CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 420 **Date: DECEMBER 30, 2004**

CHANGE REQUEST 3549

SUBJECT: Good Cause Waiver of Late Claim Filing Payment Reduction Penalty and Monitoring of Late Claims Submissions. Full Replacement of CR 3402, Which Was Rescinded

I. SUMMARY OF CHANGES: Section numbers 70.8.8.1 through 70.8.8.8 are added to Chapter 1 of the Medicare Claims Processing Manual. Similar provisions were included in the Medicare Carriers Manual Part 3, but had been inadvertently omitted from the new Internet Only Manual (IOM) and are now being manualized into the IOM. These instructions concern procedures related to waiver for good cause of the 10% payment reduction penalty applicable to claims that meet the timely filing requirements for submission and payment of claims, but were submitted more than one year after the date of service. The instructions also provide the procedures for monitoring of claims filed more than one year after date of service.

MANUALIZATION - EFFECTIVE DATE: January 31, 2005
***IMPLEMENTATION DATE: January 31, 2005**

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
N	1/Table of Contents
N	1/70.8.8.1/Extend Time For Good Cause
N	1/70.8.8.2/Conditions Which Establish Good Cause
N	1/70.8.8.3/Procedure To Establish Good Cause
N	1/70.8.8.4/Good Cause Is Not Found
N	1/70.8.8.5/Preparing Common Working File (CWF) Claim Records for Services Subject to 10 Percent Payment Reduction
N	1/70.8.8.6/Monitoring Late Claims Submission Violations
N	1/70.8.8.7/Sample Notification Letter
N	1/70.8.8.8/Violations That Are Not Developed For Referral

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Medicare contractors only**

Medicare Claims Processing Manual

Chapter 1 - General Billing Requirements

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(Rev. 420, 12-30-04)

70.8.8.1 – Extend Time for Good Cause

(Rev. 420, Issued: 12-30-04, Effective: January 31, 2005, Implementation: January 31, 2005)

Extend the 1 year limit under §1848(g)(4), of the Social Security Act, claim filing provision if "good cause" is shown. Resolve the finding of good cause using the guidelines in §70.8.8.2 below. If an assigned claim is filed more than one year after the date of service, but within the time limits specified in §70.8.6, Chapter 1, of this manual, and if you determine that good cause exists, treat it as a timely-filed claim for payment and compliance monitoring purposes and waive the 10 percent payment reduction for that service. The time limit for filing may not be extended beyond the time limits specified in §70.8.6, chapter 1, of this manual, unless administrative error is applicable. If an assigned service is filed after the time limits specified in §70.8.6, chapter 1, of this manual, waive the 10 percent payment reduction only for administrative error.

70.8.8.2 – Conditions Which Establish Good Cause

(Rev. 420, Issued: 12-30-04, Effective: January 31, 2005, Implementation: January 31, 2005)

Good cause may be found when a physician or supplier claim filing delay was due to:

o Administrative error – that is, incorrect or incomplete information was furnished by official Medicare sources (e.g., carrier, intermediary, CMS) to the physician or supplier;

o Unavoidable delay in securing required supporting claim documentation or evidence from one or more third parties despite reasonable efforts by the physician/supplier to secure such documentation or evidence;

o Unusual, unavoidable, or other circumstances beyond the service provider's control which demonstrate that the physician or supplier could not reasonably be expected to have been aware of the need to file timely; or

o Destruction or other damage of the physician's or supplier's records unless such destruction or other damage was caused by the physician's or supplier's willful act or negligence.

70.8.8.3 – Procedure to Establish Good Cause

(Rev. 420, Issued: 12-30-04, Effective: January 31, 2005, Implementation: January 31, 2005)

If a claim for a service is filed after the expiration of the 1 year time period (for services furnished on or after September 1, 1990), apply the following procedures:

o If the claim includes an explanation for the delay (or other evidence which establishes the reason), determine good cause based primarily on that statement or evidence. If there is no such statement or other evidence, apply the 10 percent payment reduction to applicable assigned services.

o If the physician or supplier's statement for delay is sufficiently clear and is not controverted by other evidence, accept it. If other evidence leads you to doubt the

validity of the statement, contact the physician or supplier for clarification or additional information necessary to make a "good cause" determination.

o If you find good cause on an assigned claim, do not apply the 10 percent payment reduction provided for in §70.8.8, chapter 1, of this manual and do not develop a claim submission violation.

70.8.8.4 – Good Cause is Not Found

(Rev. 420, Issued: 12-30-04, Effective: January 31, 2005, Implementation: January 31, 2005)

Monitor claim submission violations in accordance with §70.8.8.6 if you do not find good cause for late filing. In addition, if the claim is assigned, apply the 10 percent payment reduction to services on the claim for a service that was furnished on or after September 1, 1990 but the claim was not filed within one year. Approved charges applied to a beneficiary's Part B deductible are not subject to the 10 percent reduction. Send appropriate message(s) with your remittance advice, such as claim adjustment reason code B4, "Late Filing Penalty". Include an appropriate MSN message such as, MSN message 16.11, to advise the beneficiary of the payment reduction for late filing and to inform him/her that he/she is not liable for the 10 percent reduction.

70.8.8.5 – Preparing Common Working File (CWF) Claim Records for Services Subject to 10 Percent Payment Reduction

(Rev. 420, Issued: 12-30-04, Effective: January 31, 2005, Implementation: January 31, 2005)

Use the following instructions to prepare CWF claim records involving services subject to a 10 percent payment reduction.

Apply a 10 percent payment reduction to services that meet all of the following conditions:

o The service expense date is on or after September 1, 1990;

o The service is approved;

o The service expense date is more than one year before the claim receipt date and good cause for late filing does not apply; and

o The payment amount for the service is at least 10 cents.

When all of these conditions are met, reduce payment to the physician or supplier for applicable assigned services by 10 percent. (If multiple services are billed on a line item, apply the 10 percent payment reduction only to assigned services within the line item that are on or after September 1, 1990, and are received more than one year after the service date. If necessary, split line items within a claim in order to correctly apply the 10 percent reduction.) Display the payment reduction on your CWF claim record in the following fields:

o Payment to Provider field --Enter the payment amount resulting after the 10 percent penalty and any other applicable payment calculations are performed. Round to the nearest penny;

NOTE: *If multiple payment rules apply (e.g., 10 percent reduction, interest, and/or Gramm-Rudman-Hollings), calculate the payment amount based on the following formula. Payment amount (after deductible, coinsurance and MSP rules are applied) minus the 10 percent payment reduction (Indicator F) plus clean claim interest (Indicator B) minus Gramm-Rudman-Hollings reductions (Indicator A).*

o Other Amounts Applied field -- Enter the 10 percent payment reduction amount; and

o Other Amount Indicators field -- Enter the letter "F" to identify a service whose payment amount in the Payment to Provider field is reduced due to application of the 10 percent payment reduction provision.

70.8.8.6 – Monitoring Late Claims Submission Violations

(Rev. 420, Issued: 12-30-04, Effective: January 31, 2005, Implementation: January 31, 2005)

A. General--Section 1848(g)(4) of the Social Security Act requires physicians and suppliers to submit claims to Medicare carriers for services furnished on or after September 1, 1990. It also prohibits physicians and suppliers from imposing a charge for completing and submitting a claim. Payment for assigned services not filed within 1 year (for services on or after 9/1/90) are reduced 10 percent. Physicians and suppliers who fail to submit a claim or who impose a charge for completing the claim are subject to sanctions. CMS is responsible for assessing sanctions and monetary penalties for noncompliance.

Physicians and suppliers are not required to take assignment of Medicare benefits unless they are enrolled in the Medicare Participating Physician and Supplier Program or, in the case of physician services, the Medicare beneficiary is also a recipient of State medical assistance (Medicaid) or the service is otherwise subject to mandatory assignment.

B. Compliance Monitoring and Provider Education--Potential violations of the mandatory claim submission requirement should be identified and subsequently developed on processed Form CMS-1490S claims that include approved charges for items/services performed on or after September 1, 1990.

Compile data on the number of CMS-1490S claims received that include charges for services performed on or after September 1, 1990 and the number of processed Form CMS-1490S claims that include approved charges for items/services performed on or after September 1, 1990. Use the data to identify physicians, suppliers, and beneficiaries involved and to compile individual physician, supplier, and beneficiary profiles as to the number of CMS-1490S claims processed that are potential violations or compliance problems.

In addition, for educational contact purposes, use beneficiary and other third party complaints to identify physicians and suppliers who refuse to complete and/or submit Medicare claims on behalf of beneficiaries.

Send educational letters to physicians and suppliers for whom 11 or more potential violations are identified during a month (i.e., a processed Form CMS-1490S included an approved service that was performed on or after September 1, 1990). In determining whether the 11 case threshold is met or exceeded, exclude cases in which you can readily determine that a duplicate claim was filed by the service provider. A sample notification letter that may be used for this purpose is contained in §70.8.8.7 Include, either as an

attachment or in the body of the letter, information concerning processed Form CMS-1490S claims which included approved charges for services furnished on or after September 1, 1990 that were paid during the period covered by your notification letter. At a minimum, provide the following information:

- *Beneficiary name;*
- *Procedure code(s);*
- *Date(s) of service;*
- *Submitted charge(s); and*
- *Any other relevant information that is releasable and can assist the physician/supplier in identifying the service(s) involved.*

If periodic warning letters do not correct the underlying claim submission problem, make follow up telephone and/or face-to-face contacts with providers.

Maintain records of contacts with physicians/suppliers for referral purposes. Send warning letters and conduct educational activities until you determine that such efforts are unproductive.

Send appropriate cases to the appropriate CMS Program Safeguard Contractor (PSC) for referral to CMS. Do not refer claim submission violations until the applicable one year time period has expired and it is determined that a claim was never filed by the service provider. Cases involving charging for claim completion are not subject to the one year requirement and should be referred to PSC if reasonable education efforts are unproductive.

C. Exception When Physician, Other Practitioner, or Supplier Is Excluded From Participating in Medicare Program--Section 1848(g)(4) of the Social Security Act requires physicians, other practitioners, or suppliers to submit claims to Medicare carriers for services furnished after September 1, 1990. This ***does not*** *apply to physicians, other practitioners, or suppliers who have been excluded from participating in the Medicare program. Physicians, other practitioners, and suppliers who have been excluded from the Medicare program are prohibited from submitting claims or causing claims to be submitted. See the Medicare Program Integrity Manual for procedures concerning claims submitted by an excluded practitioner, his/her employer, or a beneficiary for services or items provided by an excluded physician, other practitioner, or supplier. Carriers must maintain the systems capability to identify claims submitted by excluded physicians, other practitioners, or suppliers as well as items or services provided, ordered, prescribed, or referred by an excluded party.*

When an excluded physician, other practitioner, or supplier has not submitted a claim on behalf of the beneficiary and/or the beneficiary has submitted the claim themselves, do ***not*** *send a notification letter to the physician, other practitioner, or supplier warning of civil monetary penalties due to noncompliance with §1848(g)(4)(A) of the Act. Instead, follow the instructions in the Program Integrity Manual.*

70.8.8.7 – Sample Notification Letter

(Rev. 420, Issued: 12-30-04, Effective: January 31, 2005, Implementation: January 31, 2005)

"Dear (Name of Doctor/Supplier):

All physicians and suppliers who treat Medicare patients are required by law to complete and submit Part B claims for services furnished on or after September 1, 1990. The requirement that physicians and suppliers complete and submit Part B claims was intended to aid Medicare patients and improve the completeness of submitted claims and the timeliness of claims processed by Medicare carriers.

This letter stresses the importance of your compliance with this requirement and also requests that you take measures to discourage Medicare patient-submitted claims. It is being provided to you at this time for educational purposes only.

As part of our effort to monitor compliance with this requirement, we recently conducted an analysis of approved claims that were submitted by Medicare patients. We found that (unduplicated number) of your patients submitted Part B claims for covered services that you furnished on or after September 1, 1990. The patient-submitted claims were processed during the period (beginning MM/DD/YYYY) through (ending MM/DD/YYYY). (Enclosed/Following) is a (list/summary) of patient-submitted claims on which we approved payment for services you provided on or after September 1, 1990.

NOTE: IF IT IS PREFERRABLE TO LIST CASES IN THE BODY OF THE LETTER RATHER THAN AS A LETTER ATTACHMENT, DO SO HERE.

We would appreciate any action on your part to adopt office policies or procedures that will help reduce the number of patient-submitted claims we receive. For example, we recommend that you annotate Medicare patient bills with a statement similar to the following:

'Do not use this bill for claiming Medicare benefits. A claim will be submitted to Medicare on your behalf by this office.'

*You **do not have to** respond to this letter. However, we would appreciate your advising us of any errors/inaccuracies noted in reviewing this information. We also recognize the possibility that your office **is** currently advising Medicare patients not to file their own claims, and that some patients may be filing them despite your efforts. Please let us know if this is the case.*

Be aware that if you fail to submit a Medicare claim or impose a charge for doing so, the Secretary of Health and Human Services is authorized to apply sanctions, which can include civil monetary penalties, if claims are not submitted within one year of the date of service. However, we do not envision penalties being assessed against (physicians/suppliers) that make good faith efforts to comply with the law.

For copies of the applicable laws, please contact us at the address shown in our letterhead, to the attention of the _____ Department.

At your convenience, (carrier name) representatives will be happy to discuss this letter or any aspect of Medicare's claim submission requirements with you. Please call us at (phone number)."

Sincerely,

(Representative's name)
(Unit/Title)

70.8.8.8 - Violations That Are Not Developed For Referral

(Rev. 420, Issued: 12-30-04, Effective: January 31, 2005, Implementation: January 31, 2005)

Claim submission violations need not be developed on beneficiary-submitted Form CMS-1490S claims that include approved charges for services performed on or after September 1, 1990 in the following situations:

- *Used DME purchases from private sources;*

- *Cases in which a physician/supplier does not possess information essential for filing a MSP claim. Assume this is the case if the beneficiary files a MSP claim and encloses the primary insurer's payment determination notice and there is no indication that the service provider was asked to file but refused to do so;*

- *Services paid under the indirect payment procedure;*

- *Foreign claims; and*

- *Other unusual or unique situations that you evaluate on a case-by-case basis.*

NOTE: *It is unlikely that knowing, willful, and repeated noncompliance will apply in the above situations.*