Medicare
Skilled Nursing Facility Manual

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

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REFER TO CHANGE REQUEST 1123

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
500 - 501 (Cont.)	5-5 - 5-6 (2 pp.)	5-5 - 5-6 (2 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: July 1, 2000*

Section 501, Claims Processing Timeliness, is updated to inform you that the prompt payment interest rate is now available on the Treasury Department's new web page address--www.publicdebt.treas.gov/opd/opdprmt2.htm.

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.

500. GENERAL BILLING INFORMATION

The forms used for SNF billing are:

A. HCFA-1450 Inpatient and/or Outpatient Billing.--This form is used for all provider billing, except for professional component of physicians services. See §560 for instructions on completing Form HCFA-1450.

Providers are responsible for purchasing their own forms. This form can be bought as a regular stock item from many printers as a snap-out set or as a continuous pin-feed form (either glued on the side or not). It is available as carbonless or with carbon paper. Medicare accepts any of the above. The standard form set contains five copies, one page of which is designed to bill the patient.

B. HCFA-1490S Patient's Request for Medicare Payment.--This form is used only by beneficiaries (or their representatives) who complete and file their own claims.

C. HCFA-1500 Health Insurance Claim Form.--This form was formerly known as the AMA form. It is the prescribed form for claims prepared by physicians or suppliers whether or not the claims are assigned.

D. SNFs Affiliated with HMOs and Other Billing Services to HMO Enrollees.-Use the regular billing forms above to bill for HMO enrollees. See §§415 and 560 for admission and billing procedures.

Send bills that you know will be paid by the HMO directly to it for a coverage determination, payment, and/or denial action. When forwarding bills to the HMO, attach the necessary supporting documents. Send bills that you know will be paid and processed by the intermediary, and bills where you do not know who has jurisdiction, to the intermediary in an envelope specially marked "HMO Bills" and containing only HMO bills.

In some cases the patient may have enrolled or disenrolled from an HMO plan during the billing period. If the HMO has processing jurisdiction for the HMO involved portion of the bill, the HMO will direct you to split the bill and send the HMO portion to it and the remaining portion to the intermediary. If the intermediary is responsible for processing the entire bill, it will direct you to split the bill and send both portions to the intermediary.

501. CLAIMS PROCESSING TIMELINESS

A. Claims Processing Timeliness Requirements.--"Clean" claims must be paid or denied within the applicable number of days from the date of their receipt as follows:

Time Period for Claims Received	Applicable Number of Days
01-01-93 through 09-30-93	24 for EMC & 27 for paper claims
10-01-93 and later	30

See §501 D. for the definition of a clean claim. All claims (i.e., paid claims, partial and complete denials, no payment bills) including PIP and EMCs are subject to the above requirements.

The count is started on the day after the receipt date and ends on the date payment is made. For example, for clean claims received October 1, 1993, and later, if this span is 30 days or less, the requirement is met.

B. Payment Floor Standards.--Your intermediary does not pay, issue, mail, or otherwise make payment for any claim it receives from you within the waiting period indicated below. The length of the waiting period is determined by the date a claim is received. Your intermediary starts its count on the day after the day of receipt. For example, a paper claim received October 1, 1993, can be paid on or after October 28, 1993. An electronic claim received November 1, 1993, can be paid on or after November 15, 1993.

Claims Receipt Date	Waiting Period (Calendar Days)
01-01-93 through 09-30-93	14 for EMC & 26 for paper claims
10-01-93 and later	13 for EMC & 26 for paper claims

NOTE: No payment claims are not subject to the payment floor standards.

C. Interest Payment on Clean Non-PIP Claims Not Paid Timely.--Interest must be paid on clean non-PIP claims if payment is not made within the applicable number of calendar days after the date of receipt as described in subsection A. For example, a clean claim received on October 1, 1993, must have been paid before the end of business on October 31, 1993. Interest is not paid on:

- o Claims requiring external investigation or development by your intermediary;
- o Claims on which no payment is due;
- o Full denials; or
- o Claims for which you are receiving PIP.

However, PIP on inpatient bills does not preclude interest payments on outpatient bills.

Interest is paid on a per bill basis at the time of payment.

Interest is paid at the rate used for §3902(a) of title 31, U.S. Code (relating to interest penalties for failure to make prompt payments). Interest is determined by the applicable rate on the day of payment.

This rate is determined by the Treasury Department on a 6 month basis, effective every January 1st and July 1st. Effective January 1, 2000, you may access the Treasury Department's new web page address--www.publicdebt.treas.gov/opd/opdprmt2.htm semi annually for the new rate. Your intermediary notifies you of any changes to this rate. Interest is calculated using the following formula:

Payment amount x rate x days ÷ 365 (366 in a leap year) = interest payment.