

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1173	Date: FEBRUARY 2, 2007
	Change Request 5355

NOTE: This transmittal is being re-communicated to correct the Business Requirement Table. The columns that previously had DMERCs checked have been changed to reflect Carriers. The Transmittal Number, date issued and all other information remain the same.

SUBJECT: Timeliness Standards For Processing Other-Than-Clean Claims

I. SUMMARY OF CHANGES: This instruction provides requirements for all carriers and Medicare Administrative Contractors (MACs) for timeliness for processing other-than-clean claims.

New / Revised Material

Effective Date: July 1, 2007

Implementation Date: July 2, 2007

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

One-Time Notification

****Unless otherwise specified, the effective date is the date of service.***

Attachment - One Time Notification

Pub. 100-04	Transmittal: 1173	Date: February 2, 2007	Change Request: 5355
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SUBJECT: Timeliness Standards for Processing Other-Than-Clean Claims

Effective Date: July 1, 2007

Implementation Date: July 2, 2007

I. GENERAL INFORMATION

A. Background:

The Social Security Act, at §1869(a)(2), mandates that Medicare 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 “other-than-clean” claims. “Other-than-clean” claims require investigation or development external to the contractor’s Medicare operation on a prepayment basis.

This instruction provides requirements for all carriers and Medicare Administrative Contractors (MACs) for timeliness for processing “other-than-clean” claims.

B. Policy:

The contractor shall 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, §80.2.1 for the definition of “receipt date” and for timeliness standards for clean claims.) However, when the contractor develops the claim by asking the provider/supplier or beneficiary for additional information, the contractor shall cease counting the 45 calendar days on the day that the contractor sends the development letter. Upon receiving the materials requested in the development letter from the provider/supplier and/or beneficiary, the contractor shall resume counting the 45 calendar days.

EXAMPLE:

The 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 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.

Contractors shall 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.

II. BUSINESS REQUIREMENTS TABLE

“Shall” denotes a mandatory requirement

Number	Requirement	Responsibility (place an “X” in each applicable column)												
		A / B M A C	D M M A C	F I	C A R R I E R	D M R C	R H I	E D C	Shared-System Maintainers				OTH ER	
							F I S S	M C S	V M S	C W F				
5355.1	For dates of receipt on and after July 1, 2007, the contractor shall process all “other-than-clean” claims and notify the beneficiary and the provider filing the claim within 45 calendar days of receipt, except as noted in subsequent requirements below.	X			X									
5355.1.1	When the contractor requests additional information from the provider/supplier or beneficiary, or from another contractor (e.g., the Coordination of Benefits Contractor, another claims processing contractor), the contractor shall cease counting the 45 calendar days on the day that the contractor generates the development letter. Upon receiving the materials requested in the development letter from the provider/supplier and/or beneficiary, the contractor shall resume counting the 45 calendar days.	X			X									
5355.1.2	Contractors shall follow existing procedures relative to the length of time the provider/supplier or beneficiary, or to another contractor (e.g., the Coordination of Benefits Contractor, another claims processing contractor) is afforded to return information requested in the development letters.	X			X									
5355.1.3	Contractors shall follow existing procedures relative to situations where the provider/supplier, beneficiary or other contractor does not respond.	X			X									
5355.1.4	These standards do not apply to claims in development due to processing requirements	X			X					X				

Number	Requirement	Responsibility (place an "X" in each applicable column)											
		A / B	D M E	F I	C A R R I E R	D M R C	R H I	E D C	Shared-System Maintainers				OTH ER
									F I S S	M C S	V M S	C W F	
	(e.g., medical review, PSC development), in Publication 100-8, the Medicare Program Integrity Manual												
5355.1.5	Claims where the Social Security Administration blocks a beneficiary's Health Insurance Claim Number (HIC) are not subject to this instruction.	X			X					X			
5355.1.6	Claims that the contractors are required to hold due to CMS instructions are not subject to this instruction.	X			X					X			
5355.1.7	This instruction does not apply to translator rejects.	X			X					X			
5355.1.8	Claims where CWF is unable to process due to technical issues with the CWF beneficiary record or beneficiary identification issues are not subject to the requirements of the CR.	X			X					X		X	
5355.2	Processing of claims in development will be based on the Julian date of receipt.	X			X					X			
5355.3	Claims developed due to the PIM shall be excluded from this instruction and shall not be reported on CROWD Form Y.	X			X					X			
5355.3.1	In producing claim data for reporting CROWD Form Y, the shared systems maintainers shall build reporting logic to exclude all claims not subjected to the 45 day "other-than-clean" claims rule. Exclusions are noted in requirements 5355.1.4 - 5355.1.8 and 5355.3.	X			X					X			
5355.4	For purposes of this instruction, the standard remittance advice (RA) and Medicare Summary Notice (MSN) satisfy the requirement to notify the provider/supplier and beneficiary of the payment determination.	X			X								
5355.4.1	Contractors send MSNs to beneficiaries on a quarterly basis and this practice will not change. Therefore, contractors shall notify beneficiaries of the payment determination on the next available quarterly MSN.	X			X								
5355.5	The contractors and shared systems maintainers shall continue to send data to the Claims Processing Timeliness (CPT) reports in the	X			X					X			

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A / B	D M E	F I	C A R R I E R	D M R C	R H I	E D C	Shared-System Maintainers			
		M A C	M A C					F I S S	M C S	V M S	C M S	
	education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.											

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

B. For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s):

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Post-Implementation Contact(s):

Yvette Cousar; yvette.cousar@cms.hhs.gov or (410) 786-2160

VI. FUNDING

A. For Fiscal Intermediaries, Carriers, and the Durable Medical Equipment Regional Carrier (DMERC):

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

B. For Medicare Administrative Contractors (MAC):

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of

work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.