Medicare
Carriers Manual
Part 3 - Claims Process

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

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CHANGE REQUEST 2815

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
3000 - 3004.2	3-5 – 3-13 (13 pp.)	3-5 – 3-14 (13 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: October 1, 2003*
IMPLEMENTATION DATE: October 1, 2003

Section 3000 – 3004.2, Filing the Request for Payment, has been updated to more accurately reflect timely filing as it relates to claims for payment.

Provider Education:

Carriers must share the following information with providers through a posting on their Web site within 2 weeks of receiving this instruction and publish in their next regularly scheduled bulletin. If you have a listserv that targets the affected provider community, you shall use it to notify subscribers that information about "Filing the Request for Payment" is available on your Web site.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

These instructions should be implemented within your current operating budget.

Filing the Request for Payment

3000. DEFINITION OF A CLAIM

A claim is a writing, identifying or permitting the identification of an enrollee, which requests payment for what appears to be Part B medical or other health services furnished by a physician or supplier. (See §5240, in MCM, Part 2 concerning process controls on claims.)

The writing must contain sufficient identifying information about the enrollee to permit the obtaining of any missing information through routine methods, e.g., file check, microfilm reference, mail or telephone contact based on an address or telephone number in file. Where the writing is not submitted on a claims form, there must be enough information about the nature of the medical or other health service to enable the contractor with claims processing jurisdiction to determine that the service was apparently furnished by a physician or supplier.

Under this definition, the following do not constitute claims:

o A claims form not containing sufficient information to permit you to identify the enrollee;

o Bills or claims forms referring only to services unrelated to medical or other health services;

o A writing not contained on a claims form and not accompanied by an itemized bill which does not permit you to identify the enrollee and to determine that the medical or other health services were apparently performed by a physician or supplier: and

o Claims forms, or that portion of a claims form, requesting a payment or coverage determination for services that are not within your claims processing jurisdiction (e.g., misdirected claims/services). Handle misdirected claims/services in accordance with §§3110 and 4267.1, as appropriate.

Under the foregoing definition, the following are examples of claims requiring control:

o A claim form containing full identifying information;

o A claim form giving sufficient information for basing requests for further identifying information;

o Bills for medical or other health services which permit you to identify the enrollee and to determine that the services for which you have claims processing jurisdiction were apparently performed by a physician or supplier. The bills need not be accompanied by a claim form. (See §3040.1.); and

- A writing not on a claims form or on a bill which requests payment, which permits identification of the enrollee, and which permits you to determine that the medical or other health services in question and for which you have claims processing jurisdiction were apparently performed by a physician or supplier. See §§33l1 and 33l9 for the procedures where additional evidence or information is needed to complete the claim.

3. In Accordance with CMS Instructions.--CMS instructions for submitting claims to Medicare are contained in Chapter III, Claims, Filing, Jurisdiction and Development Procedures of the Medicare Carriers Manual (MCM), these instruction are supplemented by Program Memoranda which are published on the CMS Web site and are generally incorporated into the MCM within one year of publication. In order for a request for payment to be considered to have been filed timely in accordance with CMS instructions, the claim must not be considered to be unprocessable under the definition of an unprocessable claim found in MCM, Part 3, §§3005ff.

Carriers use different processes for handling unprocessable claims. Some carrier's claims processing systems suspend and develop claims considered unprocessable because of incomplete or invalid information. Note that developed claims are not considered clean claims, and no Claims Processing Timeliness (CPT) interest is payable. If the corrections for a suspended claim are received by the carrier within the suspense period, the claim is considered to be timely, even if the corrections are submitted after the timely filing period has closed, provided the claim was filed timely. Other carrier's claims processing systems return unprocessable claims to the submitter, but do not suspend and develop to allow for corrections. Such returned requests for payment, do not constitute claims nor satisfy the timely filing requirement. In those instances, a processable claim that conforms to the requirements of MCM Part 3, §3005 as a minimum must be resubmitted within the timely filing period.

3000.1 Splitting Claims for Processing.--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:

o 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.

o 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.

o 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;

o Assigned claims from different physicians/suppliers (excluding group practices and persons or organizations to whom benefits may be reassigned). (See §§3060ff.) 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 in accordance with §§3060ff., process all of the services as a single claim;

o 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.

o 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.

o 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.

o 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.

o 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.

o 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. See §§13310ff. for instructions on reporting claims.

3000.2 Replicating Claims for Processing.--There are no prescribed reasons other than those listed in §3000.l 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 (claims created for any reasons other than those listed in §3000.l) separately. Identify replicate claims and report them in the appropriate categories for claims. (See §§l33l0ff.) Some examples of replicate claims are:

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

o Extra claims created in making partial payments;

o Claims created for carving out individual specialty types of services or for any other occurrence that is not provided for in §3000.l, e.g., unassigned claims containing both services of a podiatrist and services of a physician; and

o 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.

3001. FILING PART B CLAIMS FOR PHYSICIANS' AND SUPPLIERS' SERVICES

A. Methods of Claiming Benefits.--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.

B. Itemized Claims by Patient.—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 Form 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.

C. Assignment Method.--The physician/supplier (or the facility or organization to which the physician may reassign benefits (§§3060 - 3060.3)) 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.)

3002. CLAIMS FORMS

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:

o The reason or need for such reproduction;

o The intended user of the form;

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

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

o 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.

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

B. Form CMS-1500 (Health Insurance Claim Form).--Sometimes referred to as the AMA form, the Form CMS-1500 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. Instructions for completing Form CMS-1500 for Medicare claims are in §§4020ff.

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.

C. Form CMS-1490S (Patient's Request for Medicare Payment).--This 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 or if one of the situations in §7563 applies. 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.

D. 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 Form 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. CMS-1500). Suppliers using the 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.

E. Form CMS-l490U.--Used by the entities listed in §7065.2 under the indirect payment provision. It contains a certification by the organization requesting payment that the conditions in §7065 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. (See §§4260 and 4265 for billing instructions.)

F. Form CMS-1556 (Prepayment Plan for Group Practices Dealing Through A Carrier).--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. (See §4255 for billing instructions.)

3003. ACCEPTABILITY OF PHOTOCOPIES

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.

3004. TIME LIMITATION ON FILING PART B REASONABLE CHARGE AND FEE SCHEDULE CLAIMS

A. General.--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:

o 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. (See §4015.) 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. (Refer to MCM Part 3, §3041 and §7560).

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:		Feb	Mar	Apr	May	June
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	26	25	24

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

See §3004.1 for the effect of administrative errors of SSA, CMS, intermediaries or carriers.

B. Provider Has Billed Improperly for Professional Component.--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.

C. Penalty for Filing Claims After One Year (Effective September 1, 1990).--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.

3004.1 Extension of Time Limitation for Filing Part B Claims on Charge Basis Because of Administrative Error.--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 in §3004.A. 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.

A. When Delay Will Be Considered the Result of Administrative Error.--Situations in which failure to file within the normal time limit specified in §3004.A. will be considered to have been caused by administrative error include, but are not limited to, the following:

o 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;

o 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;

o 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

o 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.

B. Extension of Time Limit -- Definition of "Filed Promptly".--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).

C. Basis for Initiating Development of Administrative Error.--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.

D. Evidence Necessary to Honor Late Claims.--Where administrative error is alleged to be responsible for late filing, the necessary evidence ordinarily includes:

o 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

o 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

c. 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.

E. Responsibility for Decision on Extension of Time Limit.--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 F below.)

F. Coordination of Development With Social Security Administration Carriers and Other Intermediaries.--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 (see §3999, Exhibit 7) 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.

G. Statement of Intent (SOI). The purpose of an SOI is to extend the timely filing period for the submission of an initial claim. An SOI by itself does not constitute a claim, but rather is used as a placeholder for filing a timely and proper claim. Detailed instructions regarding the submission requirements for SOIs are described in Medicare Program Memorandum Transmittal AB-03-061 dated May 2, 2003.

3004.2 Time Limitation on Claims for Outpatient Physical Therapy or Speech Pathology Services Furnished by Clinic Providers.-- Effective with respect to claims filed after December 31, 1974, 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 1, 19975.) Most of the provisions in §§ 3004-3004.1 concerning the time limitation are also applicable to reasonable cost claims. However, 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). Claims in which administrative error prevents timely payment until after the close of the third year following the year in which the services were furnished (fourth year, in the case of services furnished in the October-December quarter) should be submitted to the address shown in the last paragraph of § 3004.1 for advice before a denial action. (See §§ 4160ff. for billing for outpatient physical therapy services.)

EXAMPLE: Mr. G. receives outpatient physical therapy services on 01/05/75 at Clinic X, a participating provider. For reimbursement for these services, the claim must be submitted to the carrier no later than 12/31/76. If the services were furnished on 10/15/75, the services would be deemed to be furnished in 1976, and the claim would have to be submitted by 12/31/77. If the services were furnished on 10/15/72, the claim must have been submitted by 12/31/74, the effective date of the time limit. If administrative error prevents the claim for services furnished on 10/15/72 from being filed until after 1976, the fourth year after the fourth quarter of 1972, 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.