

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2140	Date: January 21, 2011
	Change Request 7270

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

I. SUMMARY OF CHANGES: Section 6404 of the Patient Protection and Affordable Care Act (the Affordable Care Act) reduced the maximum period for submission of all Medicare fee-for-service claims to no more than 12 months, or 1 calendar year, after the date of service. As a result of the passage of this legislation, we are updating the internet-only manual sections pertaining to the time limits for filing Medicare claims.

EFFECTIVE DATE: January 1, 2010

IMPLEMENTATION DATE: February 22, 2011

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
R	1/70/Time Limitations for Filing Part A and Part B Claims
R	1/70.1/Determining Start Date of Timely Filing Period -- Date of Service
R	1/70.2/Definition of a Claim for Payment
R	1/70.2.1/Appropriate Medicare Contractor
R	1/70.2.2/Form Prescribed by CMS
R	1/70.2.3/In Accordance with CMS Instructions
R	1/70.3/Determining End Date of Timely Filing Period -- Receipt Date
R	1/70.4/Determination of Untimely Filing and Resulting Actions
R	1/70.5/Application to Special Claim Types
R	1/70.6/Filing Claim Where General Time Limit Has Expired
R	1/70.7/Exceptions Allowing Extension of Time Limit
R	1/70.7.1/Administrative Error
R	1/70.7.2/Retroactive Medicare Entitlement
R	1/70.7.3/Retroactive Medicare Entitlement Involving State Medicaid Agencies
N	1/70.7.4/Retroactive Disenrollment from a Medicare Advantage Plan or Program of All-Inclusive Care for the Elderly (PACE) Provider Organization
R	1/70.8/Filing Request for Payment to Carriers - Medicare Part B
R	1/70.8.1/Splitting Claims for Processing
D	1/70.8.6/Time Limitation for Filing Part B Reasonable Charge and Fee Schedule Claims
D	1/70.8.7/Improper Billing for Professional Component
R	1.70.8.6/Penalty for Filing Claims after One Year
D	1/70.8.8.1/Extend Time for Good Cause
D	1/70.8.8.2/Conditions Which Establish Good Cause
D	1/70.8.8.3/Procedure T Establish Good Cause
D	1/70.8.8.3/Procedure T Establish Good Cause
D	1/70.8.8.4/Good Cause is Not Found
D	1/70.8.8.5/Preparing Common Working File (CWF) Claim Records for Services Subject to 10 Percent Reduction
D	1/70.8.9/Extension of Time Limitation for Filing Part B Claims on Charge Basis Because of Administrative Error
D	1/70.8.10/Delays Considered to be the Result of Administrative Error

D	1/70.8.11/Extension of Time Limitation in Reference to Definition of "Filed Promptly"
D	1/70.8.12/Initiating Development of Administrative Error
D	1/70.8.13/Evidence Necessary to Honor Late Claims
D	1/70.8.14/Responsibility for Decision on Extension of Time Limit
D	1/70.8.15/Coordination of Development with Social Security Administration, Carriers, and Intermediaries
D	1/70.8.16/Statement of Intent
D	1/70.8.17/Time Limitation of Claims for Outpatient Physical Therapy or Speech Language Pathology Services Furnished by Clinic Providers
R	1/130.2/Inpatient Part A Hospital Adjustment Bills

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs):

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

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted 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.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2140	Date: January 21, 2011	Change Request: 7270
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SUBJECT: Changes to the Time Limits for Filing Medicare Fee-For-Service Claims

Effective Date: January 1, 2010

Implementation Date: February 22, 2011

I. GENERAL INFORMATION

A. Background: Sections 1814(a)(1), 1835(a)(1), and 1842(b)(3)(B) of the Social Security Act, as well as the Medicare regulations at 42 C.F.R. §424.44, specify the time limits for filing Medicare fee-for-service (Part A and Part B) claims. Prior to the passage of the Patient Protection and Affordable Care Act (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. Claims for services furnished in the last 3 months of a calendar year had to be submitted by December 31 of the second following year.

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

B. Policy: The time limit for filing all Medicare fee-for-service claims (Part A and Part B claims) is 12 months, or 1 calendar year from the date services were furnished. This policy is effective for services furnished on or after January 1, 2010. In addition, claims for services furnished prior to January 1, 2010 must be submitted no later than December 31, 2010. Exceptions to the 1 calendar year time limit for filing Medicare claims are as follows: (1) error or misrepresentation by an employee, Medicare contractor, or agent of the Department of HHS that was performing Medicare functions and acting within the scope of its authority; (2) retroactive Medicare entitlement to or before the date of the furnished service; (3) retroactive Medicare entitlement where a State Medicaid Agency recoups money from a provider or supplier 6 months or more after the service was furnished; (4) a Medicare Advantage plan or Program of All-inclusive Care for the Elderly (PACE) provider organization recoups money from a provider or supplier 6 months or more after the service was furnished to a beneficiary who was retroactively disenrolled to or before the date of the furnished service.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)						
		A	D	F	C	R	Shared-System Maintainers	OTHER
		/	M	I	A	H		
		B	E		R	H		

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I M I E R	C A R R I E R	R H I I S S	Shared-System Maintainers				OTH ER
						F I S S	M C S	V M S	C W F		
7270.9	<p>A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv.</p> <p>Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider 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.</p>	X	X	X	X	X					

IV. SUPPORTING INFORMATION

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

X-Ref Requirement Number	Recommendations or other supporting information:
7270.10	Section 6404 of the Patient Protection and Affordable Care Act of 2010

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): David Walczak (410) 786-4475 and Fred Grabau (410) 786-0206, for questions related to the timely filing regulations. Eric Coulson (410) 786-3352, for questions related to supplier claims processing. Tom Dorsey (410) 786-7434, for questions related to professional claims processing. Wilfred Gehne (410) 786-6148, for questions related to institutional claims processing.

Post-Implementation Contact(s): Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs)*, *Regional Home Health Intermediaries (RHHIs)*:

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

Section B: For *Medicare Administrative Contractors (MACs)*:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted 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.

Medicare Claims Processing Manual

Chapter 1 - General Billing Requirements

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70.8.6- *Penalty for Filing Claims after One Year*

70 - Time Limitations for Filing *Part A and Part B* Claims

(Rev. 2140, Issued: 01-21-11, Effective: 01-01-10, Implementation: 02-22-11)

Medicare regulations at [42 CFR 424.44](#) define the timely filing period for Medicare fee for service claims. In general, such claims must be filed *to the appropriate Medicare claims processing contractor no later than 12 months, or 1 calendar year, after the date the services were furnished.* (See section [§70.7](#) below for details of the exceptions *to the 12 month timely filing limit.*)

70.1 - Determining Start Date of Timely Filing Period -- *Date of Service*

(Rev. 2140, Issued: 01-21-11, Effective: 01-01-10, Implementation: 02-22-11)

In general, the start date for determining the 12 month timely filing period is the date of service or “From” date on the claim. For institutional claims (Form CMS-1450, the UB-04 and now the 837 I or its paper equivalent) that include span dates of service (i.e., a “From” and “Through” date span on the claim), the “Through” date on the claim is used for determining the date of service for claims filing timeliness. Certain claims for services require the reporting of a line item date of service. For professional claims (Form CMS-1500 and 837-P) submitted by physicians and other suppliers that include span dates of service, the line item “From” date is used for determining the date of service for claims filing timeliness. (This includes DME supplies and rental items.) If a line item “From” date is not timely but the “To” date is timely, contractors must split the line item and deny the untimely services as not timely filed. Claims

having a date of service on February 29 must be filed by February 28 of the following year to be considered timely filed. What constitutes a claim *is* defined below.

70.2 - Definition of *a* Claim for *Payment*

(Rev. 2140, Issued: 01-21-11, Effective: 01-01-10, Implementation: 02-22-11)

Medicare regulations at 42 CFR 424.5 describe basic conditions for Medicare payment. These regulations at *paragraphs* (5) and (6) define a claim *for payment* as a *request for payment* from a provider, supplier, or beneficiary, *and the provider, supplier, or beneficiary requesting payment must furnish* the *appropriate* Medicare contractor with sufficient information to determine the amount of payment. Institutional claims are in all cases filings by the provider and issues of assigned or non-assigned claims do not apply.

Medicare regulations at 42 CFR 424.32 *describe* the basic requirements for *all* claims. Specifically, 42 CFR 424.32 (a) (1) states, “A claim must be filed with the appropriate intermediary or carrier on a form prescribed by CMS in accordance with CMS instructions.” Therefore, this regulation sets out three distinct conditions that must be satisfied in order for a provider submission to be considered a claim

- it must be filed with the appropriate Medicare contractor,
- it must be filed on the prescribed form and
- it must be filed in accordance with all pertinent CMS instructions. The sections below define each of these conditions in greater detail.

70.2.1 - Appropriate Medicare Contractor

(Rev. 2140, Issued: 01-21-11, Effective: 01-01-10, Implementation: 02-22-11)

Submissions for services must be filed with *the appropriate Medicare contractor*. It is the provider’s *or supplier’s* responsibility to submit each claim to the appropriate contractor. Medicare contractors may attempt to re-route claims appropriately if they have enough information to do so. In the case of re-routed claims, services submitted for payment are not considered claims under Medicare regulations until received by the appropriate *Medicare contractor*.

70.2.2 - Form Prescribed by CMS

(Rev. 2140, Issued: 01-21-11, Effective: 01-01-10, Implementation: 02-22-11)

Regulations at 42 CFR 424.32 (b) prescribe *the* claim forms *to be used for a paper claim submission*. The paper form prescribed for institutional providers is Form CMS-1450, also known as the UB-04 uniform billing form. *The paper form prescribed for physicians and suppliers is Form CMS-1500 (Health Insurance Claim Form)*. However, the Administrative Simplification Compliance Act mandated the electronic submission of all Medicare claims received on or after October 16, 2003, with a very limited number of exceptions as defined in

regulations. Even prior to this mandate, the overwhelming majority of Medicare claims were submitted in electronic formats, so the electronic format equivalent to the paper form is key to determining the prescribed form used in a submission.

The prescribed electronic format for Medicare institutional claims was defined by HIPAA as the 837 institutional claim transaction as defined by the American National Standards Institute Accredited Standards Committee X12. Services submitted for payment by institutional providers on a format other than the 837 I, or its paper equivalent in the limited case where applicable, are not considered claims under Medicare regulation. Claims submitted on paper forms are entered into Medicare's electronic claims processing system and converted into electronic records in order to be processed. After the point of entry into the electronic system, handling of claims submitted on the prescribed electronic format and on its paper equivalent is identical with regard to determining timely filing.

70.2.3 - In Accordance with CMS Instructions

(Rev. 2140, Issued: 01-21-11, Effective: 01-01-10, Implementation: 02-22-11)

The CMS instructions for submitting institutional claims to Medicare are contained in this manual. General instructions that reflect guidance on the use of the paper UB-04, as established by the National Uniform Billing Committee, are found in Chapter 25. These instructions apply to all institutional claim types. Additional chapters in this manual supplement these general instructions. *For example, see instructions for inpatient hospital billing in Chapter 3, or inpatient skilled nursing billing in Chapter 6. For physician and supplier Part B claims, see Chapter 26 "Completing and Processing Form CMS-1500 Data Set".* In order to constitute a Medicare claim, services submitted for payment must be entered in a claim format in accordance with these instructions. Services submitted for payment in a manner not complete and consistent according to these instructions will not be accepted into Medicare's electronic claims processing system and will not be considered filed for purposes of determining timely filing.

70.2.3.1 - Incomplete or Invalid Submissions

(Rev. 2140, Issued: 01-21-11, Effective: 01-01-10, Implementation: 02-22-11)

Services not submitted in accordance with CMS instructions include:

- Incomplete Submissions - Any submissions missing required information (e.g., no provider name).
- Invalid submissions - Any submissions that contains complete and required information; however, the information is illogical or incorrect (e.g., incorrect HIC#, invalid procedure codes) or does not conform to required claim formats.

The following definitions may be applied to determine whether submissions are incomplete or invalid:

- Required - Any data element that is needed in order to process the submission (e.g., Provider Name).

- Not Required - Any data element that is optional or is not needed in order to process the submission (e.g., Patient's Marital Status).
- Conditional - Any data element that must be completed if other conditions exist (e.g. if there is insurance primary to Medicare, then the primary insurer's group name and number must be entered on a claim). If these conditions exist, the data element becomes required.

Submissions that are found to be incomplete or invalid are returned to the provider (RTP). The incomplete or invalid information is detected by the FI's claims processing system. The electronic submission is returned to the provider of service electronically, with notation explaining the error(s). Assistance for making corrections is available in the on-line processing system (Direct Data Entry) or through the FI. In the limited cases where paper submission are applicable, paper submissions found to be incomplete or invalid prior to or during entry into the contractor's claims processing system are returned to the provider of service by mail, with an attached form explaining the error(s).

The electronic records of claims that are RTP are held in a temporary storage location in the FI's claims processing system. The records are held in this location for a period of time that may vary among FIs, typically 60 days or less. During this period, the provider may access the electronic record and correct it, enabling the submission to be processed by the FI. If the incomplete or invalid information is not corrected within the temporary storage period, the electronic record is purged by the FI. There is no subsequent audit trail or other record of the submission being received by Medicare. These submissions are never reflected on a RA. No permanent record is kept of the submissions because they are not considered claims under Medicare regulation.

70.2.3.2 - Handling Incomplete or Invalid Submissions

(Rev. 2140, Issued: 01-21-11, Effective: 01-01-10, Implementation: 02-22-11)

The following provides additional information detailing submissions that are considered incomplete or invalid.

The matrix in Chapter 25 specifies whether a data element is required, not required, or conditional. (See definitions in §70.2 above.) The status of these data elements will affect whether or not an incomplete or invalid submission (hardcopy or electronic) will be returned to provider (RTP). FIs should not deny claims and afford appeal rights for incomplete or invalid information as specified in this instruction. (See §80.3.1 for Definitions.)

The FIs should take the following actions upon receipt of incomplete or invalid submissions:

- If a required data element is not accurately entered in the appropriate field, RTP the submission to the provider of service.
- If a not required data element is accurately or inaccurately entered in the appropriate field, but the required data elements are entered accurately and appropriately, process the submission.

- If a conditional data element (a data element which is required when certain conditions exist) is not accurately entered in the appropriate field, RTP the submission to the provider of service.
- If a submission is RTP for incomplete or invalid information, at a minimum, notify the provider of service of the following information:
 - Beneficiary's Name;
 - Health Insurance Claim (HIC) Number;
 - Statement Covers Period (From-Through);
 - Patient Control Number (only if submitted);
 - Medical Record Number (only if submitted); and
 - Explanation of Errors.

NOTE: Some of the information listed above may in fact be the information missing from the submission. If this occurs, the FI includes what is available.

- If a submission is RTP for incomplete or invalid information, the FI shall not report the submission on the MSN to the beneficiary. The notice must only be given to the provider or supplier.

The matrix in Chapter 25 specifies data elements that are required, not required, and conditional. These standard data elements are minimal requirements. A crosswalk is provided to relate CMS-1450 (UB-04) form locators used on paper submissions with loops and data elements on the ANSI X12N 837 I used for electronic submissions.

The matrix does not specify loop and data element content and size. Refer to the implementation guide for the current HIPAA standard version of the 837I for these specifications. If a claim fails edits for any one of these content or size requirements, the FI will RTP the submission to the provider of service.

NOTE: The data element requirements in the matrix may be superceded by subsequent CMS instructions. The CMS is continuously revising instructions to accommodate new data element requirements. The matrix will be updated as frequently as annually to reflect revisions to other sections of the manual.

The FIs must provide a copy of the matrix listing the data element requirements, and attach a brief explanation to providers and suppliers. FIs must educate providers regarding the distinction between submissions which are not considered claims, but which are returned to provider (RTP) and submissions which are accepted by Medicare as claims for processing but are not paid. Claims may be accepted as filed by Medicare systems but may be rejected or denied. Unlike RTPs, rejections and denials are reflected on RAs. Denials are subject to appeal, since a denial is a payment determination. Rejections may be corrected and re-submitted.

70.3 - Determining End Date of Timely Filing Period—Receipt Date **(Rev. 2140, Issued: 01-21-11, Effective: 01-01-10, Implementation: 02-22-11)**

A submission, as defined above, is considered to be a filed claim for purposes of determining timely filing on the date that the submission *is received by the appropriate Medicare claims processing contractor*. At this point, the submission receives a permanent receipt date that remains part of the claim record. *Once a submission (or claim) passes edits for completeness and validity described in §70.2 above, it is accepted into the Medicare claims processing system.*

The receipt date has two functions. It is used for determining whether the claim was timely filed (see 70.4 below). The same date is also used as the receipt date for purposes of determining claims processing timeliness on the part of the intermediary. (See §80 for details on determining claims processing timeliness.)

70.4 - Determination of Untimely Filing and Resulting Actions **(Rev. 2140, Issued: 01-21-11, Effective: 01-01-10, Implementation: 02-22-11)**

Medicare denies a claim *for untimely filing if the receipt date applied to the claim exceeds 12 months or 1 calendar year from the date the services were furnished (i.e., generally, the “From” date, with the exception of the “Through” date for institutional claims that have span dates of services, as specified in §70.1)*. When a claim is denied for having been filed after the timely filing period, such denial does not constitute an “initial determination”. As such, the determination that a claim was not filed timely is not subject to appeal.

Where the beneficiary request for payment was filed timely (or would have been filed the request timely had the provider taken action to obtain a request from the patient whom the provider knew or had reason to believe might be a beneficiary) but the provider is responsible for not filing a timely claim, the provider may not charge the beneficiary for the services except for such deductible and/or coinsurance amounts as would have been appropriate if Medicare payment had been made. In appropriate cases, such claims should be processed because of the spell-of-illness implications and/or in order to record the days, visits, cash and blood deductibles. The beneficiary is charged utilization days, if applicable for the type of services received.

70.5 - Application to Special Claim Types **(Rev. 2140, Issued: 01-21-11, Effective: 01-01-10, Implementation: 02-22-11)**

- Adjustments - If a provider fails to include a particular item or service on its initial claim, an adjustment submission to include such an item(s) or service(s) is not permitted after the expiration of the time limitation for filing of the initial claim. There is no longer timely filing period for adjustments. There are special timeliness requirements for filing adjustment requests for inpatient services subject to a prospective payment system, if the adjustment results in a change to a higher weighted DRG. These adjustments must be submitted within 60 days of the date of the remittance for the original claim, or the adjustment will be rejected.

However, to the extent that an adjustment bill otherwise corrects or supplements information previously submitted on a timely claim about specified services or items furnished to a specified individual, it is subject to the rules governing administrative finality, rather than the time limitation for filing (see Chapter 29 on Reopenings).

- Emergency Hospital Services and Services Outside the United States - The time limit for claims for payment for emergency hospital services and hospital services outside the United States, whether or not the hospital has elected to bill the program, is the same as for participating hospitals. (See §70.1 above.) The claim for emergency hospital services and other services outside the United States will be considered timely filed if filed with any intermediary within the time limit.

70.6 - Filing Claim Where *General* Time Limit Has Expired **(Rev. 2140, Issued: 01-21-11, Effective: 01-01-10, Implementation: 02-22-11)**

As a general rule, where the contractor receives a late filed claim submitted by a provider *or supplier* with no explanation attached as to the circumstances surrounding the late filing, the contractor should assume that the provider *or supplier* accepts responsibility for the late filing.

Where it comes to the attention of a provider *or supplier* that health services that are or may be covered were furnished to a beneficiary but that the *general* time limit (defined in §70.1 above) on filing a claim for such services has expired, the provider *or supplier* should take the following action.

- Where the provider *or supplier* accepts responsibility for late filing, it should file a no-payment claim. (See Chapter 3 for no-payment bill processing instructions.) Where the provider *or supplier* believes the beneficiary is responsible for late filing, it should contact the *contractor* and also file a no-payment claim and include a statement in the remarks field on the claim explaining the circumstances which led to the late filing and giving the reasons for believing that the beneficiary (or other person acting for him/her) is responsible for the late filing. If a paper claim is submitted, such a statement may be attached and, if practicable, may include the statement of the beneficiary as to the beneficiary's view on these circumstances.
- Where the beneficiary does not agree with the determination that the claim was not filed timely or the determination that he/she is responsible for the late filing, the usual appeal rights are available to the beneficiary. Where the provider or supplier is protesting the denial of payment or the assignment of responsibility, no formal channels of appeal are available. However, the contractor may, at the request of the provider or supplier, informally review its initial determination.

70.7 - Exceptions Allowing Extension of Time Limit **(Rev. 2140, Issued: 01-21-11, Effective: 01-01-10, Implementation: 02-22-11)**

Medicare regulations at 42 C.F.R. §424.44(b) allow for the following exceptions to the 1 calendar year time limit for filing fee for service claims:

(1) Administrative error, if failure to meet the filing deadline was caused by error or misrepresentation of an employee, Medicare contractor, or agent of the Department that was performing Medicare functions and acting within the scope of its authority (See 70.7.1).

(2) Retroactive Medicare entitlement, 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 subsequently receives notification of Medicare entitlement effective retroactively to or before the date of the furnished service (See 70.7.2).

(3) Retroactive Medicare entitlement involving State Medicaid Agencies, where a State Medicaid Agency recoups payment from a provider or supplier 6 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 retroactively 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 the timely filing limit has expired (See 70.7.3).

(4) Retroactive disenrollment from a Medicare Advantage (MA) plan or Program of All-inclusive Care of the Elderly (PACE) provider organization, 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 6 months or more after the date the service was furnished (See 70.7.4).

The conditions for meeting each exception, and a description of how filing extensions will be calculated, are described in sections 70.7.1 – 70.7.4.

Where the initial request for an exception to the timely filing limit is made by a provider or supplier, the Medicare contractor has responsibility for determining whether a late claim may be honored based on all pertinent documentation submitted by the provider or supplier. As explained in sections 70.7.1 – 70.7.4, the contractor will determine if the requirements for a particular exception are met. The contractor should contact the appropriate CMS regional office (RO) to see if it wants to participate in the review and decision-making of the exception request. In limited circumstances, the RO will determine if the exception request should go to CMS Central Office for a final determination.

70.7.1 - Administrative Error

(Rev. 2140, Issued: 01-21-11, Effective: 01-01-10, Implementation: 02-22-11)

Medicare regulations at 42 CFR 424.44 allow that where Medicare program error causes the failure of the provider *or supplier* to file a claim for payment within the time limit in §70.1 above, the time limit will be extended through the last day of the *6th* calendar month following the month in which the error is rectified by notification to *either* the provider, *supplier*, or

beneficiary. *In order to avoid having two extension of time triggers, contractors must notify the beneficiary and the provider or supplier in writing about the correction of the error on the same day.* Administrative error may include misrepresentation, delay, mistake, or other action of Medicare, or its contractors. *Contractors will not accept requests for extensions for such errors that extend beyond 4 years from the date of service.*

The administrative error that prevents timely filing of the claim may affect the provider *or supplier* directly or indirectly, i.e., by preventing the beneficiary or his or her representative from filing a timely request for payment. Situations in which failure to file within the usual time limit will be considered to have been caused by administrative error include but are not limited to the following:

- The failure resulted from misinformation from *an employee, Medicare contractor, or agent of the Department acting within the scope of its authority*, e.g., that certain services were not covered *under Part A or Part B*, although in fact they were covered.
- The failure resulted from excessive delay by Medicare, or the *Medicare contractor* in furnishing information necessary for the filing of the claim.
- The failure resulted from advice by *an employee, Medicare contractor, or agent of the Department acting within the scope of its authority* that precluded the filing of a claim until the provider *or supplier* receives certain information from the *Medicare contractor* (e.g., a hospital following manual instructions does not file a billing for outpatient services where the services are expected to be paid for by workmen's compensation; but the hospital learns after the expiration of the time limit of the ultimate denial of workmen's compensation liability).
- Any claim involving situations other than those listed above, where it appears that an extension of the time limit might be justified on the basis of administrative error, should be submitted by the *appropriate Medicare claims processing contractor with a recommendation, before payment, to the appropriate CMS RO. Contractors should consult with the appropriate RO. ROs may in turn consult with CMS Central Office.*

Where administrative error is alleged to be responsible for late filing, the necessary evidence would ordinarily include:

- A statement from the beneficiary, his/her representative or the provider *or supplier*, depending on whom the error directly affected, as to how he/she learned of the error, and when it was corrected, and one of the following:
 - A written report by *Medicare or the Medicare contractor* describing how its error caused failure to file within the time limit; or
 - Copies of a *CMS or Medicare contractor* letter or *other* written notice reflecting the error, or

- A written statement of an agency employee having personal knowledge of the error.

However, the statement of the beneficiary, his/her representative, or the provider *or supplier* is not essential if the other evidence establishes that his/her failure to file within the usual time limit resulted from administrative error, and that he/she filed a claim within six months after the month in which he/she was notified that the error was corrected. There must be a clear and direct relationship between the administrative error and the late filing of the claim. Where the evidence is in the *Medicare contractor's* own records, it should annotate the claims file to this effect.

If the claims processing contractor determines that a late claim should be honored because the facts support that an error or misrepresentation has caused the claim to be late, the provider, supplier, or beneficiary will have until the end of the 6th calendar month from the month in which the provider, supplier, or beneficiary received notification that the error or misrepresentation has been corrected.

70.7.2 - Retroactive Medicare Entitlement

(Rev. 2140, Issued: 01-21-11, Effective: 01-01-10, Implementation: 02-22-11)

The time for filing a claim will be extended if CMS or one of its contractors determines that a failure to meet the filing deadline is caused by all of the following conditions:

- (a) At the time the service was furnished the beneficiary was not entitled to Medicare.*
- (b) The beneficiary subsequently received notification of Medicare entitlement effective retroactively to or before the date of the furnished service.*

Thus, a provider or supplier may have furnished services to an individual who was not entitled to Medicare. More than a year later, the individual receives notification from SSA that he or she is entitled to Medicare benefits retroactive to or before the date he or she received services from the provider or supplier. In this situation, the provider or supplier may submit a request for a filing extension to the appropriate Medicare claims processing contractor, as long as the provider or supplier submits supporting documentation that verifies that the conditions above are met.

If the beneficiary and the provider or supplier is notified on different days about the beneficiary's retroactive Medicare entitlement, there will be two extensions of time triggers. One extension of time trigger is when the beneficiary is first notified about the beneficiary's retroactive Medicare entitlement and the other extension of time trigger is when the provider or supplier is the first party notified. If the beneficiary is submitting the claim, the time to file the claim is based on the day the beneficiary is notified of the retroactive Medicare entitlement. If the provider or supplier is submitting the claim, the time to file the claim is based on the day the provider or supplier is notified of the retroactive Medicare entitlement.

Where retroactive Medicare entitlement is alleged, the provider, supplier, or beneficiary will need to provide the contractor with:

- *an official letter notifying the beneficiary of Medicare entitlement and the effective date of the entitlement; and,*
- *documentation describing the service/s furnished to the beneficiary and the date of the furnished service/s.*

If the contractor determines that both of the conditions for meeting this exception described above are met, the time to file a claim will be extended through the last day of the 6th calendar month following the month in which either the beneficiary or the provider or supplier received notification of Medicare entitlement effective retroactively to or before the date of the furnished service.

70.7.3 - Retroactive Medicare Entitlement Involving State Medicaid Agencies (Rev. 2140, Issued: 01-21-11, Effective: 01-01-10, Implementation: 02-22-11)

The time for filing a claim will be extended if CMS or one of its contractors determines that failure to meet the filing deadline is caused by all of the following conditions:

- At the time the service was furnished the beneficiary was not entitled to Medicare.*
- The beneficiary subsequently received notification of Medicare entitlement effective retroactively to or before the date of the furnished service.*
- A State Medicaid Agency recovered the Medicaid payment for the furnished service from a provider or supplier 6 months or more after the date of the furnished service.*

In these situations, at the time services were furnished the beneficiary was entitled to Medicaid but not to Medicare. After the date of the furnished services, the beneficiary is then notified that he or she is entitled to Medicare. Finally, sometime after the date of the furnished service, the State Medicaid Agency recoups the money it paid the provider or supplier. If the State Medicaid Agency recoups the money it paid the provider or supplier 6 months or more after the date the service was furnished, the provider or supplier may be given an extension to have those claims filed to Medicare.

In order to qualify for this exception, the provider or supplier will need to provide the claims processing contractor with information that verifies:

- *the date that the State Medicaid Agency recouped money from the provider/supplier;*
- *documentation verifying that the beneficiary was retroactively entitled to Medicare to or before the date of the furnished service (i.e., the official letter to the beneficiary); and,*
- *documentation verifying the service/s furnished to the beneficiary and the date of the furnished service/s.*

If the contractor determines that all of the conditions described above for meeting this exception are met, the contractor will notify the provider or supplier in writing that a filing extension will be allowed from the end of the 6th calendar month from the month in which the State Medicaid Agency recovered its money.

70.7.4 - Retroactive Disenrollment from a Medicare Advantage plan or Program of All-inclusive Care for the Elderly (PACE) Provider Organization (Rev. 2140, Issued: 01-21-11, Effective: 01-01-10, Implementation: 02-22-11)

The time for filing a claim will be extended if CMS or one of its contractors determines that a failure to meet the filing deadline is caused by all of the following conditions:

- (a) At the time the service was furnished the beneficiary was enrolled in a Medicare Advantage (MA) plan or Program of All-inclusive Care for the Elderly (PACE) provider organization.*
- (b) The beneficiary was subsequently disenrolled from the Medicare Advantage plan or Program of All-inclusive Care for the Elderly (PACE) provider organization effective retroactively to or before the date of the furnished service.*
- (c) The Medicare Advantage plan or Program of All-inclusive Care for the Elderly (PACE) provider organization recovered its payment for the furnished service from a provider or supplier 6 months or more after the service was furnished.*

There may be situations where a beneficiary is enrolled in an MA plan or in a PACE provider organization, and later becomes disenrolled from the MA plan or PACE provider organization. And, if the MA plan or the PACE provider organization recoups the money it paid the provider or supplier 6 months or more after the service was furnished, the provider or supplier may be granted an exception to have those claims filed with Medicare.

In order to qualify for this exception, the provider or supplier will need to provide the claims processing contractor with information that verifies:

- prior enrollment of the beneficiary in an MA plan or PACE provider organization;*
- the beneficiary, the provider, or supplier was notified that the beneficiary is no longer enrolled in the MA plan or PACE provider organization;*
- the effective date of the disenrollment; and,*
- the MA plan or PACE provider organization recouped money from the provider or supplier for services furnished to a disenrolled beneficiary.*

If the contractor determines that all of the conditions described above are satisfied, the contractor will notify the provider or supplier in writing that a filing extension will be allowed from the end of the 6th calendar month from the month in which the MA plan or PACE provider organization recouped its money from the provider or supplier.

70.8 - Filing Request for Payment to Carriers—Medicare Part B (Rev. 2140, Issued: 01-21-11, Effective: 01-01-10, Implementation: 02-22-11)

Medicare regulations at 42 CFR 424.44 define the timely filing period for Medicare fee-for-service claims. *Such claims must be filed no later than 12 months (or 1 calendar year) after the date the services were furnished.*

70.8.1 – Splitting Claims for Processing

(Rev. 2140, Issued: 01-21-11, Effective: 01-01-10, Implementation: 02-22-11)

There are a number of prescribed situations where a claim is received for certain services that require the splitting of the single claim into one or more additional claims. The splitting of such a claim is necessary for various reasons such as proper recording of deductibles, separating expenses payable on a cost basis from those paid on a charge basis, or for accounting and statistical purposes. Split a claim for processing in the following situations:

- Expenses incurred in different calendar years cannot be processed as a single claim. A separate claim is required for the expenses incurred in each calendar year;

EXCEPTION FOR DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS (DMERCs):

Expendable items (disposable items such as blood glucose test strips and PEN nutrients) that will be used in a time frame that spans two calendar years and are required to be billed with appropriately spanned “from” and “to” dates of service may be processed on a single claim line. For these types of items, DMERCs must base pricing and deductible calculations on the “from” date, since that is the date when the item was furnished.

- A claim other than a DMERC claim that spans two calendar years where the “from” date of service is untimely but the “to” date of service is timely should be split and processed as follows:
 1. Where the number of services on the claim is evenly divisible by the number of days spanned, assume that the number of services for each day is equal. Determine the number of services per day by dividing the number of services by the number of days spanned. Then split the claim into a timely claim and an untimely claim. Deny the untimely claim and process the timely claim.
 2. Where the number of services on the claim is not evenly divisible by the number of days spanned and it is not otherwise possible to determine from the claim the dates of services, suspend and develop the claim in order to determine the dates of services. After determining the dates of services, split the claim accordingly into a timely claim and an untimely claim. Deny the untimely claim and process the timely claim.
- A claim containing both assigned and unassigned charges. Split assigned and unassigned services from non-participating physicians/suppliers into *separate assigned and unassigned claims for workload counts and processing*;

- Assigned claims from different physicians/suppliers (excluding group practices and persons or organizations to whom benefits may be reassigned). Process a separate claim for the services from each physician/supplier. Where the assigned claim is from a person or organization to which the physicians performing the services have reassigned their benefits, process all of the services as a single claim;
- A claim where there is more than one beneficiary on a single claim. There can only be one beneficiary per claim; and

NOTE: Roster bills for covered immunization services furnished by mass immunizers may be submitted for multiple beneficiaries. You must create individual claims for each Medicare beneficiary based on the roster bill information.

- Outpatient physical therapy services furnished on a cost basis by a physician-directed clinic cannot be processed when combined on the same claim with other charge-related services by the clinic. Process the cost related services as a separate claim.
- If an unassigned claim includes services by an independent physical therapist together with other physician services, process the physical therapy services as a separate claim. Process an assigned claim from an independent physical therapist as a single claim.
- A claim that is a duplicate of a claim previously denied is treated as a new claim if there is no indication that the claim is a resubmittal of a previous claim with additional information, or there is no indication on the second claim that the beneficiary is protesting the previous determination.
- In a claim containing services from physicians/suppliers covering more than one carrier jurisdiction, the carrier receiving the claim must split off the services to be forwarded to another contractor and count the material within the local jurisdiction as a claim. The carrier receiving the transferred material must also count it as a separate claim.
- When services in a claim by the same physician/supplier can be identified as being both second/third opinion services and services not related to second/third opinion, the "opinion" services must be split off from the "non-opinion" services and counted as a separate claim. When one physician/supplier in an unassigned claim has provided the "opinion" service and another physician(s)/supplier(s) has provided the "non-opinion" services, the claim may not be split.
- Claims containing any combination of the following types of services must be split to process each type of service as a separate claim. These services are:
 - Physical therapy by an independent practitioner,
 - outpatient psychiatric, or
 - any services paid at 100 percent of reasonable charges.

(Any of these types of services may be combined on the same claim with any other type of service.)

Do not deviate from defining claims as described above. Split claims in accordance with the appropriate definition. Throughout the claims process count each of the separate claims, resulting from the split, as an individual claim.

70.8.6 – Penalty for Filing Claims after One Year

(Rev. 2140, Issued: 01-21-11, Effective: 01-01-10, Implementation: 02-22-11)

Section 1848(g)(4) of the Social Security Act (*the Act*) requires that physicians and suppliers complete and submit Part B claims for medical services, equipment and supplies (furnished on or after September 1, 1990) within 12 months of the service date. Only assigned claims submitted more than 12 months after the service date will be subject to a 10 percent reduction of the amount that would otherwise have been paid. Payment on an assigned claim submitted by a physician or other supplier 12 months or longer after the service is furnished, shall be reduced by 10 percent from the amount that would have otherwise been paid. *On March 23, 2010, Congress passed the Patient Protection and Affordable Care Act (the Affordable Care Act). Section 6404 of the Affordable Care Act amended sections 1814(a)(1), 1835(a)(1), and 1842(b)(3)(B) of the Act, by reducing the maximum time period for filing Medicare Part A and Part B claims to no more than 12 months after the date of service. Therefore, this nullifies the 10 percent reduction requirement on physician and supplier claims submitted after 12 months from the date of service, because the claim will be denied as untimely filed; unless, an exception for the late filing is granted. And, if an exception for late filing is granted, then the 10 percent penalty is waived.*

130.2 - Inpatient Part A Hospital Adjustment Bills

(Rev. 2140, Issued: 01-21-11, Effective: 01-01-10, Implementation: 02-22-11)

For UB-04 adjustment requests, the hospital places the ICN/DCN of the original bill in the appropriate form locator. Information regarding the form locator number that corresponds to the ICN/DCN field and a table to crosswalk UB-04 form locators to the 837 transaction is found in Chapter 25. Where payment is handled through the cost reporting and settlement processes, the hospital accumulates a log for those items not requiring an adjustment request. For cost settlement, the FI pays on the basis of the log. This log must include:

- Patient name;
- HICN;
- Dates of admission and discharge, or from and thru dates;
- Adjustment in charges (broken out by ancillary or routine service); and
- Any unique numbering or filing code necessary for the hospital to associate the adjustment charge with the original billing.

NOTE: Hospitals in Maryland, which are not paid under PPS or cost reports, submit an adjustment request for inpatient care of \$500 or more, and keep a log as described above for lesser amounts. Because there are no adjustment requests, the FI enters the payment amounts

from the summary log into the PPS waiver simulation and annually pays the items on the log after the cost report is filed.

After cost reports are filed, the FI makes a lump sum payment to cover these charges as shown on the summary log. The hospital uses the summary log for late charges only under cost settlement (outpatient hospital), except in Maryland.

Maryland and cost hospitals are required to meet the *12*-month timeframe for timely filing of claims, including late charges.

For all adjustments other than QIO adjustments (e.g., provider submitted *adjustments* and/or those the FI initiates), the FI submits an adjustment request to CWF following its acceptance of the initial bill. To verify CMS's acceptance, the FI can submit a status query.

Under inpatient hospital prospective payment, adjustment requests are required from the hospital where errors occur in diagnosis and procedure coding that changes the DRG, or where the deductible or utilization is affected. A hospital is allowed 60 days from the date of the FI payment notice (remittance advice) for adjustment requests where diagnostic or procedure coding was in error resulting in a change to a higher weighted DRG. Adjustments reported by the QIO have no corresponding time limit and are adjusted automatically by the FI without requiring the hospital to submit an adjustment request. However, if diagnostic and procedure coding errors have no effect on the DRG, adjustment requests are not required.

Under PPS, for long-stay cases, hospitals may bill 60 days after an admission and every 60 days thereafter if they choose. The FI processes the initial bill through Grouper and PRICER. When the adjustment request is received, it processes it as an adjustment. In this case, the 60-day requirement for correction does not apply.