

CMS Manual System

Pub 100-05 Medicare Secondary Payer

Transmittal 40

Department of Health & Human Services (DHHS)

Center for Medicare & Medicaid Services (CMS)

Date: OCTOBER 21, 2005

Change Request 4012

SUBJECT: Updates to the Group Health Plan (GHP) Demand Letters

I. SUMMARY OF CHANGES: This change involves updating and creating model language specific to GHP demands within the contractor standard systems and HIGLAS. The sections listed as new below may be under a previous sections number which has either been deleted totally or moved into another section or chapter of the MSP manual.

NEW/REVISED MATERIAL

EFFECTIVE DATE: April 01, 2006

IMPLEMENTATION DATE: April 03, 2006

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revise information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R = REVISED, N = NEW, D = DELETED – Only One Per Row.

R/N/D	Chapter / Section / SubSection / Title
N	7/10.3.2/Recovery from the Provider, Physician or Other Supplier
N	7/10.3.3/Recovery from the Beneficiary that has Received Payment from Both Medicare AND a GHP
N	7/10.5.3/Provider, Physician or other Supplier GHP Demand Letter (DPP scenario)
N	7/10.5.4/Beneficiary GHP Demand Letter (DPP scenario)
N	7/10.11/ReMAS/HIGLAS GHP General Information
N	7/10.11.1/ReMAS/HIGLAS GHP Demand Process
N	7/10.11.2/ReMAS/HIGLAS GHP Demand Letter
N	7/10.11.2.1/How to Resolve this Demand

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
F I S S	M C S					V M S	C W F			
4012.4	Contractors shall initiate duplicate primary payment recovery from the beneficiary upon the contractor’s identification of the beneficiaries receipt of a GHP primary payment AND a Medicare primary payment.	X	X	X	X					
4012.5	Contractors shall use the enclosed Beneficiary GHP duplicate primary payment demand letter when appropriate.	X	X	X	X	X	X	X		
4012.6	Contractors with full ReMAS functionality shall follow guidelines specific to ReMAS/HIGLAS GHP demands, when ReMAS has interfaced two complete debtors (employer/insurer/TPA) to HIGLAS.	X	X	X	X					

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
F I S S	M C S					V M S	C W F			
	None.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: None

X-Ref Requirement #	Instructions

B. Design Considerations: None

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: None

D. Contractor Financial Reporting /Workload Impact: None

E. Dependencies: None

F. Testing Considerations:

V. SCHEDULE, CONTACTS, AND FUNDING

<p>Effective Date*: April 1, 2006</p> <p>Implementation Date: April 3, 2006</p> <p>Pre-Implementation Contact(s): Tina Merritt and Bill Zavoina</p> <p>Post-Implementation Contact(s): Tina Merritt and Bill Zavoina</p>	<p>No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.</p>
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***Unless otherwise specified, the effective date is the date of service.**

Medicare Secondary Payer (MSP) Manual

Chapter 7 - Contractor MSP Recovery Rules

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Medicare Secondary Payer (MSP) Manual

Chapter 7 - Contractor MSP Recovery Rules

10.3.2. Recovery from the Provider, Physician, or *Other* Supplier

(Rev.40, Issued: 10-21-05, Effective: 04-01-06, Implementation: 04-03-06)

If both Medicare and the GHP made primary payment to the provider, physician, or *other* supplier, the contractor *shall* recover from the provider, physician, or other supplier. *Interest charges shall be assessed if repayment of the debt does not occur within the identified timeframe.*

When a provider, physician, or *other* supplier receives payment from a GHP where Medicare has also paid, the provider, physician, or *other* supplier submits an adjustment bill showing the primary payment amount. *The fact that the provider, physician or other supplier received two primary payments establishes the repayment obligation. The contractor shall* instruct the provider, physician, or *other* supplier to return to the beneficiary the amounts of the Medicare deductible and coinsurance already paid. The provider, physician, or *other* supplier may retain any excess GHP payment over the gross amount payable by Medicare.

If duplicate payment was or will be made to the provider, physician, or supplier, i.e., the provider, physician, or supplier received both primary GHP payments and primary Medicare benefits, the *contractor shall* collect the *duplicate primary payment* from the provider, physician, or *other* supplier *by sending the letter found at 10.5.3. The amount to be recovered is the lesser of the amount paid by Medicare and the amount that the GHP paid as its full primary payment. If the GHP is an HMO that paid the provider/physician or other supplier on a capitation basis, the appropriate amount to recover is the amount that Medicare paid.*

10.3.3. Recovery from a Beneficiary Who Has Received Primary Payment from Both Medicare and a GHP

(Rev.40, Issued: 10-21-05, Effective: 04-01-06, Implementation: 04-03-06)

If both Medicare and the GHP made primary payment to the beneficiary, the contractor recovers *the appropriate amount* from the beneficiary. *See section 10.5.4 for a copy of the Beneficiary GHP demand letter. (Contractors shall send this letter via a PC.) The appropriate amount to be recovered is the lesser of the amount that Medicare paid and the amount that the GHP paid as*

*its full primary payment. Interest charges **shall not** be accessed to the beneficiary for this type of recovery situation.*

*If Medicare paid the provider, **physician or other supplier** and the GHP paid the beneficiary, Medicare does not recover from either entity. Likewise, Medicare does not recover from any entity if the GHP paid the provider, physician or other supplier and Medicare paid the beneficiary. Medicare has recovery rights against providers, physicians and other suppliers, and beneficiaries only if **BOTH Medicare and the GHP** paid the same entity.*

10.5.3 – Provider/Physician and other supplier GHP Demand Letter (DPP scenario)

(Rev.40, Issued: 10-21-05, Effective: 04-01-06, Implementation: 04-03-06)

Provider, Physician or Other Supplier Name

Provider, Physician or Other Supplier Address

Provider, Physician or Other Supplier City, State, Zip

Debt Owed to Medicare: \$ _____

Debt Identification Number: _____

Dear _____:

Medicare has identified a claim or a number of claims (see enclosed documentation) for which you received primary payment from Medicare and the identified group health plan. The group health plan has acknowledged that it was the proper primary payer and has reported that it also made primary payment to you. We were unable to locate any records showing that you previously refunded Medicare's payment or submitted an adjustment claim, as required in these situations. When providers, physicians or other suppliers receive multiple primary payments, they are required to repay Medicare within 60 days from the date that payment is received from the group health plan. As we have no record of repayment, Medicare must recover at this time.

*The Centers for Medicare & Medicaid Services has determined that a debt is owed to Medicare in the amount of \$ [insert lesser of Medicare payment or GHP payment unless provider, physician or other supplier was obligated to accept a lesser GHP payment as payment in full. **In that case, insert the Medicare payment**]. Please send us a check for the full amount due. Do not submit an adjustment claim. If you do not repay this amount or provide a valid documented defense within the timeframe specified below, we will collect against future Medicare payments to you.*

If this debt is resolved within 60 days of the date of this letter, you will not have to pay any interest charges. Failure to resolve this debt within 60 days will result in interest being charged. Interest accrues from the date of this letter and is charged for each full 30-day period that payment is delayed. The current rate of interest is _____.

We will follow standard procedures for recoupment. This means that, if we haven't received full payment from you by the date indicated, we will automatically begin to recoup the amount of the debt against Medicare payments to you for pending and future claims on the 16th day following the date of this letter if you are a provider or on the 41st day from the date of this letter if you are a physician or other supplier. The contractor will follow standard procedures for recoupment if the debt remains owing. If this debt is not resolved within 180 days, we may refer this debt to the Department of Treasury for further collection action.

Please send your payment to us at the following address. The check should be made payable to Medicare and reference the debt identification number provided in this letter.

Contractor Name – MSP Unit

Contractor Address

City, State, Zip

You may request that Medicare waive this overpayment (debt) if: (1) the overpayment is not your fault because you filed proper claims with the group health plan and with Medicare and did not know and could not reasonably be expected to know that you received primary payments from both the group health plan and Medicare; and (2) paying this debt would cause financial hardship. In deciding whether to seek a waiver of this debt, you should understand that, in the absence of compelling evidence to the contrary, CMS considers a provider, physician or other supplier to be aware that it received two primary payments or could reasonably be expected to be so aware.

In addition, if full repayment of this debt cannot be made within 60 days of the date of this letter, you may request in writing an extended repayment plan. The proposed repayment schedule should explain why repayment in full cannot be made at this time. Documentation to support the requested repayment plan must be provided at the time the request is made. The initial payment (first month) must accompany the request for an extended repayment plan. Interest is charged on unpaid balances. As explained above, if payment in full or a written request for an extended repayment plan is not received within the time period identified above, Medicare will recoup this debt through offset of future payments.

[contractors-Insert standard paragraph concerning appeal rights pursuant to 42 CFR 405.700ff or 405.800ff]. Remember that institutional providers such as hospitals, SNFs, etc. do not have appeal rights specific to duplicate primary payments at this time.

*If you have any questions regarding this matter, you may contact _____
at _____.*

Sincerely,

MSP Manager

Enclosures

10.5.4 – Beneficiary GHP Demand Letter (DPP scenario)

(Rev.40, Issued: 10-21-05, Effective: 04-01-06, Implementation: 04-03-06)

Beneficiary Name:

Beneficiary Address:

Beneficiary City, State, Zip Code

Debt Owed to Medicare: \$_____

Debt Identification Number: _____

Dear [Beneficiary Name]:

Medicare has identified a claim or a number of claims (see enclosed documentation) for which you received primary payment from Medicare and the identified group health plan. The group health plan has acknowledged that it was the proper primary payer and has reported that it also made primary payment to you. Medicare's regulations require beneficiaries that receive a primary payment from Medicare and a primary payment from a group health plan to repay Medicare within 60 days of receipt of the second primary payment. We were unable to find any records showing that you previously refunded Medicare's payment. As we have no record of repayment, Medicare must recover at this time.

The Centers for Medicare & Medicaid Services (CMS) has determined that the amount of this debt is **[insert lesser of Medicare payment or GHP payment]**. Please send us a check or money order for the full amount due. Please make the check or money order payable to Medicare and reference the debt identification number provided in this letter. Please send your payment to:

Contractor Name – MSP Unit

Contractor Address

City, State, Zip Code

If full repayment of this debt cannot be made within 60 days of the date of this letter, you may send us a written request for an extended repayment plan. Your proposed repayment schedule should explain why repayment in full cannot be made at this time. Documentation to support the requested repayment schedule must be provided at the time that the request is made. The initial payment (first month) must accompany the request for an extended repayment plan.

[contractors-Insert standard paragraph concerning appeal rights pursuant to 42 CFR 405.700ff or 405.800ff]. You may request that collection of this debt (duplicate payment) be waived. For a waiver to be approved, both of the following conditions must be satisfied:

- 1. This debt (overpayment) was not your fault because the information you provided to the party that submitted the claim to Medicare was complete and accurate (including the name and primary payment responsibility of the identified group health plan); and, when the Medicare payment was made, you thought the amount of the payment was correct; **AND***
- 2. Paying this debt to Medicare would cause financial hardship OR would be unfair for some other reason.*

If you believe that both of these conditions apply in this case, please let us know and provide a brief statement of the reasons for your belief. We may ask for additional information regarding your income, assets, expenses, etc. We will notify you if recovery of this debt (overpayment) can be waived.

If you have any questions about this letter or debt to Medicare, you may contact _____ at _____.

Sincerely,

MSP Supervisor

Enclosures

10.11 – ReMAS/HIGLAS GHP Initiated Recoveries: General Information

(Rev.40, Issued: 10-21-05, Effective: 04-01-06, Implementation: 04-03-06)

10.11.1 – ReMAS/HIGLAS GHP Demand Process

(Rev.40, Issued: 10-21-05, Effective: 04-01-06, Implementation: 04-03-06)

*The ReMAS and HIGLAS interface will afford the use of dual addressees. The ReMAS/HIGLAS GHP demand letter will be generated in HIGLAS when there is employer **and** insurer/TPA information (on CWF) interfaced from ReMAS to HIGLAS. This letter will be addressed to both the employer and the insurer/TPA.*

If the ReMAS case has employer information contained within CWF and no insurer information, then HIGLAS will send a GHP demand to the employer only. If insurer information is contained within CWF without any or complete employer information, then the interface will take place with HIGLAS and an insurer/TPA GHP demand letter generated.

Contractors on the ReMAS/HIGLAS systems shall follow debt collection and referral procedures as defined in section 60 of Pub. 100-5 Chapter 7 and Pub. 100-6, Chapter5. All activities associated to the collection, adjustment, write off, referral or closure of this debt shall be documented within the HIGLAS. The employer within the ReMAS/HIGLAS dual addressee demand letter is the “prime” debtor and shall be referred for cross-servicing, if appropriate.

Contractors on the ReMAS/HIGLAS systems shall follow section 10.9 specific to insurer/TPA employer authorizations and defenses.

HIGLAS will generate the demand letter specific to the debtor and type of case identified. Two letters will be printed; 1 for the employer and one for the insurer/TPA. The employer is the primary debtor, therefore any actions specific to non-response or delinquency shall be initiated against the employer. The ReMAS/HIGLAS GHP Demand letter will contain certain enclosures not reflected in these instructions. Those enclosures are listed at the end of the model letter (section 10.11.2.1).

10.11.2. – ReMAS/HIGLAS GHP Demand Letter

(Rev.40, Issued: 10-21-05, Effective: 04-01-06, Implementation: 04-03-06)

Date: &LETTER_DT

&DEBTOR_EMPLOYER_NAME

&DEBTOR_ADDRESS1

&DEBTOR_ADDRESS2

&DEBTOR_CITY, &DEBTOR_STATE &DEBTOR_POSTAL_CODE

&DEBTOR2_INSURER_NAME

&DEBTOR2_ADDRESS1

&DEBTOR2_ADDRESS2

&DEBTOR2_CITY, &DEBTOR2_STATE &DEBTOR2_POSTAL_CODE

RE: Debt Identification No: &CASE_NUMBER

Demand Amount: &DEMAND_AMOUNT

Dear Sir/Madam:

We are writing to advise you that your organization is liable or shares liability for a debt to the Medicare program. The following explains how this happened and what you must do to resolve this matter.

How This Happened

This repayment claim arises because Medicare mistakenly made primary payments for services furnished to Medicare beneficiaries (identified in an enclosure to this letter) that should have been the primary payment responsibility of a group health plan that: (1) you, as an employer, sponsor or to which you financially contribute; or (2) you insure or for which you act as a third party administrator. The Medicare Secondary Payer (MSP) provisions of the Social Security Act require group health plans to make primary payment for services provided to Medicare beneficiaries if those individuals are also covered by the group health plan and certain conditions delineated in the Medicare law (42 U.S.C. 1395y(b)) and regulations (42 C.F.R. 411.20ff) are satisfied. (Individual Medigap/Medicare Supplement policies qualify as group health plans if they are purchased by or through an employer.) Medicare did not know that these conditions were satisfied at the time that Medicare made primary payment for certain services; however, the information now available to Medicare indicates that they were satisfied when the services were provided.

*CMS is required under the Medicare law to recover primary payments that Medicare mistakenly made when a group health plan was the proper primary payer. With respect to services provided on or after August 5, 1997, Medicare may recover from **any** entity responsible for making primary payment, including employers, other plan sponsors, insurers and third party administrators ('responsible entities'). A responsible entity may not assert that Medicare has failed to satisfy a group health plan's timely filing requirement of less than 3 years from date of service if it receives this recovery demand letter within 3 years of the date of service or otherwise has knowledge that the services were provided to the beneficiary; e.g., through receipt of a claim for a supplemental payment to Medicare. We are sending this letter to you because you are an entity responsible for payment under the Medicare law.*

The Medicare beneficiaries are identified and the amounts of Medicare's recovery claim are summarized in enclosures to this letter. Detailed information about each beneficiary and the services for which Medicare mistakenly paid primary are also provided in enclosures to this letter. We have also enclosed detailed information on how to resolve this matter.

The Medicare Report Identification Number from the summary sheet must be shown on all correspondence. This enables Medicare to reconcile its records.

*Your failure to respond as requested within sixty (60) days of the date of this letter may result in the initiation of additional recovery procedures **without further notice**, including referral to the Department of Justice for legal action and/or the Department of the Treasury for other collection actions. You should be aware that the Debt Collection Improvement Act of 1996 requires Federal Agencies to refer debts to the Department of the Treasury or its designated debt collection agents for recovery actions including collection by offset against any monies otherwise payable to the debtor by any agency of the United States and through other collection methods. Under this and other authorities (31 U.S.C. 3720A), the Internal Revenue Service may collect this debt by offset against tax refunds owed to individuals or other entities.*

If you fail to pay this debt to Medicare or otherwise resolve this matter within 60 days of the date of this letter, interest is due beginning with the date of this letter (42 C.F.R. 411.24(m), 42 U.S.C. 1395y(b)(2)(B)(I)). The current rate of interest is _____. Any payments made in satisfaction of this debt will be applied first to the amount of interest due, then to the principal.

*If you fail to repay Medicare or provide the information requested to rebut the debt to Medicare, Medicare may also determine that the group health plan is a nonconforming group health plan. If a group health plan is determined to be nonconforming for a particular year, the **Internal Revenue Service will impose a 25 percent excise tax on all health plan expenditures of employers and employee organizations which contribute to the health plan** (Section 5000 of Internal Revenue Code). If a group health plan fails to make primary payment when required to do so by the MSP provisions and later fails to repay Medicare for its mistaken primary payments, the group health plan may be found to be nonconforming both for the year in which it fails to make primary payment and for the year in which it did not repay Medicare.*

For further reference to the Medicare program's rights of recovery and potential penalties for noncompliance, please see 42 U.S.C. 1395y(b) and regulations found at 42 C.F.R. 411.20-.37, 411.100-.206.

If you have any questions concerning this matter, please write &CONTRACTOR_NAME or call&CONTRACT_STATE_TOLL_FREE_NUM.

When you are enclosing payments, please make the check payable to Medicare. Mail the check and any information concerning this matter to:

*&CONTRACTOR_NAME
&CONTRACTOR_ADDRESS 1
&CONTRACTOR_ADDRESS 2
&CONTRACTOR_CITY, &CONTRACTOR_STATE
&CONTRACTOR_POSTAL_CODE*

Sincerely,

MSP Supervisor

*Enclosures:
How to Resolve this Demand
Payment Summary form*

10.11.2.1. – How to Resolve This Demand

(Rev.40, Issued: 10-21-05, Effective: 04-01-06, Implementation: 04-03-06)

Listed below are mostly commonly used defenses to a demand (this list is not inclusive of all possible defenses but shall be used as a guide). Contractors shall issue this guidance as an enclosure to the letter in section 10.11.1.1.

Supplemental Guidance on Resolving MSP Debts for Employers, Insurers, Third Party Administrators (TPAs), Group Health Plans (GHPs), and Other Plan Sponsors

The Centers for Medicare & Medicaid Services (CMS) anticipates that the employer or insurer may ask its health insurance contractors (i.e., the GHP or any entity responsible for payment under the plan (employer, insurer, TPA, or other plan sponsor) to assist in resolving these Medicare Secondary Payer (MSP) debts. This is certainly acceptable. However, the employer, the insurer, and other health insurance contractors must recognize that the date of Medicare's original demand letter is the date applicable to any defense that the employer, insurer, or health insurance contractors may have to any portion of this debt. The date that the employer, insurer (or other entity to the demand letter was issued) elected to share MSP claims information with a particular health insurance contractor is not relevant.

The numbered sections below show what you must take into consideration and what documentation you must provide if you wish to assert that the debt is not past due or legally enforceable. If you determine that you can resolve the debt based upon the information in a particular section, you do not need to proceed to the next numbered section.

The numbered sections will reference proper documentation. When copies of claim detail, demand letters, and report identification numbers are requested, you may use the copies we are providing you but the information of most importance is documentation to support your defense.

Number 1

Many employers and entities that process claims for employer group health plans (EGHPs) organize their records by the name and unique identifier of the employee to whom individual or family health insurance coverage is afforded. We provide information on the individual (in most cases the employee) to whom the health insurance was afforded. This information is the primary insurance that usually covers the individual beneficiary that received the medical services. We have observed that some employers and claims processors neglect to check the MSP Summary Data Sheet and mistakenly assume that the beneficiary is an employee. Historically, the majority of MSP recovery claims have involved services provided to spouses of employed individuals. The employer and any health insurance contractors that assist the employer in this effort must utilize the individual claim and the associated MSP Summary Data sheet to determine coverage at the time services were provided.

Number 2

The health plan information that Medicare provided in the original demand letters was, in almost all cases provided by the employer in response to Internal Revenue Service (IRS)/Social Security Administration (SSA)/CMS Data Match questionnaires. In other cases, the health plan information was obtained from the beneficiary, the insurer, or the provider/physician/other supplier that furnished services to the beneficiary. Thus, the information is presumed to be accurate as of the time it was provided. Many employers offer employees the opportunity periodically to choose among several available GHPs. Because CMS was not advised of changes in employees' GHP choices, the GHP Medicare identified as providing the health insurance may not be correct as of the date particular services were provided to an identified beneficiary.

The MSP debt is still valid as long as the Medicare beneficiary, entitled to Medicare on the basis of age or disability, had coverage under any employer plan based on their own or spouse's current employment status. (A disabled beneficiary may also have had coverage based on another family member's current employment status.) In the case of a beneficiary entitled to Medicare on the basis of ESRD (end stage renal disease), the debt is still valid if the beneficiary had coverage under any employer plan on any basis. If you are unclear about your responsibility relative to ESRD, please call the Medicare contractor.

The original demand letters explain that interest is due on any debt that is not resolved timely (60 days from the date of the original demand letter) and advises the recipient of the applicable interest rate. Interest applies from the date of the demand letter for each full 30-day period that the debt is unresolved. Accordingly, to resolve any MSP claim for which payment is due, the responsible entity (GHP, employer, insurer, (TPA, or other plan sponsor) must pay both the principal due and the applicable interest. To assist the responsible entity in determining the amount due on any individual unresolved MSP debt and CMS in verifying that the correct payment has been made, the responsible entity should provide the Medicare contractor with the following information:

- *A copy of the individual claim or claim detail;*
- *Date of the original demand letter containing the claim or claim detail;*
- *Associated claim identification number for that claim as provided in the demand letter;*
- *Explanation of how the principal payment was determined; and*
- *Explanation of how applicable interest was computed.*

The responsible entity (employer, insurer, TPA, GHP, or other plan sponsor) should contact the Medicare contractor with any question on the exact amount the responsible entity owes.

Number 3

It is possible that a beneficiary, entitled to Medicare on the basis of age or disability, did not have coverage under any employer plan based on their own or a spouse's current employment status at the time the services were provided, because the individual or his/her spouse had retired or left employment. (A disabled beneficiary may also have had coverage based on another family member's current employment status.) If properly

documented, the retirement or termination of the individual through whom the beneficiary had coverage is a valid defense to associated debts. Proper documentation would consist of the following:

- *A copy of the individual claim or claim detail;*
- *Date of original demand letter containing the claim or claim detail;*
- *Associated claim identification numbers for that claim as provided in the demand letter;*
- *Identification of the individual through whom the beneficiary had coverage; and*
- *Certification of the date of retirement or termination of that individual.*

We will consider all claims for which such a documented defense is provided and Medicare determines to be valid to be fully resolved.

Number 4

It is also possible that a beneficiary who has employer plan coverage that is obligated to be a primary payer may have had services not covered by the employer's plan. This would mean that the services are not the responsibility of the employer's plan. If properly documented, this would be a valid defense to the debt associated with those services. Proper documentation would consist of the following:

- *A copy of the individual claim or claim detail with the non-covered services annotated;*
- *Date of the original demand letter containing the claim or claim detail;*
- *Associated claim identification number; and*
- *Copy of plan documents (e.g., Employee Services Handbook, Member Services Booklet, etc.) that establishes that the services are not covered under the plan with the applicable coverage terms annotated.*

We will consider all claims for which such a documented defense is provided and Medicare determines to be valid to be fully resolved.

Number 5

It is possible that both Medicare and an employer plan made primary payment for the services identified on any unique MSP claim. If properly documented, an employer plan's full primary payment for the services on an MSP claim is a valid defense to the debt that had been associated with that claim. Proper documentation generally would consist of the following:

- *A copy of the individual claim or claim detail;*
- *Date of the original demand letter containing the claim or claim detail;*
- *Associated claim identification number for that claim as provided in the demand letter;*
- *Explanation of how the prior primary payment was determined; and*
- *Proof of payment (e.g., copy of remittance advice).*

If the employer plan is an HMO and the employer plan's full primary payment responsibility was resolved by a capitation payment to the provider, physician or other

supplier that treated the Medicare beneficiary, proper documentation would consist of the following:

- A copy of the individual claim or claim detail;*
- Date of the original demand letter containing the claim or claim detail;*
- Associated claim identification number for that claim as provided in the original demand letter;*
- Copy of the relevant portions of the HMO contract with the provider, physician or other supplier stipulating that the only payment obligation of the HMO was payment of a capitated amount;*
- Proof that the capitated amount for the individual for the time period when the services were furnished was paid.*

In these instances, Medicare will recover from the medical provider or supplier that received Medicare's payment.

Number 6

Most group health plans (GHPs) have established time limits during which claims must be submitted in order to qualify for payment. If a GHP or any entity responsible for payment under the plan (employer, insurer, TPA, or other plan sponsor ("responsible entities")) does not receive a claim within those time limits, the plan is not obligated to make payment (even if it would be obligated to make payment if the claim had been submitted prior to the expiration of the time limit). These time limits are typically called "timely filing" requirements. Applicable Federal law limits the ability of any responsible entity (including the employer/insurer/TPA/GHP/other plan sponsor) that received a demand letter to assert a timely filing defense to an MSP-based debt.

As a first point, the date of Medicare's original demand letter is the date applicable to any defense that the recipient of the demand letter, or any entity acting on its behalf may have to the debt or any portion of the debt. This is true regardless of which of these entities the original demand letter is issued to, and regardless of whether or not the demand is immediately shared among these entities. For example, the insurer may not establish a timely filing defense on behalf of an employer based upon the date the insurer received the demand letter from the employer. The insurer may only establish a timely filing defense for the employer based upon the date of the demand letter to the employer.

Additionally, two different rules are applicable to the MSP claims that comprise the Medicare debts. These rules are explained below.

The first rule applies to all services, regardless of the date those services were provided. The recipient of the demand letter (regardless of whether it is the employer/insurer/TPA or other responsible entity) does not have a valid timely filing defense if either the employer, the insurer, the TPA, or other responsible entity had knowledge within the plan's timely filing period that the services were provided. This knowledge could come from a variety of sources, but is often due to the receipt of a claim from a provider, physician or other supplier (or the plan member) which included the services at issue.

The second rule applies to services provided on or after August 5, 1997, and further restricts the use of a timely filing defense. The Balanced Budget Act of 1997 eliminated timely filing defenses for "at least" three (3) years from the date of the service. For

services on or after August 5, 1997, there is no timely filing defense if Medicare's original demand letter is dated within three (3) years of the date of the service. This rule applies even if the plan's timely filing period is less than three (3) years. (If the services were provided on or after August 5, 1997, and Medicare's original demand letter is not dated within three (3) years from the date of the service, then the first rule applies.)

Under the first rule, proper documentation of a timely filing defense would consist of the following:

- *A copy of the individual Medicare claim or claim detail supplied with the demand letter with the services for which the defense is offered annotated by the entity asserting the defense;*
- *The date of the original Medicare demand letter containing the claim or claim detail (and the associated report identification number for Data Match recoveries);*
- *A copy of plan documents that establish the timely filing period with the applicable provisions annotated; and*
- *A written statement by or behalf of the recipient of the demand letter that claims records of all responsible entities exist for the time period when the services were provided, were searched, and no record of the services being provided to the beneficiary were found.*

Medicare considers all claims for which such a documented defense is provided to be fully resolved, subject to Medicare's subrogated appeal rights described in Number 8.

Remember that if a demand letter is sent to an employer and another responsible entity such as an insurer or TPA responds, the responding entity must supply a signed authorization from the employer, which will allow the insurer/TPA to act as their (employers) agent. In this situation, the date of the original demand letter to the employer is the date applicable to any asserted timely filing defense.

Number 7

When the entity that received the demand letter is a TPA, the TPA will not be required to repay Medicare or provide a claim specific defense for services provided prior to August 5, 1997, if the TPA provides the following documentation:

- *Copies of individual claims or claim detail;*
- *Dates of original demand letters containing the claims or claim detail;*
- *Associated claim identification numbers for those claims as provided in the original demand letters;*
- *Copy of the relevant portion of the contract with the employer or other plan sponsor stipulating that the entity was a TPA only.*

Number 8

As explained in the original demand letter, in addition to its statutory recovery rights, Medicare also has subrogation rights. Medicare utilizes its subrogated rights to appeal a denial of payment due to a timely filing defense and/or seek waiver of the timely filing requirements to the same extent that the patient could appeal and/or seek such a waiver. Where there is a denial of payment based upon a timely filing defense, Medicare's original demand letter must be treated as a request for appeal of that denial. Similarly, if

the right to seek a waiver of the plan's requirement exists, Medicare's original demand letter must be treated as a request for waiver. If such rights do not exist, a copy of the plan's documents that explain that such rights do not exist must be provided.

When a patient's rights to appeal a timely filing denial and/or to seek a waiver of the plan's timely filing requirements exist(s), the employer/insurer/TPA/GHP/other plan sponsor must apply the same criteria to Medicare's appeal and request for waiver as they would have had the appeal or waiver request been made by the patient. For example, if the timely filing requirement is always waived for the patient if the claim was not filed timely through no-fault of the patient, the employer/insurer/TPA/GHP/other plan sponsor must waive the timely filing requirements for Medicare. Accordingly, before a case can be closed with respect to a particular service (or services) due to presentation of a valid fully documented timely filing defense, the employer/insurer/TPA/GHP/other plan sponsor must furnish to the contractor a notification that the appeal and waiver requests have been denied and provide copies of any provision upon which the denial is based. (This documentation is in addition to the information previously described as necessary for a timely filing defense.)