



Do you have your NPI? National Provider Identifiers (NPIs) will be required on claims sent on or after May 23, 2007. Every health care provider needs to get an NPI. Learn more about the NPI and how to apply for an NPI by visiting <http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/NationalProvIdentStand/index.html> on the CMS website.

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Related Change Request (CR) #: 5355

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Related CR Transmittal #: R1173CP

Implementation Date: July 2, 2007

Timeliness Standards for Processing Other-Than-Clean Claims

Note: This article was updated on April 17, 2014, to show that the Coordination of Benefits Contractor (COBC) is now known as the Benefits Coordination and Recovery Center (BCRC). All other information remains unchanged.

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare Carriers and Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries

Provider Action Needed

This article is intended as informational only and is based on Change Request (CR) 5355, which provides requirements for all carriers and MACs for timeliness for processing “other-than-clean” claims.

Background

The Social Security Act (Section 1869(a)(2); http://www.ssa.gov/OP_Home/ssact/title18/1869.htm) mandates that the Centers for Medicare & Medicaid Services (CMS) process all “other-than-clean” claims and notify the individual filing such claims of the determination within 45 days of receiving such claims. Claims that do not meet the definition of “clean” claims are classified as “other-

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than-clean” claims, and “other-than-clean” claims require investigation or development external to the contractor’s Medicare operation on a prepayment basis.

“**Clean claim**” means a claim that does not contain a defect requiring the Medicare contractor to investigate or develop prior to adjudication. Clean claims must be filed within the timely filing period (see the Social Security Act 1842(c)(2)(B); http://www.ssa.gov/OP_Home/ssact/title18/1842.htm).

“**Other Than Clean Claims**” Any claim that does not meet the definition of clean claim above. These are complete claims that require manual intervention on the part of the contractor to be adjudicated.

CR 5355 instructs the Medicare contractor (carrier/MAC) to process all “other-than-clean” claims and notify the provider and beneficiary of the determination within 45 calendar days of receipt. See *Medicare Claims Processing Manual* (Publication 100-4, Chapter 1, Section 80.2.1; <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf>) for the definition of “receipt date” and for timeliness standards for clean claims.

However, when the Medicare contractor develops the claim by asking the provider/supplier or beneficiary for additional information, the contractor will:
Cease counting the 45 calendar days on the day that the contractor sends the development letter requesting the additional information, and
Resume counting the 45 calendar days upon receiving the materials requested in the development letter from the provider/supplier and/or beneficiary.

EXAMPLE:

The Medicare contractor receives a claim on June 1st, but does not send a development letter to the provider/supplier/ and/or beneficiary until June 5th. In this situation, 5 of the 45 allotted calendar days will have already passed before the contractor requested the additional information.

Upon receiving the information back from the provider/supplier and/or beneficiary, the Medicare contractor has 40 calendar days left to:

- Process the claim, and
- Notify the individual that filed the claim of the payment determination for that claim.

CR 5355 instructs Medicare contractors to follow existing procedures relative to both: The length of time the provider/supplier and/or beneficiary is afforded to return information requested in the development letters, and

Situations where the provider/supplier and or beneficiary does not respond.

For dates of receipt on and after July 1, 2007, Medicare contractors are instructed to process all “other-than-clean” claims and notify the beneficiary and the provider filing the claim within 45 calendar days of receipt, except when the contractor requests additional information from the provider/supplier or beneficiary, or to another contractor

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(e.g., the Medicare Benefits Coordination and Recovery Center (BCRC), formerly known as the Coordination of Benefits Contractor (COBC), another claims processing contractor) Instructions in CR 5355 do not apply to the following types of claims:

- Claims where the Social Security Administration blocks a beneficiary's Health Insurance Claim Number (HIC),
- Claims the contractors are required to hold due to CMS instructions,
- Claims rejected by the translator process,
- Claims where the Medicare contractor is unable to process due to technical issues with Medicare's beneficiary record or beneficiary identification issues, and
- Claims in development due to processing requirements (e.g., medical review), in Publication 100-8, the "Medicare Program Integrity Manual" (<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html>).

Additional Information

For complete details, please see the official instruction issued to your carrier/MAC regarding this change. That instruction may be viewed at

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1173CP.pdf> on the CMS website.

If you have any questions, please contact your Medicare contractor 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/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map> on the CMS website.

Flu Shot Reminder [It's Not Too Late to Give and Get a Flu Shot!](#) The peak of flu season typically occurs between late December and March; however, flu season can last until May. Protect yourself, your patients, and your family and friends by getting and giving the flu shot. Each office visit presents an opportunity for you to talk with your patients about the importance of getting an annual flu shot and a lifetime pneumococcal vaccination. Remember - influenza and pneumococcal vaccination and their administration are covered Part B benefits. Note that influenza and pneumococcal vaccines are NOT Part D covered drugs. For more information about Medicare's coverage of adult immunizations and educational resources, go to CMS' website: <http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/SE0667.pdf> on the CMS website.

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