CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

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CHANGE REQUEST 2815

I. SUMMARY OF CHANGES: This transmittal manualizes the filing request for payment—Medicare Part B in the Internet Only Manual.

MANUALIZATION: EFFECTIVE/*IMPLEMENTATION DATE: N/A

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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:
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
N	1/Table of Contents
N	1/70.8-Filing Request for Payment—Medicare Part B
N	1/70.8.1-Splitting Claims for Processing
N	1/70.8.2-Replicating Claims for Processing
N	1/70.8.3-Methods of Claiming Benefits for Services by Physicians and Suppliers
N	1/70.8.4-Claims Forms
N	1/70.8.5-Photocopies
N	1/70.8.6-Time Limitation for Filing Part B Reasonable Charge and Fee Schedule Claims
N	1/70.8.7-Improper Billing for Professional Component
N	1/70.8.8-Penalty for Filing Claims After One Year
N	1/70.8.9-Extension of Time Limitation for Filing Part B Claims on Charge Basis Because of Administrative Error
N	1/70.8.10-Delays Considered to be the Result of Administrative Error
N	1/70.8.11-Extension of Time Limit in Reference to Definition of “Filed Promptly”
N	1/70.8.12-Initiating Development of Administrative Error
N	1/70.8.13-Evidence Necessary to Honor Late Claims
N	1/70.8.14-Responsibility for Decision on Extension of Time Limit
N	1/70.8.15-Coordination of Development with Social Security Administration, Carriers, and Intermediaries
N	1/70.8.16-Statement of Intent (SOI)
N	1/70.8.17-Time Limitation of Claims for Outpatient Physician Therapy or Speech Pathology Services Furnished by Clinic Providers

***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

Table of Contents

(Rev. 170, 05-07-04)

70.8 - Filing Request for Payment—Medicare Part B

(Rev. 170, 05-07-04)

Medicare regulations at 42 CFR 424.44 define the timely filing period for Medicare fee-for-service claims. In general, claims must be filed on, or before, December 31 of the calendar year following the year in which the services were furnished. Services furnished in the last quarter of the year are considered furnished in the following year (i.e., the time limit is the second year after the year in which such services were furnished).

70.8.1 – Splitting Claims for Processing

(Rev. 170, 05-07-04)

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 <u>unassigned</u> 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 l00 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.

70.8.2 - Replicating Claims for Processing

(Rev. 170, 05-07-04)

There are no prescribed reasons other than those aforementioned for splitting claims and for counting additional claims into your workload. However, claims are frequently split for other reasons that are dictated by the systems or the methods of processing them. Such additional claims are labeled "Replicate Claims." Tally and report all replicate claims (other than those aforementioned) separately. Identify replicate claims and report them in the appropriate categories for claims. Some examples of replicate claims are:

- *Additional claims created because of a line item limitation (regardless of the methodology used for coding line items);*

- *Extra claims created in making partial payments;*

- *Claims created for carving out individual specialty types of services and*

- *Extra claims created to apply special payment reductions (e.g., Gramm-Rudmann-Hollings) efficiently for applicable dates of service.*

NOTE: *For budget requests and cost reports (CMS-l524, CMS-l528, CMS-l6l6, and CMS-2599), the workload must exclude the number of replicate claims produced.*

70.8.3 - Methods of Claiming Benefits for Services by Physicians and Suppliers

(Rev. 170, 05-07-04)

The method of claiming Part B benefits depends upon whether the patient is claiming payment or is assigning benefit payments to his/her source of medical treatment or services.

As a rule, beneficiaries do not submit claims for reimbursement. However, if there is reason for a beneficiary to submit a claim for reimbursement, the beneficiary uses the CMS-1490S. For covered services furnished on or after September 1, 1990, physicians and suppliers must complete and submit in accordance with SSA §1848(g)(4)(A) all Part B claims whether assigned or unassigned for beneficiaries who desire Medicare benefit payment determinations.

The physician/supplier (or the facility or organization to which the physician may reassign benefits, claims the payment. The patient or his representative agrees to assign the benefits and the physician/supplier agreeing to the assignment accepts the Medicare reasonable charge determination as the full charge for the services. (See §§3045ff. about specific assignment procedures and the nature and effect of assignments.)

70.8.4 - Claims Forms

(Rev. 170, 05-07-04)

A number of prescribed claims forms have been developed for use when requesting payment for Part B Medicare services. Many are printed and distributed nationally free of cost through CMS's Printing and Publications Branch. (See NOTE below for exception.)

In order to maintain control over the content and format of the forms, private printing of a Government form is not routinely permitted. However, if you or another organization wishes to independently print a prescribed claims form, the reproduction of a claims form must be in accordance with §422.527 of Title 20, Chapter III, Part 422 of the Code of Federal Regulations. Obtain CMS approval for printing a prescribed form. Route the written request for approval through the RO. Include the following:

- *The reason or need for such reproduction;*

- *The intended user of the form;*

- *The proposed modifications or format changes, with printing or other specifications (such as realignment of data or line designations);*

- *The type of automatic data processing machinery, if any, for which the form is designed; and*

- *Estimates of printing quantity, cost per thousand, and annual usage.*

NOTE: *This procedure does not apply to the Form CMS-1500, Health Insurance Claim Form. Carriers, physicians and suppliers are responsible for purchasing their own forms. This form can be bought in single, multipart snap-out sets or in continuous pin-feed format. Medicare accepts any version. Forms can be obtained from local printers or printed in-house as long as it follows the CMS approved specifications developed by the American Medical Association.*

The Form CMS-l490 was formerly the basic Part B claims form. It was replaced by Form CMS-l500 for claims completed by physicians and suppliers (except ambulance suppliers), and Form CMS-l490S for claims from beneficiaries. You must, however, continue to accept and process claims received on Form CMS-1490 form after conversion to Forms CMS-l500 and CMS-l490S.

The Form CMS-1500 (Health Insurance Claim Form), sometimes referred to as the AMA form, is the prescribed form for claims prepared and submitted by physicians or suppliers (except for ambulance services), whether or not the claims are assigned. It can be purchased in any version required i.e., single sheet, snap-out, continuous, etc.

The forms described below are printed and distributed to contractors by CMS and are available in single sheets, multipart snap-out sets, or in pin-feed format.

The Form CMS-1490S (Patient's Request for Medicare Payment) form is used only by beneficiaries (or their representatives) who complete and file their own claims. It contains only the first six comparable items of data that are on the Form CMS-1500. When the Form CMS-1490S is used, an itemized bill must be submitted with the claim. Social Security Offices use the Form CMS-1490S when assisting beneficiaries in filing Part B Medicare claims. For Medicare covered services received on or after September 1, 1990, the Form CMS-1490S is used by beneficiaries to submit Part B claims only if the service provider refuses to do so. Inasmuch as the Form CMS-1490S has no provision for an ICD-9 code, the ICD-9 code is not required at the time of claim submission.

The Form CMS-l49l (Request for Medicare Payment-Ambulance).--This form used by suppliers of ambulance services for claiming this Part B benefit payment. The ambulance

supplier uses this form to claim assigned Part B benefits or, when filing an unassigned claim for ambulance services.

For services furnished prior to September 1, 1990, if the ambulance supplier does not accept assignment or does not complete and submit the patient's claim, all essential data required on the CMS-l49l should be entered on the supplier's itemized statement to the patient.
Honor claims from ambulance suppliers that are submitted on forms other than the Form CMS-1491, (e.g., Form CMS-1500). Suppliers using the Form CMS-l49l may avoid delay in receiving payment as the Form CMS-l490 and Form CMS-1500 do not include all required information and further development may be necessary.

The Form CMS-l490U is used by the entities payed under the indirect payment provision. It contains a certification by the organization requesting payment that specific conditions are met. Make payment on the basis of a claim filed on this form only if the organization has paid the physician or supplier in full.

The Form CMS-1556 (Prepayment Plan for Group Practices Dealing Through A Carrier) is used by plans which, for Medicare purposes are, both Group Practice Prepayment Plans, and are paid on the basis of reasonable charges related to their costs for furnishing services to their subscribers.

70.8.5 – Photocopies

(Rev. 170, 05-07-04)

Some enrollees may want to keep the original itemized physician and supplier bills for income tax or complementary insurance purposes. Photocopies of itemized bills are acceptable for Medicare deductible and payment purposes if there is no evidence of alteration.

70.8.6 – Time Limitation for Filing Part B Reasonable Charge and Fee Schedule Claims

(Rev. 170, 05-07-04)

Medicare law prescribes specific time limits within which claims for benefits may be submitted with respect to physician and other Part B services payable on a reasonable charge or fee schedule basis (including those services for which the charge is related to cost). For these services, the terms of the law require that the claim be filed no later than the end of the calendar year following the year in which the service was furnished, except as follows:

- *The time limit on filing claims for service furnished in the last 3 months of a year is the same as if the services had been furnished in the subsequent year. Thus, the time limit on filing claims for*

services furnished in the last 3 months of the year is December 31 of the second year following the year in which the services were rendered.

(Whenever the last day for timely filing of a claim falls on a Saturday, Sunday, Federal non-workday or legal holiday, the claim will be considered filed timely if it is filed on the next workday. Also note that a claim received by the contractor more than one year after the service has been rendered is subject to a 10 percent reduction.)

EXAMPLE: *An enrollee received surgery in August 2000. He must file a claim for payment for such services on or before December 31, 2001. Note also that a service provided in October 2000, must be filed on or before December 31, 2002.*

The table that follows illustrates the timely filing limit for dates of service in each calendar month.

Table: Usual Time Limit

Date of service in:	*Jan*	*Feb*	*Mar*	*Apr*	*May*	*June*
Timely filing date	*Dec 31: Service year plus 1 year*	*Dec 31: Service year plus 1 year*	*Dec 31: Service year plus 1 year*	*Dec 31: Service year plus 1 year*	*Dec 31: Service year plus 1 year*	*Dec 31: Service year plus 1 year*
*Months to file **	*23*	*22*	*21*	*20*	*19*	*18*

Date of service in:	*July*	*Aug*	*Sep*	*Oct*	*Nov*	*Dec*
Timely filing date	*Dec 31: Service year plus 1 year*	*Dec 31: Service year plus 1 year*	*Dec 31: Service year plus 1 year*	*Dec 31: Service year plus 1 year*	*Dec 31: Service year plus 1 year*	*Dec 31: Service year plus 1 year*
*Months to file **	*17*	*16*	*15*	*28*	*27*	*26*

** The number specified in "Months to file" represents the number of full months remaining after the month in which the service was rendered.*

70.8.7 – Improper Billing for Professional Component

(Rev. 170, 05-07-04)

In some cases, a hospital or other provider may have incorrectly billed for a Part B professional component as a provider expense. For example, this might occur when physicians' services were erroneously considered entirely administrative in nature and the error might be discovered in connection with the final cost settlement. Where such billings have been filed with a Part A intermediary within the time limit, this establishes protective filing for a subsequent filing of a Part B claim.

Such claims will be considered filed timely as of the date the incorrect billing was submitted to the intermediary provided the usual claims information (e.g., the Form CMS-1490S and itemized bill) is submitted within 6 months after the month in which the claimant is advised to furnish it or within the usual time limit, whichever is later.

The perfected claim may be filed by the physician on the basis of an assignment, or by the hospital (where the hospital has a contractual arrangement to bill and receive payment for the physician's services) or by the patient on the basis of an itemized bill. You and the intermediary should make your own arrangements regarding exchange of information and submission of the delayed claims. When there is more than one claim, it is preferable that they be submitted as a group.

A provider claim filed within the Part B time limit will not establish a filing date for the related professional component where such component was recognized and included in the provider bill, e.g., no claim was filed for the professional component as a nonprovider expense because the physician and hospital could not agree on the exact amount of the component charge or who would bill for it.

70.8.8 – Penalty for Filing Claims after One Year

(Rev. 170, 05-07-04)

Section 1848(g)(4) of the Social Security 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.

70.8.9 – Extension of Time Limitation for Filing Part B Claims on Charge Basis Because of Administrative Error

(Rev. 170, 05-07-04)

Medicare law extends the time limitation for filing claims payable on a reasonable charge basis, if:

- *The failure to submit the claim within the timeframes specified in §3004.A. was due to "administrative error" (i.e., misrepresentation, delay, mistake or other action) of an officer, employee, FI, carrier, or agent of the DHHS performing functions under the Medicare program, and acting within the scope of his/her authority; and*

- *The claim is filed promptly (see subsection B for definition) after the "error" is corrected.*

The time limit provided by the law has been adequate for the great majority of claims. However, potential claimants (enrollees, their representatives or assignees) have failed to file timely claims due to an administrative error. For example, in some unusual cases the failure was caused by misinformation from an official source, a delay in establishing SMI entitlement, or some administrative action which appeared to be correct on the basis of information available at the time, but resulted in delaying the filing of a claim.

An extension of the time limits applies only if the delay resulted primarily from some administrative error. The fact that the enrollee was "without fault" or otherwise showed "good cause" for his failure to submit a claim timely is not a basis for extending the time limits, in the absence of administrative error.

Relief may be given in any case which comes to light in the normal routine of work provided it meets the criteria outlined in subsection A. Neither you nor SSA will conduct a search for such claims.

70.8.10 – Delays Considered to be the Result of Administrative Error

(Rev. 170, 05-07-04)

Situations in which failure to file within the normal time limit will be considered to have been caused by administrative error include, but are not limited to, the following:

- *The failure resulted from SSA's delay in establishing the individual's entitlement to SMI until many months after SMI coverage was effective. Until the enrollee's name is entered on the SMI rolls, he has no basis for claiming SMI benefits, since any SMI benefit claims made would have been disallowed;*

- *The failure to file resulted from SSA's failure to notify the individual that his enrollment application had been approved, or in giving him (or his*

representative or assignee) cause to believe that he was not entitled to SMI;

- *The failure resulted from misinformation from you or SSA, e.g., that certain services were not covered under SMI although in fact, they were covered; or*

- *Because of a policy or other issue, you advise the physician or supplier to hold his claims until further notice and do not advise him timely to resume submitting them.*

Submit any claim with a recommendation before payment involving situations other than those listed above in which it appears that an extension of the time limit might be justified on the basis of administrative error to your Regional Office for a particular situation. If the issue has a national implication the Regional Office will refer the matter to the Central Office.

70.8.11 – Extension of Time Limit in Reference to Definition of "Filed Promptly"

(Rev. 170, 05-07-04)

Where failure to file a claim within the usual time limit results from an administrative error, the claim will be deemed filed promptly and timely if it is filed within 6 calendar months following the month in which the error is corrected. A claimant always has at least 6 calendar months after the month of correction in which to file. Correction of the error less than 6 full calendar months before expiration of the usual time limit will warrant an extension of time for the remainder of the 6 months.

EXAMPLE 1: Information submitted in connection with a claim for services during the period May 1989-September 1989, filed in March 1991, shows that the enrollee's request for enrollment in SMI was initially denied. He/she was first notified on January 15, 1991, that he/she had SMI effective May 1989. Under these circumstances, pay appropriate SMI benefits for the services. Although the usual time limit expired December 31, 1990, the error in this case - delay in establishing SMI entitlement - was not corrected until January 15, 1991, thus extending the time limit to July 31, 1991.

EXAMPLE 2: An individual requested enrollment in SMI in March 1989, the month before he attained age 65. He/she received covered services in July 1989, but filed no claim because he/she had received no notice of his/her SMI entitlement. Such notice was mailed to him/her on October 3, 1990. Although the regular time limit for the services in July 1989, expired on December 31, 1990, the claim will be considered promptly and timely filed if it is filed on or before April

30, 1991 (within the 6-month period following the month in which the notice was sent).

70.8.12 – Initiating Development of Administrative Error

(Rev. 170, 05-07-04)

Consider extending the time limit only if there is some reasonable basis for concluding that the claimant (the enrollee or his/her representative or assignee) was prevented from timely filing by administrative error, e.g., he/she states that official misinformation has caused late filing, or the Social Security office calls to your attention a situation in which such an error has caused late filing. Do not routinely initiate development for such a possibility. Make no search for possible administrative cause for delay in filing among cases previously denied because of the time limit. If a previously denied claim containing such an allegation or other basis for inferring such error comes to your attention, reexamine the case.

70.8.13 – Evidence Necessary to Honor Late Claims

(Rev. 170, 05-07-04)

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

- *A statement from the claimant, his/her representative, or assignee regarding the nature and affect of the error, how he/she learned of the error, when it was corrected, and if the claim was filed previously, when it was filed; and*

- *One of the following:*

  - *A written report by the agency or other responsible party (SSA, CMS), based on its own records, describing how its error caused failure to file within the usual time limit;*

  - *Copies of an official letter or written notice reflecting the error; or*

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

However, the statement of the claimant is not essential if the other evidence establishes that his failure to file within the usual time limit resulted from administrative error, and that he filed a claim within 6 months after the month in which he was notified that the fault 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 carrier's own records, it should annotate the claims file to this effect.

70.8.14 – Responsibility for Decision on Extension of Time Limit

(Rev. 170, 05-07-04)

The carrier has the responsibility for deciding, on the basis of all pertinent circumstances, whether a late claim may be honored. The carrier will ordinarily accept a statement from some other component which shows that there was (not) error, as a result of which the claimant could reasonably have been prevented or deterred from filing his claim within the usual time limit. Similarly, the carrier will ordinarily accept a statement from the component which corrected the error as to whether and when this was done. However, where information submitted to the carrier by another component involved in SMI administration is incomplete or questionable, the carrier may request clarification. (See 70.8.15)

70.8.15 – Coordination of Development with Social Security Administration, Carriers, and Intermediaries

(Rev. 170, 05-07-04)

Where the initial allegation of administrative error on the part of the Government is made to SSA, the servicing SSO will forward any necessary report, statement, and/or other evidence to the carrier.

There may be situations in which the enrollee still owes for services during a period for which the time limit has expired and it is clear that an extension of the time limit will apply on the basis of administrative error if a claim is now filed promptly. If the enrollee wishes to assign the claim and the enrollee or the SSO believes that the physician (or supplier) may be willing to accept assignment, the SSO will give the enrollee a report of the kind described above for the physician to attach to the assigned claim, and (when necessary) call the physician's office to explain both the time limit and the need for prompt filing of the claim.

If an allegation of administrative error by the SSA is made to the carrier or if the information furnished by the SSO is incomplete, the carrier will request the necessary evidence (see D above), from the SSO servicing the enrollee. Such request may be made on Form SSA-l980-Carrier or Intermediary Request for SSA Assistance and, unless RO instructions provide otherwise, will be made through the parallel SSO. Where allegedly another carrier or intermediary is involved in the delay, the request for and the furnishing of necessary information and evidence may be made by letter.

70.8.16 – Statement of Intent (SOI)

(Rev. 170, 05-07-04)

Medicare regulations at 42 CFR 424.45 allow for the submission of written statements of intent (SOI) to claim Medicare benefits. The purpose of a SOI is to extend the timely filing period for the submission of an initial claim. A SOI, by itself, does not constitute a claim, but rather is used as a placeholder for filing a timely and proper claim. The timely filing period to file a specific Medicare claim defined in section A above may be extended when a valid SOI, with respect to that claim, is furnished to the appropriate Medicare intermediary (i.e., the one that will be responsible for processing the claim), or regional office (RO) serving the area of the beneficiary's residence within the timely filing period. After a valid SOI has been filed, a completed claim that meets the requirements defined in section B above must be submitted to the appropriate Medicare contractor within six months after the month in which the contractor notifies the party who submitted the SOI that a claim may be filed, or by the end of the applicable timely filing period, whichever is later.

70.8.17 – Time Limitation of Claims for Outpatient Physical Therapy or Speech Pathology Services Furnished by Clinic Providers

(Rev. 170, 05-07-04)

Effective with respect to claims filed after December 3l, l974, claims for payment for services reimbursable on a reasonable cost basis are subject to the same limitation as claims for payments for services reimbursable on a reasonable charge basis (including a charge-related-to-cost basis). (The only Medicare claims for payments reimbursable strictly on a reasonable cost basis under the carriers' jurisdiction are those relating to outpatient physical therapy or speech pathology services furnished by clinic providers. There was no time limit on filing for such services for claims submitted before January l, l975.) In the case of services reimbursable on a reasonable cost basis, administrative error of SSA or its agents will not ordinarily extend the time limit beyond the close of the third year following year in which the services were furnished (deeming services furnished in the last quarter of the year to have been furnished in the following year).

***EXAMPLE**: Mr. G. receives outpatient physical therapy services on January 05, 1995 at Clinic X, a participating provider. For reimbursement for these services, the claim must be submitted to the carrier no later than December 31, 1996. If the services were furnished on October 15, 1995, the services would be deemed to be furnished in l996, and the claim would have to be submitted by December 31, 1997. If the services were furnished on October 15, 1992, the claim must have been submitted by l2/3l/94, the effective date of the time limit. If administrative error prevents the claim for services furnished on October 15, 1992 from being filed until after l996, the fourth year after the fourth quarter of l992, the case should be submitted to BHI for advice.*

If an enrollee request for payment is filed with the provider timely (or would have been filed timely had the provider taken action to obtain a request from a patient whom the provider knew or had good reason to believe was an enrollee) but the provider does not

file a timely claim, the provider may not charge him for the services except for such deductible and/or coinsurance amounts and noncovered services as would be appropriate if Medicare payment were made.