CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 697	**Date: May 7, 2010**
	Change Request 6960

SUBJECT: Systems Changes Necessary to Implement the Patient Protection and Affordable Care Act (PPACA) Section 6404 - Maximum Period for Submission of Medicare Claims Reduced to Not More Than 12 Months

I. SUMMARY OF CHANGES: The time period for filing Medicare FFS claims is specified in sections 1814(a), 1835(a)(1), and 1842(b)(3) of the Social Security Act and in the Code of Federal Regulations (CFR), 42 CFR Section 424.44. Section 6404 of the Patient Protection and Affordable Care Act (PPACA) amended the timely filing requirements to reduce the maximum time period for submission of all Medicare FFS claims to one calendar year after the date of service.

EFFECTIVE DATE: January 1, 2010
IMPLEMENTATION DATE: October 4, 2010

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
N/A	

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One-Time Notification

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

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 697	Date: May 7, 2010	Change Request: 6960

SUBJECT: **Systems Changes Necessary to Implement the Patient Protection and Affordable Care Act (PPACA) Section 6404 - Maximum Period for Submission of Medicare Claims Reduced to Not More Than 12 Months**

Effective Date: January 1, 2010

Implementation Date: October 4, 2010

I. GENERAL INFORMATION

A. Background: Sections 1814(a), 1835(a)(1), and 1842(b)(3) of the Social Security Act as well as the Code of Federal Regulations (CFR), 42 CFR Section 424.44 specify the timely filing limits for submitting claims for Medicare Fee-for-Service (FFS) reimbursement. As indicated in the regulation, the service provider or supplier must submit the claim for services furnished on or before December 31 of the following year for dates of service occurring during the first nine (9) months of the year. For services furnished during the last quarter of the calendar year, the provider or supplier must submit the claim on or before December 31st of the second following year.

Section 6404 of PPACA amended the timely filing requirements to reduce the maximum time period for submission of all Medicare Fee-for-Service claims to one calendar year after the date of service. These amendments apply to services furnished on or after January 1, 2010. Additionally, this section mandates that all claims for services furnished prior to January 1, 2010 must be filed with the appropriate Medicare claims processing contractor no later than December 31, 2010.

B. Policy: Medicare contractors shall adjust (as necessary) all relevant system edits so that:
1) claims with dates of service prior to October 1, 2009 will be subject to pre-PPACA timely filing rules and associated edits;
2) claims with dates of service October 1, 2009 through December 31, 2009 received after December 31, 2010 will be denied as being past the timely filing statute and;
3) claims with dates of service on or after January 1, 2010 received more than 1 calendar year beyond the date of service will be denied as being past the timely filing statute (ex: claim DOS = 3/15/10, claim must be received by COB 3/15/11).

Claims for services that require the reporting of a line item date of service, the line item date is used to determine the date of service. For other claims, the claim statement's "From" date is used to determine the date of service.

Section 6404 of PPACA gives CMS the authority to specify exceptions to the one (1) calendar year time limit for filing claims. Currently, there is one exception found in the timely filing regulations at 42 CFR section 424.44(b)(1), for "error or misrepresentation" of an employee, Medicare contractor, or agent of the Department that was performing Medicare functions and acting within the scope of its authority. If CMS adds additional exceptions or modifies the existing exception to the timely filing regulations, specific instructions will be issued at a later date explaining those changes.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6960.1	Contractors shall continue to subject claims with dates of service prior to October 1, 2009 to all relevant timely filing edits put in place prior to the effective date of this CR.	X	X	X	X	X	X	X	X		
6960.2	Contractors shall adjust all relevant claims processing system edits to ensure that claims with dates of service October 1, 2009 through December 31, 2009 received after December 31, 2010 will be denied as being past the timely filing statute.	X	X	X	X	X	X	X	X		
6960.3	Contractors shall adjust all relevant claims processing system edits to ensure that claims with dates of service January 1, 2010 and beyond received more than 1 calendar year from the claim's date of service will be denied as being past the timely filing statute.	X	X	X	X	X	X	X	X		
6960.4	Contractors shall use the following remittance advice and MSN messages when denying claims as specified in 6960.1, 6960.2, and 6960.3: Reason code 29 - The time limit for filing has expired. Remark code N211 – You may not appeal this decision. Group code CO – Contractual Obligation 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	X		
6960.5	Contractors shall continue to determine whether a claim has been filed timely (within 1 calendar year from the date of service) according to the instructions contained in the Medicare Claims Processing Manual, Publication 100-04, Chapter 1, §70.	X	X	X	X	X	X	X	X	X	

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6960.6	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X	X	X	X					

IV. SUPPORTING INFORMATION

Section A:
"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
6960.7	Sec. 6404 of the Patient Protection and Affordable Care Act of 2010

Section B: N/A

V. CONTACTS

Pre-Implementation Contact(s): Contact David Walczak by email at David.Walczak@cms.hhs.gov.

Post-Implementation Contact(s): Contact the appropriate CMS Regional Office.

VI. FUNDING

Section A: No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.