CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 830

Department of Health & Human Services (DHHS)

Center for Medicare & Medicaid Services (CMS)

Date: FEBRUARY 2, 2006

Change Request 4041

SUBJECT: Denial of Claims Not Timely Filed

I. SUMMARY OF CHANGES: On June 30, 2005, CMS issues an amendment (70 Fed. Reg. 37700) to correct technical errors in the interim final rule entitled "Medicare Program: Changes to the Medicare Claims Appeal Procedures (42 CFR Parts 401 and 405)" that CMS issued on March 8, 2005 (70 Fed. Reg. 11420). Among the corrections was one that clarified that a determination regarding the untimely submission of a claim is not an initial determination. Thus, a claim that is denied because it was not timely filed is not subject to appeal.

NEW/REVISED MATERIAL
EFFECTIVE DATE: July 1, 2006
IMPLEMENTATION DATE: July 3, 2006

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. 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: (N/A if manual is not updated)
R = REVISED, N = NEW, D = DELETED – *Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	1/Table of Contents
R	1/70/Time Limitations for Filing Provider Claims to Fiscal Intermediaries and Carriers
R	1/70.4/Determination of Untimely Filing and Resulting Actions
R	1/70.8.6/Time Limitations for Filing Part B Reasonable Charge and Fee Schedule Claims
R	21/50/50.25/Time Limit for Filing

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 830	Date: February 2, 2006	Change Request 4041

SUBJECT: Denial of Claims Not Timely Filed

I. GENERAL INFORMATION

A. Background: On June 30, 2005, CMS issued an amendment (70 Fed. Reg. 37700) to correct technical errors in the interim final rule entitled "Medicare Program: Changes to the Medicare Claims Appeal Procedures (42 CFR Parts 401 and 405)" that CMS issued on March 8, 2005 (70 Fed. Reg. 11420). Among the corrections was one that clarified that a determination regarding the untimely submission of a claim is not an initial determination. Thus, a claim that is denied because it was not timely filed is not subject to appeal.

B. Policy: A determination that a provider or supplier failed to submit a claim timely or failed to submit a timely claim despite being requested to do so by the beneficiary or the beneficiary's subrogee is not an initial determination and is not appealable. (42 CFR §405.926(n)).

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4041.1	The contractor shall deny a claim received after the timely filing period (as specified in the Medicare Claims Processing Manual, Publication 100-4, Chapter 1, §70).	X	X	X	X	X	X	X		
4041.1.1	The contractor shall apply the appropriate denial messages as follows: Reason code 29: The time limit for filing has expired. Remark code N211 – You may not appeal this decision.	X	X	X	X	X	X	X		

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4041.2	Contractors shall not afford appeal rights on a denial that was the result of a claim being received after the timely filing period (as specified in the Medicare Claims Processing Manual, Publication 100-4, Chapter 1, §70).	X	X	X	X	X	X	X		
4041.3	Contractors shall not allow a grace period for claims received after the timely filing period.	X	X	X	X	X	X	X		
4041.4	Contractors shall use the following MSN message: 25.3 – The time limit for filing your claim has expired therefore appeal rights are not applicable for this claim. 25.3 – El limite de tiempo para someter su reclamación ha expirado; por lo tanto, los derechos de apelación no se aplican a esta reclamación.	X	X	X	X	X	X	X		

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4041.4	A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct	X	X	X	X					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: July 1, 2006 **Implementation Date:** July 3, 2006 **Pre-Implementation Contact(s):** Angie Costello at angie.costello@cms.hhs.gov. **Post-Implementation Contact(s):**	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

***Unless otherwise specified, the effective date is the date of service.**

Medicare Claims Processing Manual

Chapter 1 - General Billing Requirements

Table of Contents

(Rev.830, 02-02-06)

1/70/Time Limitations for Filing Provider Claims to Fiscal Intermediaries *and Carriers*

70.4 – Determination of Untimely Filing and Resulting Actions

70 - Time Limitations for Filing Provider Claims to Fiscal Intermediaries *and Carriers*

(Rev.830, Issued: 02-02-06, Effective: 07-01-06, Implementation: 07-03-06)

Medicare regulations at 42 CFR 424.44 define the timely filing period for Medicare fee-for service claims. In general, such claims must be filed on, or before, December 31 of the calendar year following the year in which the services were furnished. (See section §70.7 below for details of the exceptions.) 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.

70.4 - Determination of *Un*timely Filing and Resulting Actions

(Rev.830, Issued: 02-02-06, Effective: 07-01-06, Implementation: 07-03-06)

Medicare denies a claim that is not filed timely as specified in §70.1. Medicare determines whether a claim has been filed timely by comparing the date the services were furnished (line item date or claim statement "from" date) to the receipt date applied to the claim when it is received. If the span between these two dates exceeds the time limitation *specified* in §70.1, the claim is considered to have been *not timely* filed. *When a claim is denied for having been filed after the timely filing period, such denial does not constitute an "initial determination". As such, the determination that a claim was not filed timely is not subject to appeal.*

Where the beneficiary request for payment was filed timely (or would have been filed the request timely had the provider taken action to obtain a request from the patient whom the provider knew or had reason to believe might be a beneficiary) but the provider is responsible for not filing a timely claim, the provider may not charge the beneficiary for the services except for such deductible and/or coinsurance amounts as would have been appropriate if Medicare payment had been made. In appropriate cases, such claims should be processed because of the spell-of-illness implications and/or in order to record the days, visits, cash and blood deductibles. The beneficiary is charged utilization days, if applicable for the type of services received.

When a claim is received from a provider paid on a cost basis where only part of the services were filed within the timely filing period, FIs must reject the claim. The provider may resubmit the services, splitting them into two claims with discrete periods before and

on or after October 1. For example, if an FI received a claim on February 3, 2002, for provider services furnished from September 16, 2000, through October 30, 2000, services furnished before October 1 are rejected because the time for filing the September services expired December 31, 2001.

This same principle is applied to services paid on a fee or bundled basis for which payments can be divided into discrete periods before and after October 1. However, if services spanning October 1 are subject to prospective payment bundling provisions and cannot be split in this fashion, the contractor shall apply the timely filing period for the fourth quarter of the calendar year to the entire claim.

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

(Rev.830, Issued: 02-02-06, Effective: 07-01-06, Implementation: 07-03-06)

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.) *When a claim is denied for having been filed after the timely filing period, such denial does not constitute an "initial determination". As such, the determination that a claim was not filed timely is not subject to appeal.*

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 ***2*** year***s***	Dec 31: Service year plus ***2*** year***s***	Dec 31: Service year plus ***2*** year***s***
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.

Medicare Claims Processing Manual
Chapter 21 - Medicare Summary Notices

50.25 - Time Limit for Filing

(Rev.830, Issued: 02-02-06, Effective: 07-01-06, Implementation: 07-03-06)

25.1 - This claim was denied because it was filed after the time limit.

25.2 - You can be billed only 20% of the charges that would have been approved.

25.3 – The time limit for filing your claim has expired, therefore appeal rights are not applicable for this claim.