It is very important that Medicare Demand Letters be dealt with on a timely basis. CMS (Centers for Medicare and Medicaid Services and its contractors) will turn over an unanswered letter or an incomplete response to a collection agency. Interest accrues from the date of the letter for each 30-day period that the debt is not resolved.

The first step in the recovery process begins when CMS sends a letter (the “recovery demand”) to the entity responsible for resolving the debt. If a satisfactory response to the Demand Letter is not received within 60 days of the original letter, CMS sends a second letter (“notice of intent to refer”) which explains that the debt will be referred to the Department of Treasury for collection action at the end of 60 days if resolution is not complete. If you don’t respond appropriately to the Intent to Refer letter, the debt will be turned over to Treasury and it will go into collection. The collection agencies have the power to garnish any payroll or state-held funds, and it is very difficult to correct the claim at this point.

The law makes all entities responsible for payment under a group health plan “jointly and severally responsible” for resolving these debts. These entities include the employer that sponsors or contributes to the plan, the insurer or TPA (third party administrator) and the plan itself if it is self-funded (a separate legal entity.) An employer may direct its insurer to resolve the debt. However, if the insurer does not respond, the employer remains responsible for either paying the debt or documenting why it is not responsible.

Effective January 1, 2009 for group health plans and July 1, 2009 for Workers’ Compensation and Liability coverages, new Medicare Secondary Payer requirements went into effect. Employers and claim payers are now required to report certain information about claimants for whom Medicare may be the secondary payer. This mandated reporting must be submitted electronically to CMS on a quarterly basis by the Responsible Reporting Entities (RRE, further defined as self-insured entities and insurance carriers.) Over time, better data may help to reduce claim situations in which Medicare mistakenly pays primary.

The attached flow-chart will illustrate the timeline for response at critical points in the Medicare Demand Letter process. Using the following process will help to minimize the financial impact of a Medicare Demand Letter on your organization:

1. Designate a person within the appropriate department (Finance, Payroll, HR, etc.) to receive and date-stamp all Medicare Demand Letters. Make sure that your mail handlers know who this person is and how to identify these letters. Samples of the standard Medicare Demand Letter language are attached to this checklist for reference.

2. Notify your finance department that the Demand Letter has been received and that the employer or health plan is potentially liable for payment and interest.
MEDICARE DEMAND LETTER
OVERVIEW AND CLIENT CHECKLIST

3. Determine which medical plans were in effect during the period of the claim:
   a. If coverage for the Medicare beneficiary can be established, the claim payer for
      the health plan should be contacted immediately and supplied a copy of the
      Medicare Demand Letter. A sample of a letter to a SINGLE claim payer is
      attached to this checklist. (A copy of this letter should be sent to your
      Keenan Service Representative.)
   b. If you can’t determine which plan the Medicare beneficiary may have been
      covered by, send a copy of the Demand Letter to each of the medical carriers.
      A sample of a letter to MULTIPLE claim payers is attached to this
      checklist. (A copy of this letter should be sent to your Keenan Service
      Representative.)
   c. If you want Keenan to be allowed to assist you with resolving this issue, you
      must send a letter to CMS giving Keenan authorization to be involved. A
      sample of a Letter of Authorization is attached to this checklist. (A copy of
      this letter should be sent to your Keenan Service Representative.)

4. Follow-up with the claim payer within 5 working days to make sure that the claim has
   been received and is being reviewed. If the responsible claim payer has already made full
   primary payment to the provider of services or the Medicare beneficiary prior to the date
   of the initial recovery demand letter, they should respond to CMS with all of the
   requested information. The responsible claim payer should include your organization in
   all correspondence.

5. It takes approximately 30 days for a claim payer to make determination, so the next
   follow-up should be at 30 days.

6. If the responsible claim payer determines that the claim is eligible, payment should be
   made as soon as possible. In order to resolve the claim, both the principal due and the
   applicable interest must be received by CMS. To determine the amount due, the
   responsible claim payer must contact the CMS contractor who issued the demand letter.
   The responsible claim payer should include your organization in all payment
   correspondence.

7. If the beneficiary is determined not to have been covered by any of the organization’s
   health plans at the time of the claim, a response to the Medicare Demand Letter should
   be sent to CMS with the following documentation:
      a. A copy of the original Medicare Demand Letter with the individual claim
         information, including all reported identification numbers
      b. Identification of the individual employee through whom the beneficiary had
         coverage
      c. Certification of the date of retirement or termination of the individual employee.

8. If eligibility or claim records cannot be produced for the Medicare beneficiary who is the
   subject of the demand letter, the claim must still be paid, along with all accrued interest.
   Failure to maintain the records necessary to prove that the organization is not
   responsible does not relieve the employer from responsibility for the debt.