CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 273 **Date: AUGUST 13, 2004**

CHANGE REQUEST 2981

SUBJECT: Modification of CMS's Medicare Contingency Plan for HIPAA Implementation

I. SUMMARY OF CHANGES: This Change Request publishes material from CR 2981, Transmittal 114 that was inadvertently omitted from the Internet Only Manual.

MANUALIZATION - EFFECTIVE DATE: July 1, 2004
***IMPLEMENTATION DATE: July 6, 2004**

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
R	1/80.2.1/Receipt Date
R	1/80.2.1.1/Payment Ceiling Standards
R	1/80.2.1.2/Payment Floor Standards
R	1/80.2.2.1/Determining and Paying Interest

***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**

80.2.1 – Receipt Date

(Rev. 273, Issued 08-13-04, Effective: 07-01-04, Implementation: 07-06-04)

A3-3600.1-Item 7

The receipt date of a claim is the date the contractor receives the claim (provided the filing is in a format and contains data sufficiently complete so that the filing qualifies as a claim). The receipt date is used to: determine if the claim was timely filed *(see §70.3)*, determine the "payment floor" for the claim *(see §80.2.1.2)*, determine the "payment ceiling" on the claim *(see §80.2.1.1)* and, when applicable, to calculate interest payment due for a clean claim that is not timely processed, and to report to CMS statistical data on claims, such as in workload reports.

A paper claim that is received by 5:00 p.m. on a business day, or by closing time if the contractor routinely ends its public business day between 4:00 p.m. and 5:00 p.m., must be considered as received on that date, even if the contractor does not open the envelope which contains the claim or does not enter the claims data into the claims processing system until a later date. A paper claim that is received after 5:00 p.m., or after the contractor's routine close of business between 4:00 p.m. and 5:00 p.m., is considered as received on the next business day.

A paper claim is considered as received if it is delivered to the contractor's place of business by the U.S. Postal Service, picked up from a P.O. box, or is otherwise delivered to the contractor's place of business by its routine close of business time. If the contractor uses a P.O. box for receipt of mailed claims, it must have its mail picked up from its box at least once per business day unless precluded on a particular day by the emergency closing of its place of business or that of its postal box site.

As electronic claim tapes and diskettes *that may be* submitted by providers or their agents *to an FI* are also subject to manual delivery, rather than direct electronic transmission, the paper claim receipt rule also applies to *establish the date of receipt of claims submitted on s*uch manually delivered tapes and diskettes.

Electronic claims transmitted *directly* to a contractor, or to a clearinghouse with which the contractor contracts as its representative for the receipt of its claims, by 5:00 p.m. in the contractor's time zone, or by its closing time if it routinely closes between 4:00 p.m. and 5:00 p.m., must likewise be considered as received on that day even if the contractor does not upload or process the data until a later date. ***NOTE:*** *The differentiation between HIPAA-compliant and HIPAA-non-compliant electronic claims that is specified in §80.2.1.2 with respect to applying the payment floor, does not apply to establishing date of receipt. Use the methodology described above to establish the date of receipt for all electronic claims.*

Paper and electronic claims that do not meet the basic legibility, format, or completion requirements are not considered as received for claims processing and may be rejected from the claims processing system. Rejected claims are not considered as received until

resubmitted as corrected, complete claims. The contractor may not use the data entry date, the date of passage of front-end edits, the date the document control number is assigned, or any date other than the actual calendar date of receipt as described above to establish the official receipt date of a claim.

The following permissive exception applies to establishment of receipt date: Where its system or hours of operation permit, *a contractor* may, at its option, classify a paper or electronic claim received between its closing time and midnight, or on a Saturday, Sunday, holiday, or during an emergency closing period as received on the actual calendar date of delivery or receipt. Unless a contractor closes its place of business early in an isolated situation due to an emergency, the contractor's cutoff time for establishing the receipt date may never be earlier than 4:00 p.m.

A contractor may not make system changes, extend its hours of operation, or incur significant additional costs solely to begin to accommodate late receipt of claims if not already equipped to do so.

The cutoff time for paper claims may not exceed the cutoff time for electronic claims. However, the cutoff time for electronic claims may exceed the cutoff time for paper claims and, indeed, carriers and FIs are encouraged to use this tool where their system and overnight batch run schedules permit. Likewise, at a carrier or FI's option, it may consider electronic claims received on a weekend or holiday as received on the actual calendar date of receipt, even though paper claims received in a P.O. box on a weekend or holiday would not be considered received until the next business day.

Where a carrier or FI prepares bills for payment for purchased DME because the $50 tolerance is exceeded (see §40.4.1) it establishes any date consistent with its system processing requirements as the receipt date for the second and succeeding bills. It uses the date as close to its payment as possible.

80.2.1.1 - Payment Ceiling Standards

(Rev. 273, Issued 08-13-04, Effective: 07-01-04, Implementation: 07-06-04)

A3-3600.1A.1, B2-5240.11.C

The "payment ceiling" is the deadline for processing a "clean claim". The payment ceiling for all claims is thirty (30) days. That is, a clean claim must be paid or denied within 30 days of receipt by the contractor.

Except as noted below, all claims (i.e., fully payable claims, partial or complete denials, "no payment" bills, and "PIP" claims, whether submitted via EMC or paper are subject to the 30-day payment ceiling.

A "RAP" *(see Chapter 10, §10.1.12)* submitted by a home health agency under the HH PPS (records with type of bill 322 or 332 and dates of service on or after October 1, 2000) is not a Medicare claim as defined under the Social Security Act. Thus, such a RAP is not subjected to the payment ceiling.

For the purpose of counting days, the count starts on the day after the receipt date and ends on the date payment is made or the claim is otherwise adjudicated. A claim that is paid or otherwise adjudicated before or on the 30th day from the date of receipt by the contractor is paid within the payment ceiling. Interest must be paid on a payable clean claim that is not paid within 30 days of receipt.

80.2.1.2 - Payment Floor Standards

(Rev. 273, Issued 08-13-04, Effective: 07-01-04, Implementation: 07-06-04)

A3-3600.1, HO-401.B, B2-5240.11.D

The "payment floor" establishes a waiting period during which time the contractor may not pay, issue, mail, or otherwise finalize the initial determination on a clean claim. The "payment floor date" is the earliest day after receipt of the clean claim that payment may be made.

The payment floor date is determined by counting the number of days since the day the claim was received, i.e., the count begins the day after the day of receipt.

There are different waiting periods, and thus different payment floor dates, for electronic claims and paper claims. The waiting periods are 13 days for electronic claims and 26 days for paper claims. For the purpose of implementing the payment floor, the following definitions apply:

An "electronic claim" is a claim submitted via central processing unit (CPU) to CPU transmission, tape, diskette, direct data entry, direct wire, or personal computer upload or download. A claim that is submitted via digital FAX/OCR*, diskette, or touch-tone telephone is* not considered as an electronic claim.

A "paper claim" is submitted and received on paper, including fax print-outs. This also includes a claim that the contractor receives on paper and then reads electronically with OCR technology.

Also, for the purpose of implementing the payment floor, effective 7/1/04 and for the duration of the HIPAA contingency plan implementation, an electronic claim that does not conform to the requirements of the standard implementation guides adopted for national use under HIPAA, including electronic claims submitted electronically using pre-HIPAA formats supported by Medicare, is considered to be a paper claim.

Based on the waiting periods, the payment floor dates are as follows:

Claim Receipt Date	**Payment Floor Date**
10-01-93 *through 6/30/04*	14th day for EMC 27th day for paper claims
07-01-04 and later	*14th day for HIPAA-compliant EMC* *27th day for paper and non-HIPAA EMC*

Except as noted below, the payment floor applies to all claims. The payment floor does not apply to: "no-payment claims, *RAPs submitted by Home Health Agencies, and claims for PIP payments.*

NOTE: *The basis for treating a non-HIPAA-compliant electronic claim as a paper claim for the purpose of determining the applicable payment floor is as follows: Effective October 16, 2003, HIPAA requires that claims submitted to Medicare electronically comply with standard claim implementation guides adopted for national use under HIPAA. A claim submitted via direct data entry (DDE), if DDE is supported by the contractor is considered to be a HIPAA-compliant electronic claim. A contingency plan has been approved to enable claims to continue to be submitted temporarily after October 15, 2003 in a pre-HIPAA electronic format supported by Medicare. Effective July 1, 2004, the Medicare contingency plan is being modified to encourage migration to HIPAA formats. Effective July 1, 2004, for purposes of the payment floor, only those claims submitted in a HIPAA-compliant format will be paid as early as the 14th day after the date of receipt. Claims submitted electronically under a pre-HIPAA format supported by Medicare under the contingency plan period, including the UB-92 flat file, the National Standard Format (NSF), a pre-version 4010A1 X12 837, or on paper after July 1, 2004 will not be eligible for payment earlier than the 27th day after the date of receipt. All claims subject to the 27-day payment floor, including non-HIPAA electronically submitted claims, are to be reported in the paper claims category for workload reporting purposes.*

This differentiation in treatment of HIPAA-compliant and non-HIPAA-compliant electronic claims does not apply to Contractor Performance Evaluation (CPE) reviews of carriers and FIs conducted by CMS. For CPE purposes, carriers and FIs must continue to process the CPE specified percentage of clean paper and clean electronic (HIPAA or non-HIPAA) claims within the statutorily specified timeframes.

80.2.2.1 - Determining and Paying Interest

(Rev. 273, Issued 08-13-04, Effective: 07-01-04, Implementation: 07-06-04)

The contractor must pay interest on clean, non-PIP (FIs) claims for which it does not make payment within the payment ceiling specified in § 80.2.1.1, provided payment is due on such claim. The interest rate and formula for calculation are shown above. The interest rate is determined by the rate applicable on the carrier or FI's payment date.

The contractor applies interest to the net payment amount after all applicable deductions are determined (e.g., deductible, copayment, and/or MSP). Interest is rounded to the nearest penny.

A - Reporting Interest Payment on Remittance Record

See 100-22 for remittance advice completion instructions.

B - Payment Made to Beneficiary

If interest is paid on a claim for which payment is made directly to the beneficiary, the contractor adds the following messages on the beneficiary notice:

"Your payment includes interest since we were unable to process your claim timely."

C - Claims Paid Upon Appeal

Interest payments are not payable on clean claims initially processed to denial and on which payment is made subsequent to the initial decision as a result of an appeal request. This applies to appeals where more than the applicable number of days elapsed before an initial denial, but the claim was later paid upon appeal. Where an appeal of a previously paid claim results in increased payment FIs follow the following section.

D - Interest on Postpayment Denials and Other Adjustments

If a paid claim is later denied in full, the carrier or FI recovers any interest paid as well as the incorrect payment. It does not pay interest on the related no payment bill. If the claim is partially denied, interest is payable on the reduced amount. The FI recalculates the interest due based upon the new reimbursement amount. It uses the rate of interest and elapsed days applicable to the original claim. This can be accomplished by applying a ratio of the new reimbursement amount (from its debit action) to the reimbursement amount on the initial claim (from its credit action). It multiplies the result by the interest amount paid on the initial claim. The result is the interest amount payable on its debit action. The following formula is used to calculate interest:

$$\text{Interest} = \frac{\text{Debit action reimbursement amount}}{\text{Credit action reimbursement amount}} \times \text{original interest paid}$$

Use of the formula is preferable to expanding an FI system to handle multiple scheduled payment dates and calculation procedures.