Medicare
Intermediary Manual
Part 3 - Claims Process

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

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CHANGE REQUEST 2171

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
3600.1 (Cont.) - 3600.1 (Cont.)	6-11.2 - 6-11.5 (4 pp.)	6-11.2 - 6-11.5 (4 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: July 26, 2002*
IMPLEMENTATION DATE: July 26, 2002

Section 3600.1, Claims Processing Timeliness, adds additional information clarifying the use of Condition Code 15, and requires home regional office approval for its reporting.

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

These instructions should be implemented within your current operating budget.

- o Are investigated within your claims, medical review, or payment office without the need to contact the provider, beneficiary, SSA, or other outside source;

- o Are subject to medical review, but complete medical evidence is attached or forwarded simultaneously with EMC records in accordance with your instructions to the provider. If you need to request medical evidence, see the first example under §3600.1 A.4; or

- o Are developed on a post payment basis.

4. Other Claims.--Claims that do not meet the definition of "clean" claims are considered "other" claims. "Other" claims require investigation or development external to your Medicare operation on a prepayment basis. Other claims include those not approved by CWF which you identify as requiring outside development. Examples are claims on which you:

- o Request additional information from the provider or other external source. This includes routine data omitted from the bill, medical information, or information to resolve discrepancies;

- o Request information or assistance from another contractor. This includes requests for charge data from a carrier or any other request for information from a carrier;

- o Develop MSP information;

- o Request information necessary for a coverage determination;

- o Perform sequential processing when the earlier claim is in development;

- o Perform outside development as a result of a CWF edit; and

Enter condition code 64 to indicate that the claim is not a "clean" claim, and therefore, not subject to the mandated claims processing timeliness standard.

5. Interest Payment on Clean Non-PIP Claims, Not Paid Timely.--Pay interest on clean non-PIP claims if payment is not made within the applicable number of calendar days after the date of receipt. (See §3600.1 A.1.) For example, a clean claim received on October 1, 1993, must have been paid before the end of business on October 31, 1993, to avoid interest payment. Interest is not required on the following:

- o Claims requiring external investigation or development;
- o Claims on which no payment is due;
- o Full denials; or
- o Claims for which the provider is receiving PIP; and
- o HH PPS RAPs.

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

Pay interest on a per bill basis at the time of your payment. Interest is a Federal expense and is not assessed against you.

6. Proper Use of Condition Code 15.--In the absence of CMS direction to report Condition Code 15, when instructed to hold clean claims due to a CMS processing delay, you must request home regional office (RO) approval for its reporting. You must provide adequate justification and appropriate documentation to support the request. (See §3604 for definition of this condition code.)

The decision as to the granting of Condition Code 15 authorization in this situation will be the responsibility of the home RO. It will be based on the assessment that circumstances outside of your control will adversely affect Contractor Performance Evaluation (CPE) claims processing timeliness standards, as indicated in the MIM, Part 2, §2901.1. Timing is critical in cases where Condition Code 15 is applied. The RO should render a decision as quickly as possible. Claims containing Condition Code 15 should be reported on your Intermediary Workload Report, Form HCFA-1566 as indicated in §3894.3.

NOTE: The reporting of Condition Code 15 only applies to clean claims. It does not apply to the claims containing Condition Code 64. (See subsection A4 and §3604 for an explanation of condition code 64.) Standard Systems must assure that both condition code 15 and 64 are not reported on the same claim.

7. Continuation of PIP.--Continue PIP upon request to subsection (d) hospitals as defined in §3600.1.B. (including units excluded from PPS) that received PIP on June 30, 1987, until you meet the requirement to pay 95 percent of all clean claims (for which PIP payment is not made) in the applicable number of days for 3 consecutive months. (See §3600.1.A. for the applicable number of days.)

Regardless of your claims processing timeliness performance on clean, non-PIP bills, PIP continues, upon request, for:

- o DSHs that have at least a 5.1 percent disproportionate share adjustment (as discussed below); or
- o Rural hospitals with 100 or fewer beds.

The request to continue PIP by such hospitals is a one time opportunity and must have been made no later than July 1, 1987. It is limited to hospitals that:

- o Received PIP on June 30, 1987; and
- o Continued to meet requirements specified in regulations that were applicable on October 1, 1986. (Qualified DSHs and rural hospitals with 100 or fewer beds may receive PIP payments indefinitely provided that they continue to meet standards established by the Secretary that were applicable on October 1, 1986.)

Section 1815(e)(1)(B)(i) of the Act requires the amount of a hospital's disproportionate share adjustment percentage for purposes of this PIP provision to be based upon the data base used by CMS to standardize the FY 1987 PPS rates. The disproportionate share adjustment is calculated by CMS from the hospital's percentage of low income patients based on FY 1985 SSI/Medicare data and the Medicaid percentage from FY 1984 cost report data. The CMS furnished you a list of DSH payment percentages to use to determine whether a hospital meets the DSH requirement to retain PIP. Except as follows, use the listing to determine whether a hospital meets the 5.1 percent criterion. A hospital meets the criterion where it included adequate Medicaid days in its 1984 cost report but CMS failed to properly include them in its data base when computing the 1984 Medicaid percentage. It also can meet the criterion where it had adequate Medicaid days in its 1984 cost reporting year even though it did not include them in its cost report.

In the latter situation, a hospital must submit to you previously unsubmitted Medicaid data applicable to the 1984 cost report year (cost reports beginning October 1, 1983, through September 30, 1984). Verify the accuracy of this subsequently submitted Medicaid data and take appropriate steps, including audit where necessary, to assure the data's validity.

A hospital's request and data must be received by you no later than 3 years from the date of the Notice of Program Reimbursement for the 1984 cost report. Remove from PIP after June 30, 1987, any hospital not qualifying based on the CMS listing, or improper exclusion from the data base.

Any hospital removed from PIP that has notified you of its intention to submit additional Medicaid data, or which submitted data with its request, will remain off PIP pending your evaluation of the data.

Consult your RO for specific timeframes involved, and subsequent actions required where you permit PIP for a hospital not on the listing.

For rural hospitals to continue PIP, they must be located in a rural area (as defined for PPS) and have 100 or fewer beds on July 1, 1987. A rural hospital is a hospital outside any Metropolitan Statistical Area (MSA). Use the guidelines for determining MSAs for PPS hospitals to determine whether a hospital is rural.

In determining the bed count for rural hospitals, count only beds that are general routine or intensive care type, adult or pediatric, maintained in a patient care area for inpatient lodging. Do not count beds assigned to newborns, to custodial or domiciliary care, to units excluded from PPS, to hospital based SNFs, to areas maintained and utilized for only a portion of a patient's stay, or primarily for special procedures (e.g., labor rooms, birthing rooms, postanesthesia and postoperative recovery rooms, outpatient areas or emergency rooms, or ancillary departments).

Where hospitals have significant cash flow problems as a result of removal from PIP, accelerated payments are payable in accordance with §2412 of the Provider Reimbursement Manual.

If the provider previously elected PIP and continues to qualify, continue PIP for:

- Inpatient services from hospitals other than subsection (d) hospitals;
- Hospitals which receive payment under a State hospital payment system under §1814(b)(3) or §1886(c) of the Act, if payment on a PIP basis is approved by CMS as an integral part of such payment system;
- SNF services; or
- Home health services furnished on or before September 30, 2000. (The Balanced Budget Act of 1997 eliminated PIP for home health agencies upon the implementation of the HH PPS effective October 1, 2000.)

In addition, upon request you can implement PIP effective July 1, 1987 or later for hospices meeting the requirements to qualify for PIP.

8. Receipt Date.--The receipt date is the date you receive a claim subject to the qualifications in subsection C on whether the data are sufficiently complete to qualify as a claim. The receipt date is used to calculate interest payments when due for clean claims, to report statistical data on claims to CMS, such as in workload reports, and to determine if a claim was received timely.

Paper claims received by 5:00 p.m. on a business day, or by closing time if you routinely end your public business day between 4:00 p.m. and 5:00 p.m., must be considered as received on that date, even if you do not open the envelopes in which the claims are received or do not enter the data into the claims processing system until a later date. Paper claims received after 5:00 p.m. or your close of business between 4:00 p.m. and 5:00 p.m. may be considered as received on your next business day.

Paper claims are considered received if delivered to your place of business by the U.S. Postal Service, picked up from a P.O. box(es), or otherwise delivered to your place of business by your

normal close of business time. If you use a P.O. box for receipt of mailed claims, you must have your mail picked up from your box(es) at least once per business day unless precluded on a particular day by the emergency closing of your office or your postal box site.

As electronic claim tapes and diskettes submitted by providers or their agents are also subject to manual delivery, rather than direct electronic transmission, the paper claim receipt date establishment rule also applies to such tapes and diskettes.

Electronic claims transmitted to you, or to a clearinghouse with which you contract as your representative for the receipt of your claims, by 5:00 p.m. in your time zone, or by your closing time if you routinely close between 4:00 p.m. and 5:00 p.m., must likewise be considered as received on that day even if you do not upload or process the data until a later date.

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. You 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 any claim.

Where your system or hours of operation permit, you may, at your option, classify a paper or electronic claim received between 5:00 p.m. (or your closing time between 4:00 p.m. and 5:00 p.m.) 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 your office closes early in an isolated situation due to an emergency, your cutoff time for establishment of a receipt date may never be earlier than 4:00 p.m.

Do not make system changes, extend your hours of operation, or incur significant additional costs solely to begin to accommodate late receipts if not already equipped to do so.

The cutoff time for paper claims may not exceed the cutoff time for electronic claims. A number of intermediaries have reported that a later electronic cutoff time has been an incentive for provider use of electronic filing. You are encouraged to use this tool where your system and overnight batch run schedules permit. Likewise, at your option, you 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.

9. Scheduled Payment Date.--The scheduled payment date is the date the check you issued is mailed, deposited by you in the provider's account, or transferred electronically. For PIP claims and no payment bills, the scheduled payment date is the date for payment bills in the same adjudication batch.

B. Systems Requirements.--

1. Determine Whether You May Remove Hospitals From PIP Based on Your Processing Timeliness.--In determining whether your processing timeliness is adequate to remove hospitals from PIP, consider all clean, non-PIP bills. Select cases based upon: