CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2477	**Date: May 25, 2012**
	Change Request 7834

SUBJECT: Modifying the Timely Filing Exceptions on Retroactive Medicare Entitlement and Retroactive Medicare Entitlement Involving State Medicaid Agencies

I. SUMMARY OF CHANGES: We are revising sections 70.7, 70.7.2, and 70.7.3, in chapter 1 of Pub. 100-04, to specify that if a provider, supplier, or beneficiary is unable to provide the contractor with an official SSA letter, the contractor shall check the Common Working File (CWF) database in order to verify a beneficiary's retroactive Medicare entitlement date.

EFFECTIVE DATE: August 27, 2012
IMPLEMENTATION August 27, 2012

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	1/70.7/Exceptions Allowing Extension of Time Limit
R	1/70.7.2/Retroactive Medicare Entitlement
R	1/70.7.3/Retroactive Medicare Entitlement Involving State Medicaid Agencies

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
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: 2477	Date: May 25, 2012	Change Request: 7834

SUBJECT: Modifying the Timely Filing Exceptions on Retroactive Medicare Entitlement and Retroactive Medicare Entitlement Involving State Medicaid Agencies

Effective Date: **August 27, 2012**
Implementation Date: August 27, 2012

I. GENERAL INFORMATION

A. Background: The Medicare regulations at 42 C.F.R. §424.44 specify the time limits for filing Part A and Part B fee-for- service claims. Section 424.44 also identifies certain exceptions to the claims filing time limit. If the requirements for satisfying a timely filing exception are met, an extension to file the claim/s may be granted. Section 6404 of the Affordable Care Act reduced the maximum period for the submission of all Medicare fee-for-service claims to no more than 12 months, or one calendar year, after the date a service is furnished. Section 6404 also gave the Secretary the authority to create exceptions to the 12 month timely filing limit. As a result of this legislation, revisions were made to the timely filing regulations at 42 C.F.R. §424.44, and the relevant internet-only manual sections. (See Transmittal 2140/Change Request 7270, published on January 21, 2011.)

B. Policy: Publication 100-04, chapter 1, sections 70.7.2 and 70.7.3 currently require that, in order to be granted a timely filing extension, the provider, supplier, or beneficiary must furnish an official letter from the Social Security Administration (SSA) to the beneficiary in order to meet one of the conditions that the beneficiary was retroactively entitled to Medicare to or before the date of the furnished service. The purpose of this Change Request (CR) is to revise sections 70.7, 70.7.2, and 70.7.3 of the manual to specify that, if an official SSA letter to the beneficiary is not submitted, contractors shall check the Common Working File (CWF) database and may interpret the Common Working File (CWF) date of accretion and the CWF Medicare entitlement date for a beneficiary in order to verify that the beneficiary was retroactively entitled to Medicare on or before the date of the furnished service.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7834.1	Contractors shall accept an official SSA letter to the beneficiary, as proof of a beneficiary's retroactive date of Medicare entitlement.	X	X	X	X	X					
7834.2	If an official SSA letter to the beneficiary is not submitted, contractors shall check the Common Working File (CWF) database and may interpret the Common	X	X	X	X	X					

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	Working File (CWF) date of accretion and the CWF Medicare entitlement date for a beneficiary in order to verify a beneficiary's retroactive entitlement.										

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7834.3	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. 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.	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:
	None.

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

V. CONTACTS

Pre-Implementation Contact(s): David Walczak, david.walczak@cms.hhs.gov, (410) 786-4475.

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

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

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.

70.7 - Exceptions Allowing Extension of Time Limit

(Rev.2477, Issued: 05-25-12, Effective: 08-27-12 Implementation: 08-27-12)

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 it 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*, and for the exceptions described in sections 70.7.2 and 70.7.3, based on its review of the relevant information contained in the Common Working File (CWF) database.* As explained in sections 70.7.1 – 70.7.4, the contractor will determine if the requirements for a particular exception are met. *However, in certain circumstances, t*he contractor *may* contact the appropriate CMS regional office (RO) *to ascertain whether* it wants to participate in the review and decision-making of the *specific* exception request. In limited circumstances, the RO *may conclude that* the exception request should go to CMS Central Office for a final determination.

70.7.2 – Retroactive Medicare Entitlement

(Rev.2477, Issued: 05-25-12, Effective: 08-27-12 Implementation: 08-27-12)

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 *of the beneficiary's retroactive Medicare entitlement.* If the beneficiary is submitting the claim, the time to file the claim is based on the day the beneficiary is *first* 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 *first* notified of the retroactive Medicare entitlement.

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

- an official *Social Security Administration (SSA)* 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 provider, supplier, or beneficiary is unable to provide the contractor with an official SSA letter, the Medicare contractor shall check the Common Working File (CWF) database and may interpret the CWF date of accretion and the CWF Medicare entitlement date for a beneficiary in order to verify a beneficiary's retroactive entitlement. For example, if the CWF indicates a Medicare entitlement date of March 1, 2008 and a date of accretion of December 14, 2010, then the contractor may interpret the CWF data to mean that the beneficiary was retroactively entitled to Medicare as of March 1, 2008 and that this data was added to the CWF database on

December 14, 2010. If the contractor has any problems or concerns with respect to interpreting the CWF data, then the contractor should consult with the appropriate CMS regional office.

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

(Rev2477, Issued: 05-25-12, Effective: 08-27-12 Implementation: 08-27-12)

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:

(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.

(c) 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 *the following* information:

- *documentation verifying* 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 *(e.g., an official SSA letter to the beneficiary, or if an official SSA letter is not available, the contractor shall check the CWF database and may interpret the CWF date of accretion and the CWF Medicare entitlement date for a beneficiary in order to verify a beneficiary's retroactive entitlement; see the example in section 70.7.2 above concerning the CWF for additional details regarding this contractor verification process);* 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.