Mandatory Claims Submission and its Enforcement – JA0908

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Key Words	SE0908, Mandatory, Claims, Submission
Contractors Affected	• Part A/B Medicare Administrative Contractors (A/B MACs) • Medicare Carriers
Provider Types Affected	Physicians and suppliers submitting claims to Medicare Carriers and/or A/B MACs for services provided to Medicare beneficiaries

SE0904 reminds physicians and suppliers of the Medicare requirements for mandatory electronic claims submission and its enforcement.

Provider Needs to Know...

Mandatory Claims Submission

- The mandatory claims submission requirement applies to all physicians and suppliers who provide covered services to Medicare beneficiaries.
- The requirement to submit Medicare claims does not mean physicians or suppliers must accept assignment.

Compliance to Mandatory Claim Filing

- Compliance to mandatory claim filing requirements is monitored by the Centers for Medicare & Medicaid Services (CMS).

- Violations of the requirement may be subject to:
  - A civil monetary penalty of up to $2,000 for each violation;
  - A 10 percent reduction of a physician's/supplier's payment once the physician/supplier is eventually brought back into compliance; and/or
  - Medicare program exclusion.
- Medicare beneficiaries may not be charged for preparing or filing a Medicare claim.
- For the official requirements, providers may see the following:
  - Social Security Act (Section 1848(g)(4)(A); "Physician Submission of Claims") at *http://www.ssa.gov/OP_Home/ssact/title18/1848.htm* on the Internet.
  - Requirement to file claims – *The Medicare Claims Processing Manual*, Chapter 1, Section 70.8.8: *http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf* on the CMS website.

Exceptions to Mandatory Filing

- Physicians and suppliers are not required to file claims on behalf of Medicare beneficiaries for:
  - Used durable medical equipment purchased from a private source;
  - Medicare secondary payer claims when the providers do not possess all the information necessary to file a claim;
  - Foreign claims (except in certain limited situations);
  - Services furnished by opt-out physicians or practitioners (except in emergency or urgent care situations when the opt-out physician or practitioner has not previously entered into a private contract with the beneficiary);
  - Services that are furnished for free; or
  - Services paid under the indirect payment procedure.
- For more information, providers may review the *Medicare Claims Processing Manual* (Chapter 1, Section 70.8.8.8) at *http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf* on the CMS website.

Note: Providers are not required to file a claim for a service that is categorically excluded from coverage (e.g., cosmetic surgery, personal comfort services, etc; see 42 Code of Federal Regulations (CFR) 411.15 for details). However, many Medicare supplemental insurance policies pay for services that Medicare does not allow, and they may require a Medicare denial notice.

Beneficiary Submitted Claims

- The current Medicare manual requirement instructs Medicare contractors to provide education to the providers and suppliers explaining the statutory requirement, including possible penalties for repeatedly refusing to submit claims for services provided.

- Medicare contractors are instructed to process beneficiary submitted claims for services that:
  - Are not covered by Medicare (e.g., for hearing aids, cosmetic surgery, personal comfort services, etc.; see 42 CFR 411.15 for details at *http://edocket.access.gpo.gov/cfr_2004/octqtr/pdf/42cfr411.15.pdf* on the Internet) in accordance with its normal processing procedures, and
  - Are covered by Medicare when the beneficiary has submitted a complete claim (Patient's Request for Medical Payment Form CMS-1490S; see *http://www.cms.hhs.gov/CMSForms/CMSForms/* or *http://www.cms.hhs.gov/cmsforms/downloads/cms1490s-english.pdf* on the CMS website) and all supporting documentation associated with the claim, including an itemized bill with the following information:
    - Date of service,
    - Place of service,
    - Description of illness or injury,
    - Description of each surgical or medical service or supply furnished,
    - Charge for each service,
    - The doctor's or supplier's name, address, and
    - The provider or supplier's National Provider Identifier (NPI).

Beneficiary Submitted Claims

- If an incomplete claim (or a claim containing invalid information) is submitted, the contractor will return the claim as incomplete with an appropriate letter.
- Contractors will manually return (to the beneficiary) beneficiary-submitted claims, when the beneficiary used Form CMS-1500. The contractor will include the appropriate beneficiary claims Form CMS-1490S with instructions how to complete and return it for processing.
- When manually returning a beneficiary submitted claim (Form CMS-1490S) for a Medicare-covered service (because the claim is not complete or contains invalid information), the contractor will maintain a record of the beneficiary submitted claim for purposes of the timely filing rules in the event that the beneficiary re-submits the claim.
- When returning a beneficiary submitted claim, the contractor will inform the beneficiary by letter that:
  - The provider or supplier is required by law to submit a claim on behalf of the beneficiary (for services that would otherwise be payable), and
  - In order to submit the claim, the provider must enroll in the Medicare program.

- If a beneficiary receives services from a provider or supplier that refuses to submit a claim on the beneficiary's behalf (for services that would otherwise be payable by Medicare), the beneficiary should:
  - Notify the contractor in writing that the provider or supplier refused to submit a claim to Medicare; and
  - Submit a complete Form CMS-1490S with all supporting documentation.
- Upon receipt of both the beneficiary's complaint that the provider/supplier refused to submit the claim, and the beneficiary's claim Form CMS-1490S (and all supporting documentation), the contractor will process and pay the beneficiary's claim if it is for a service that would be payable by Medicare had the provider's or supplier's not refused to submit the claim and/or enroll in Medicare.

Background

- The Social Security Act (Section 1848(g)(4)) requires that claims be submitted for all Medicare patients for services rendered on or after September 1, 1990.
- This requirement applies to all physicians and suppliers who provide covered services to Medicare beneficiaries.

Operational Impact

N/A

Reference Materials

The related MLN Matters® article can be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0908.pdf* on the CMS website.