



# MLN Matters<sup>®</sup>



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MLN Matters Number: MM5683

Related Change Request (CR) #: 5683

Related CR Release Date: September 5, 2008

Effective Date: Claims received on or after August 18, 2008

Related CR Transmittal #: R1588CP

Implementation Date: August 18, 2008



**News Flash - Physician Quality Reporting Initiative (PQRI)** - The Centers for Medicare & Medicaid Services (CMS) will begin testing eleven new quality measures for possible adoption in the PQRI program in future years. To learn more about how you can help CMS test these measures, visit <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html> on the CMS website and select the "Measures/Codes" link on the left side of the page. And as a reminder, all educational resources about the 2008 PQRI are available on the dedicated PQRI webpage on the CMS website. To access this web page, visit <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html> on the CMS website.

## Beneficiary Submitted Claims

Note: This article was updated on June 15, 2013, to reflect current Web addresses. This article was previously revised on September 9, 2008, to reflect changes made to CR5683. The CR was revised to emphasize that the changes apply to claims received on or after August 18, 2008, regardless of the date of service. The CR release date, transmittal number and Web address for accessing CR5683 were also changed. All other information remains the same.

## Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, and Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries

## Provider Action Needed

Change Request (CR) 5683 updates the procedures for processing claims submitted by Medicare beneficiaries to carriers and/or A/B MACs and serves as a reminder to providers and suppliers that they are required by law to submit claims to Medicare for services they render to Medicare beneficiaries.. These updates do not apply to beneficiary claims submitted to Durable Medical Equipment (DME) MACs.

### Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

## Background

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All providers and suppliers are required to enroll in the Medicare program in order to receive payment. In addition, the Social Security Act (Section 1848 (g)(4)(A); [http://www.ssa.gov/OP\\_Home/ssact/title18/1848.htm](http://www.ssa.gov/OP_Home/ssact/title18/1848.htm)) requires all providers and suppliers to submit claims for services rendered to Medicare beneficiaries. The current 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 also instructed to process beneficiary submitted claims for services that:

- (1) **Are not covered by Medicare** (e.g., for hearing aids, cosmetic surgery, personal comfort services, etc., in accordance with its normal processing procedures; see 42 CFR 411.15 at [http://edocket.access.gpo.gov/cfr\\_2004/octqtr/pdf/42cfr411.15.pdf](http://edocket.access.gpo.gov/cfr_2004/octqtr/pdf/42cfr411.15.pdf) for details); and
- (2) **Are covered by Medicare** when the beneficiary has submitted a complete claim (Patient's Request for Medical Payment Form CMS-1490S; <http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS1490S-ENGLISH.pdf>) 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. The Centers for Medicare & Medicaid Services (CMS) will be providing suggested language for that letter in a later Transmittal. 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.

**Note:** CMS will be providing suggested language for the above mentioned letter in a later Transmittal.

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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.

Medicare contractors should encourage beneficiaries to always seek non-emergency care from a provider or supplier that is enrolled 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:

- (1) Notify the contractor in writing that the provider or supplier refused to submit a claim to Medicare, and
- (2) 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.

Contractors will maintain:

- (1) Documentation of beneficiary complaints involving violations of the mandatory claims submission policy, and
- (2) A list of the top 50 violators (by State) of the mandatory claim submission policy.

The instructions provided in CR 5683 do not apply to foreign claims, and they do not apply to beneficiary claims submitted to DME MACs (for durable medical equipment, prosthetics, orthotics and supplies). The processing of foreign claims will remain unchanged, and DME MACs should continue to follow procedures that are currently in place.

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## Additional Information

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The official instruction, CR5683, issued to your carrier, A/B MAC, and DME MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1588CP.pdf> on the CMS website.

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

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