https://go.cms.gov/mirghp>.
- Internet-Only Manuals: <https://www.cms.gov/Regulations-and-Guidance/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 number
- 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 (Template)

[Written on corporate letterhead of the identified debtor]

[Date]

To: Commercial Repayment Center (CRC)
Medicare Commercial Repayment Center – GHP
P.O. Box 248909
Oklahoma City, OK 73124

Re: Beneficiary Name:
Medicare ID:
Case ID Number:

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, screen-prints, or plan documentation

Timely Filing (Sample)

[Written on corporate letterhead of identified debtor]

[Date]

To: Medicare Commercial Repayment Center – GHP
P.O. Box 248909
Oklahoma City, OK 73124

Re: Beneficiary Name:
Medicare ID:
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 date(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, screen-prints, or plan documentation

Appendix B: Sample Explanation of Benefits

Figure B-1: Sample EOB

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 B-2: 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: Acronyms

Table C-1: Acronyms

Term	Definition
BCRC	Benefits Coordination & Recovery Center
CARC	Claim Adjustment Reason Code
COBRA	Consolidated Omnibus Budget Reconciliation Act
CRC	Commercial Repayment Center
EOB	Explanation of Benefits
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
TPA	Third-Party Administrator