Medicare Learning Network
MLN Matters®
CMS
Information for Medicare Fee-For-Service Health Care Professionals

News Flash – As of January 1, 2009, eligible professionals can participate in the E-Prescribing Incentive Program by reporting on their adoption and use of an E-Prescribing system by submitting information on one e-prescribing measure on their Medicare Part B claims. For the 2009 E-P-prescribing reporting year, to be a successful E-Prescriber and to qualify to receive an incentive payment, an eligible professional must report one E-Prescribing measure in at least 50% of the cases in which the measure is reportable by the eligible professional during 2009. There is no sign-up or pre-registration to participate in the E-Prescribing Incentive Program. For more information, visit http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive/index.html on the CMS website.

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Note: This article was updated on January 25, 2013, to reflect current Web addresses. All other information remains unchanged.

Mandatory Claims Submission and its Enforcement

Provider Types Affected

Physicians and suppliers submitting claims to Medicare contractors (carriers and/or Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries

Provider Action Needed

STOP – Impact to You

The Centers for Medicare & Medicaid Services (CMS) is issuing this special edition article to remind physicians and suppliers of the Medicare requirements for mandatory electronic claims submission and its enforcement.


CAUTION – What You Need to Know

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, and the requirement to submit Medicare claims does not mean physicians or suppliers must accept assignment.


GO – What You Need to Do

See the Background and Additional Information Sections of this article for further details regarding these changes.

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, and the requirement to submit Medicare claims does not mean physicians or suppliers must accept assignment. Compliance to mandatory claim filing requirements is monitored by CMS, and 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, 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.gov/Regulations-and-Guidance/Guidance/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 (DME) purchased from a private source;
- Medicare Secondary Payer (MSP) claims when you 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 further details, see the Medicare Claims Processing Manual (Chapter 1, Section 70.8.8.8) at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf on the CMS website.

Note: You 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 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 (carriers and MACs) 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://www.gpo.gov/fdsys/pkg/CFR-2004-title42-vol2/pdf/CFR-2004-title42-vol2-sec411-15.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.gov/Medicare/CMS-Forms/CMS-Forms/index.html or http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/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).

If an incomplete claim (or a claim containing invalid information) is submitted, the contractor will return the claim as incomplete with an appropriate letter. In addition, contractors will manually return (to the beneficiary) beneficiary submitted claims when the beneficiary used Form CMS-1500 with instructions how to complete and return the appropriate beneficiary claims Form CMS-1490S 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 were it not for the provider's or supplier's refusal to submit the claim and/or enroll in Medicare.

Additional Information

If you have any questions, please contact your carrier or MAC at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.