



News Flash – In an effort to inform Medicare Fee-For-Service (FFS) providers about how to avoid common billing errors and other improper activities when dealing with the Medicare Program, the Medicare Learning Network® (MLN) has developed the MLN Provider Compliance web page. This page contains MLN products and MLN Matters articles that educate FFS providers about common billing errors and other improper activities identified through the Centers for Medicare & Medicaid Services' various claim review programs. The web page is now available at http://www.cms.gov/MLNProducts/45_ProviderCompliance.asp and will be updated as new products and articles are developed and existing products and articles are revised.

MLN Matters® Number: MM7270 **Revised**

Related Change Request (CR) #: 7270

Related CR Release Date: January 21, 2011

Effective Date: January 1, 2010

Related CR Transmittal #: R2140CP

Implementation Date: February 22, 2011

Changes to the Time Limits for Filing Medicare Fee-For-Service Claims

Note: This article was revised on May 17, 2011, to add a reference to MLN Matters® article MM7396 (<http://www.cms.gov/MLNMattersArticles/downloads/MM7396.pdf>) for information on how CMS will apply this policy to Home Health Requests for Anticipated Payment (RAPs). All other information remains the same.

Provider Types Affected

This article is for all providers and suppliers submitting Part A and/or Part B claims to Medicare contractors (Carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) for services furnished to Medicare beneficiaries.

Provider Action Needed



STOP – Impact to You

This article is based on Change Request (CR) 7270, regarding changes to the time limits for filing Medicare Fee-For-Service (FFS) claims.

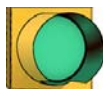
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CAUTION – What You Need to Know

Section 6404 of the Affordable Care Act reduced the maximum period for submission of all Medicare Fee-For-Service claims to no more than 12 months, or one calendar year, after the date of service. As a result of the passage of this legislation, the Centers for Medicare & Medicaid Services (CMS) is updating the Medicare Claims Processing Manual (Chapter 1) pertaining to the time limits for filing Medicare claims.



GO – What You Need to Do

CR 7270 also establishes exceptions, if certain conditions are met, to the time limit for filing Medicare claims. (See the Background and Additional Information Sections of this article, for further details regarding these changes.)

Background

The Social Security Act (Sections 1814(a)(1), 1835(a)(1), and 1842(b)(3)(B)) as well as the Medicare regulations at 42 CFR §424.44 (see http://edocket.access.gpo.gov/cfr_2009/octqtr/pdf/42cfr424.44.pdf on the Internet), specify the time limits for filing Medicare Fee-For-Service (Part A and Part B) claims.

Prior to the passage of the Affordable Care Act on March 23, 2010, a provider or supplier had from 15 to 27 months (depending on the date of service) to file a timely claim.

- For services furnished **in the first 9 months of a calendar year**, claims had to be submitted to the appropriate Medicare contractor by **December 31 of the following year**.
- For services furnished **in the last 3 months of a calendar year**, claims had to be submitted to the appropriate Medicare contractor by **December 31 of the second following year**.

The Affordable Care Act (Section 6404) reduced the maximum period for submission of all Medicare Fee-For-Service claims to no more than 12 months (one calendar year) after the date services were furnished. This time limit policy for claims submission became effective for services furnished on or after January 1, 2010. In addition, claims for services furnished prior to January 1, 2010, had to be submitted no later than December 31, 2010. The Affordable Care Act (Section 6404) also mandated that CMS may specify exceptions to the one calendar year time limit for filing Medicare claims.

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CR 7270 instructs that claims for services furnished:

- Prior to January 1, 2010, must be submitted no later than December 31, 2010.
- On or after January 1, 2010, the time limit for filing all Medicare Fee-For-Service claims (Part A and Part B claims) is 12 months, or one calendar year from the date services were furnished.

Exceptions Allowing Extension of Time Limit

Medicare will allow for the following exceptions to the one calendar year time limit for filing Fee-For-Service claims:

- **Administrative Error:** This is where the failure to meet the filing deadline was caused by error or misrepresentation of an employee, the Medicare contractor, or agent of the Department that was performing Medicare functions and acting within the scope of its authority. In these cases, Medicare will extend the timely filing limit through the last day of the sixth month following the month in which the beneficiary, provider, or supplier received notice that an error or misrepresentation was corrected.
- **Retroactive Medicare Entitlement:** This is where a beneficiary receives notification of Medicare entitlement retroactive to or before the date the service was furnished. For example, at the time services were furnished the beneficiary was not entitled to Medicare. However, after the timely filing period has expired, the beneficiary receives notification of Medicare entitlement effective retroactive to or before the date of the furnished service. In these cases, Medicare will extend the timely filing limit through the last day of the sixth month following the month in which the beneficiary, provider, or supplier received notification of Medicare entitlement retroactive to or before the date of the furnished service.
- **Retroactive Medicare Entitlement Involving State Medicaid Agencies:** This is where a State Medicaid Agency recoups payment from a provider or supplier six months or more after the date the service was furnished to a dually eligible beneficiary. For example, at the time the service was furnished the beneficiary was only entitled to Medicaid and not to Medicare. Subsequently, the beneficiary receives notification of Medicare entitlement effective retroactive to or before the date of the furnished service. The State Medicaid Agency recoups its money from the provider or supplier and the provider or supplier cannot submit the claim to Medicare, because the timely filing limit has expired. In these cases, Medicare will extend the timely filing limit through the last day of the sixth month following the month in which a State Medicaid Agency recovered Medicaid payment from a provider or supplier.

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- **Retroactive Disenrollment from a Medicare Advantage (MA) Plan or Program of All-inclusive Care of the Elderly (PACE) Provider Organization:** This is where a beneficiary was enrolled in an MA plan or PACE provider organization, but later was disenrolled from the MA plan or PACE provider organization retroactive to or before the date the service was furnished, and the MA plan or PACE provider organization recoups its payment from a provider or supplier six months or more after the date the service was furnished. In these cases, Medicare will extend the timely filing limit through the last day of the sixth month following the month in which the MA plan or PACE provider organization recovered its payment from a provider or supplier.

Additional Information

The official instruction, CR 7270, issued to your Carriers, DME MACs, FIs, A/B MACs, and RHHs regarding this change may be viewed at <http://www.cms.gov/transmittals/downloads/R2140CP.pdf> on the CMS website. Attached to CR 7270 are the revised Manual instructions, which provide complete details on the timely filing requirements, including the exceptions process.

If you have any questions, please contact your carriers, DME MACs, FIs, A/B MACs, or RHHs at their toll-free number, which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

News Flash – Get Your Flu Vaccine - Not the Flu. Don't forget to immunize yourself and your staff. Protect your patients. Protect your family. Protect yourself. While seasonal flu outbreaks can happen as early as October, flu activity usually peaks in January. This year's vaccine will protect against three different flu viruses, including the H1N1 virus that caused so much illness last flu season. The risks for complications, hospitalizations, and deaths from the flu are higher among individuals aged 65 years and older. Medicare pays for the seasonal flu vaccine and its administration for seniors and others with Medicare with no co-pay or deductible. Health care workers, who may spread the flu to high risk patients, should get vaccinated too. **Remember** – the influenza vaccine plus its administration are covered Part B benefits. Note that the influenza vaccine is NOT a Part D covered drug. For information about Medicare's coverage of the influenza vaccine and its administration, as well as related educational resources for health care staff, please visit http://www.cms.gov/MLNProducts/Downloads/Flu_Products.pdf and <http://www.cms.gov/AdultImmunizations> on the Centers for Medicare & Medicaid Services (CMS) website.

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