

MLN Matters Number: MM5513

Related Change Request (CR) #: 5513

Related CR Release Date: July 20 2007

Effective Date: January 1, 2008

Related CR Transmittal #: R1312CP

Implementation Date: January 7, 2008

Timeliness Standards for Processing 'Other-Than-Clean' Claims

Provider Types Affected

Providers and suppliers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), DME Medicare Administrative Contractors (DME MACs), and/or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries

Provider Action Needed



STOP – Impact to You

This article is based on Change Request (CR) 5513 which implements requirements for timeliness standards for processing other-than-clean claims. The article is informational in nature and requires no action on your part.



CAUTION – What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) published instructions in a separate transmittal to implement requirements for all carriers and Medicare Administrative Contractors (MACs) for timeliness standards for processing other-than-clean claims, and CR5513 implements those same requirements for FIs, A/B MACs, DME MACs, and RHHIs, effective for claims received on or after January 1, 2008.



GO – What You Need to Do

See the Background and Additional Information Sections of this article for further details regarding these requirements.

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Background

The Social Security Act (Section 1869(a)(2); http://www.ssa.gov/OP_Home/ssact/title18/1869.htm) mandates that Medicare process all “other-than-clean” claims and notify the provider/supplier filing such claims of the determination within 45 days of receiving such claims. The Social Security Act (Section 1869; http://www.ssa.gov/OP_Home/ssact/title18/1869.htm) further defines the term “clean claim” as meaning “a claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this title.” Claims that do not meet the definition of “clean” claims are “other-than-clean” claims, and they require investigation or development external to the contractor’s Medicare operation on a prepayment basis.

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

However, when the Medicare contractor develops the ‘other-than-clean’ claim by asking the provider/supplier or beneficiary for additional information, the Medicare contractor should cease counting the 45 calendar days on the day that the Medicare contractor sends the development letter to the provider/supplier and/or beneficiary. Upon receiving the materials requested in the development letter from the provider/supplier and/or beneficiary, the Medicare contractor should resume counting the 45 calendar days.

EXAMPLE:

A 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 example, 5 of the 45 allotted calendar days will have already passed before the Medicare 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.

Medicare contractors should follow existing procedures relative to both 1) the length of time the provider/supplier and/or beneficiary is afforded the opportunity to return information requested in the development letters and 2) situations where the provider/supplier and or beneficiary does not respond.

This timeliness standard does not apply:

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- Where the Social Security Administration blocks a beneficiary's Health Insurance Claim Number (HIC);
- Where there is a problem with the beneficiary's record in Medicare's files **are not subject to this instruction**;
- Where the claim is rejected by the translator software;
- Where CMS instructs Medicare contractors to hold certain claims for processing, e.g., while system changes are being made to handle such claims correctly; or
- To claims submitted by a hospice and these claims are to be processed per instructions in the *Medicare Claims Processing Manual* (Chapter 1, Section 50.2.3; <http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf>)

Additional Information

The official instruction, CR5513, issued to your FI, RHHI, A/B MAC, or DME MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1312CP.pdf> on the CMS website.

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

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