CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 12909	**Date: October 24, 2024**
	Change Request 13834

SUBJECT: Corrections to Change Request (CR) 7270 - Changes to the Time Limits for Filing Medicare Fee For Service Claims

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to delete section 70.8.8 of Pub. 100-04, ch.1 because it should have been deleted by CR 7270. We are also making the correction of renumbering sections 70.8.8.6, 70.8.8.7, and 70.8.8.8 of Pub. 100-04, ch. 1 to sections 70.8.6.1, 70.8.6.2, and 70.8.6.3 because those three sections were numbered incorrectly in CR 7270.

EFFECTIVE DATE: November 26, 2024
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: November 26, 2024

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	1/70.4/Determination of Untimely Filing and Resulting Actions
R	1/70.5/Application to Special Claim Types
R	1/70.6/Filing Claim Where General Time Limit Has Expired
R	1/70.7/Exceptions Allowing Extension of Time Limit
R	1/70.8.3/Methods of Claiming Benefits for Services by Physicians and Suppliers
D	1/70.8.8/Penalty for Filing Claims after One Year
D	1/70.8.8.6/Monitoring Claims Submission Violations
D	1/70.8.8.7/Notification Letters
D	1/70.8.8.8/Violations That Are Not Developed For Referral
N	1/70.8.6.1/Monitoring Claims Submission Violations
N	1/70.8.6.2/Notification Letters
N	1/70.8.6.3/Violations That Are Not Developed For Referral

III. FUNDING:

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:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 12909	Date: October 24, 2024	Change Request: 13834

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II. GENERAL INFORMATION

A. Background: Sections 1814(a)(1), 1835(a)(1), and 1842(b)(3)(B) of the Social Security Act, as well as the Medicare regulations at 42 C.F.R. §424.44, specify the time limits for filing Medicare fee-for-service (Part A and Part B) claims. Prior to the passage of the Patient Protection and Affordable Care Act (the Affordable Care Act), on March 23, 2010, a provider or supplier had from 15 to 27 months, depending on the date of service, to file a timely claim. For services furnished in the first 9 months of a calendar year, claims had to be submitted to the appropriate Medicare contractor by December 31 of the following year. Claims for services furnished in the last 3 months of a calendar year had to be submitted by December 31 of the second following year.

Section 6404 of the Affordable Care Act (the ACA) reduced the maximum period for submission of all Medicare fee-for-service claims to no more than 12 months (1 calendar year) after the date services were furnished. This time limit policy became effective for services furnished on or after January 1, 2010. In addition, claims for services furnished prior to January 1, 2010, have to be submitted no later than December 31, 2010. Section 6404 of the ACA also mandated that the Secretary may specify exceptions to the 1 calendar year time limit for filing Medicare claims.

B. Policy: We are correcting several issues in this CR that should have been corrected by CR 7270.

III. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
13834.1	Contractors shall refer to sections 70 - 70.8.6.3 of Publication 100-04, Chapter 1, Medicare Claims Processing Manual for information regarding the time limits for filing Medicare Part A and Part	X	X	X	X					

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	B claims.									

IV. PROVIDER EDUCATION

None

Impacted Contractors: None

V. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

VI. CONTACTS

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VII. FUNDING

Section A: 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.

ATTACHMENTS: 0

Medicare Claims Processing Manual
Chapter 1 - General Billing Requirements

Table of Contents
(Rev. 12909; Issued: 10-24-24)

Transmittals for Chapter 1

70.4 - Determination of Untimely Filing and Resulting Actions

(Rev. 12909; Issued: 10-24-24; Effective: 11-26-24; Implementation: 11-26-24)

Medicare denies a claim for untimely filing if the receipt date applied to the claim exceeds 12 months or 1 calendar year from the date the services were furnished (i.e., generally, the "From" date, with the exception of the "Through" date for institutional claims that have span dates of services, as specified in §70.1). 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 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.

70.5 - Application to Special Claim Types

(Rev. 12909; Issued: 10-24-24; Effective: 11-26-24; Implementation: 11-26-24)

- Adjustments - If a provider fails to include a particular item or service on its initial claim, an adjustment submission to include such an item(s) or service(s) is not permitted after the expiration of the time limitation for filing of the initial claim. There is no longer *a* timely filing period for adjustments. There are special timeliness requirements for filing adjustment requests for inpatient services subject to a prospective payment system, if the adjustment results in a change to a higher weighted DRG. These adjustments must be submitted within 60 days of the date of the remittance for the original claim, or the adjustment will be rejected.

- Reopenings - However, to the extent that an adjustment bill otherwise corrects or supplements information previously submitted on a timely claim about specified services or items furnished to a specified individual, it is subject to the rules governing administrative finality, rather than the time limitation for filing (see Chapter 34 on Re-openings). These claims must be submitted with a "Q" in the 4th position of the Type of Bill to identify them as a Reopening.

- Emergency Hospital Services and Services Outside the United States - The time limit for claims for payment for emergency hospital services and hospital services outside the United States, whether or not the hospital has elected to bill the program, is the same as for participating hospitals. (See §70.1 above.) The claim for emergency hospital services and other services outside the United States will be considered timely filed if filed with any A/B MAC (A) within the time limit.

- Home health Requests for Anticipated Payment (RAPs) - Since by regulation RAPs are not claims for purposes of Title 18 of the Social Security Act, timely filing enforcement will be bypassed for any RAP for which the associated home health prospective payment system (HH PPS) claim could still be timely. RAPs for which the associated HH PPS claim could not still be timely will continue to be rejected, to prevent payment of RAP amounts that would be subject to recovery later.

70.6 - Filing Claim Where General Time Limit Has Expired

(Rev. 12909; Issued: 10-24-24; Effective: 11-26-24; Implementation: 11-26-24)

As a general rule, where the contractor receives a late filed claim submitted by a provider or supplier with no explanation attached as to the circumstances surrounding the late filing, the contractor should assume that the provider or supplier accepts responsibility for the late filing.

Where it comes to the attention of a provider or supplier that health services that are or may be covered were furnished to a beneficiary but that the general time limit (defined in §70.1 above) on filing a claim for such services has expired, the provider or supplier should take the following action.

- Where the provider or supplier accepts responsibility for late filing, it should file a no-payment claim. (See Chapter 3 for no-payment bill processing instructions.) Where the provider or supplier believes the beneficiary is responsible for late filing, it should contact the contractor and also file a no-payment claim and include a statement in the remarks field on the claim explaining the circumstances which led to the late filing and give the reasons for believing that the beneficiary (or other person acting for him/her) is responsible for the late filing. If a paper claim is submitted, such a statement may be attached and, if practicable, may include the statement of the beneficiary as to the beneficiary's view on these circumstances.

- Where the beneficiary does not agree with the determination that the claim was not filed timely or the determination that he/she is responsible for the late filing, the usual appeal rights are available to the beneficiary. Where the provider or supplier is protesting the denial of payment or the assignment of responsibility, no formal channels of appeal are available. However, the contractor may, at the request of the provider or supplier, informally review its initial determination.

70.7 - Exceptions Allowing Extension of Time Limit

(Rev. 12909; Issued: 10-24-24; Effective: 11-26-24; Implementation: 11-26-24)

Medicare regulations at 42 C.F.R. §424.44(b) allow for the following exceptions to the 1 calendar year time limit for filing fee for service claims:

(1) Administrative error, if failure to meet the filing deadline was caused by 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 (See 70.7.1).

(2) Retroactive Medicare entitlement, where a beneficiary receives notification of Medicare entitlement retroactive to or before the date the service was furnished. For example, at the time services were furnished the beneficiary was not entitled to Medicare. However, after the timely filing period has expired, the beneficiary subsequently receives notification of Medicare entitlement effective retroactively to or before the date of the furnished service (See 70.7.2).

(3) Retroactive Medicare entitlement involving State Medicaid Agencies, where a State Medicaid Agency recoups payment from a provider or supplier 6 months or more after the date the service was furnished to a dually eligible beneficiary. For example, at the time the service was furnished the beneficiary was only entitled to Medicaid and not to Medicare. Subsequently, the beneficiary receives notification of Medicare entitlement effective retroactively to or before the date of the furnished service. The State Medicaid Agency recoups its money from the provider or supplier and the provider or supplier cannot submit the claim to Medicare, because the timely filing limit has expired (See 70.7.3).

(4) Retroactive disenrollment from a Medicare Advantage (MA) plan or Program of All-inclusive Care of the Elderly (PACE) provider organization, where a beneficiary was enrolled in an MA plan or PACE provider organization, but later was disenrolled from the MA plan or PACE provider organization retroactive to or before the date the service was furnished, and the MA plan or PACE provider organization recoups it payment from a provider or supplier 6 months or more after the date the service was furnished (See 70.7.4).

The conditions for meeting each exception, and a description of how filing extensions will be calculated, are described in sections 70.7.1 – 70.7.4.

Where the initial request for an exception to the timely filing limit is made by a provider or supplier, the Medicare contractor has responsibility for determining whether a late claim may be honored based on all pertinent documentation submitted by the provider or supplier, and for the exceptions described in sections 70.7.2 and 70.7.3, based on its review of the relevant information contained in the Common Working File (CWF) database. As explained in sections 70.7.1 – 70.7.4, the contractor will determine if the requirements for a particular exception are met. However, in certain circumstances, the contractor may contact the appropriate CMS regional office (RO) to ascertain whether it wants to participate in the review and decision-making of the specific exception request. In limited circumstances, the RO may conclude that the exception request should go to CMS Central Office for a final determination.

70.8.3 - Methods of Claiming Benefits for Services by Physicians and Suppliers

(Rev. 12909; Issued: 10-24-24; Effective: 11-26-24; Implementation: 11-26-24)

The method of claiming Part B benefits depends upon whether the patient is claiming payment or is assigning benefit payments to his/her source of medical treatment or services.

As a rule, beneficiaries do not submit claims for reimbursement. However, if there is reason for a beneficiary to submit a claim for reimbursement, the beneficiary uses the CMS-1490S. For covered services furnished on or after September 1, 1990, physicians and suppliers must complete and submit in accordance with SSA §1848(g)(4)(A) all Part B claims whether assigned or unassigned for beneficiaries who desire Medicare benefit payment determinations.

The physician/supplier or the facility or organization to which the physician may reassign benefits, claims the payment. The patient or his representative agrees to assign the benefits and the physician/supplier agreeing to the assignment accepts the Medicare reasonable charge determination as the full charge for the services. (See §§*30.2 through 30.3.8* about specific assignment procedures and the nature and effect of assignments.)

70.8.6.1 – Monitoring Claims Submission Violations

(Rev. 12909; Issued: 10-24-24; Effective: 11-26-24; Implementation: 11-26-24)

A. General

Section 1848(g)(4) of the Social Security Act requires physicians and suppliers to submit claims to Medicare carriers for services furnished on or after September 1, 1990. It also prohibits physicians and suppliers from imposing a charge for completing and submitting a claim. Physicians and suppliers who fail to submit a claim or who impose a charge for completing the claim are subject to sanctions. CMS is responsible for assessing sanctions and monetary penalties for noncompliance.

Physicians and suppliers are not required to take assignment of Medicare benefits unless they are enrolled in the Medicare Participating Physician and Supplier Program or, in the case of physician services, the Medicare beneficiary is also a recipient of State medical assistance (Medicaid) or the service is otherwise subject to mandatory assignment.

B. Compliance Monitoring

To ensure that providers and suppliers are enrolled in the Medicare program and submit claims in compliance with the mandatory claims submission requirements found in §1848(g)(4) of the Social Security Act, contractors shall:

1) *Process beneficiary claims submitted to A/B MACs or carriers for services that are <u>not</u> covered by Medicare (e.g., for hearing aids, cosmetic surgery, personal comfort services, etc.; see 42 CFR 411.15 for details), in accordance with its normal processing procedures;*

2) *Process beneficiary claims submitted to A/B MACs or carriers for services that are covered by Medicare and the beneficiary has submitted a complete and valid claim (Form CMS-1490S) and all supporting documentation associated with the claim, including an itemized bill with the following information:*

- *Date of service,*
- *Place of service,*
- *Description of illness or injury,*
- *Description of each surgical or medical service or supply furnished,*
- *Charge for each service,*
- *The doctor's or supplier's name and address,*
- *The provider or supplier's National Provider Identifier (NPI)*
- *The ordering & referring provider's legal name and address and the National Provider Identifier (NPI) if known when the itemized bill is from:*
  A Clinical laboratory for ordered tests
  An independent diagnostic imaging center for ordered imaging procedures
  A supplier of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) for ordered DMEPOS

If the beneficiary furnishes all other information but fails to supply the provider or supplier's NPI the contractor shall not return the claim but rather look up the provider or supplier's NPI using the NPI registry. If the contractor determines that the provider or supplier was not a Medicare enrolled provider with a valid NPI, the contractor shall follow previously established procedures in order to process and adjudicate the claim.

3) *Retain the Form-1490S and supporting documentation and manually return a copy to the beneficiary if it is for a Medicare-covered service and the claim is incomplete, does not include all required supporting documentation and/or contains invalid information. Contractors shall also include an appropriate letter that specifically communicates all the items listed above which were missing or invalid. In addition, the CMS-1490S and supporting documentation shall be maintained for purposes of the timely filing rules in the event that the beneficiary re-submits the claim.*

If the Beneficiary submits a claim on the English or Spanish Form CMS-1490S (version 01/05) on or after April 1, 2019, manually return the Form CMS-1490S (version 01/05) claim to the beneficiary, and include a copy of the Form CMS-1490S (version 01/18), along with a letter instructing the beneficiary to complete and return the Form CMS-1490S (version 01/18) for processing within the time period prescribed in §70.5.

If a beneficiary submits a claim on the Form CMS-1500, manually return the Form CMS-1500 claim to the beneficiary, and include a copy of the Form CMS-1490S, along with a letter instructing the beneficiary to complete and return the Form CMS-1490S for processing within the time period prescribed in §70.5, above. Include in the letter a description of missing, invalid or incomplete items required for the Form CMS-1490S that were not included with the submitted Form CMS-1500 or were invalid.

4) *Retain Medicare claims records using the following disposition rules.*

DISPOSITION:

1. Carriers who Microform Claims

a) Hardcopy Records - Cut off no later than the close of the calendar year (CY) in which paid. The hardcopy claim must be retained in accordance with the following:

(1) If a corresponding master microfilm has been made and verified, transfer to a Federally-approved records storage facility or hold onsite. Destroy after a total retention of 3 years after the close of the CY in which paid.

(2) If a corresponding master microform record has NOT been made and verified, transfer to a Federally-approved records storage facility or hold onsite. Destroy after a total retention of 6 years and 3 months after the close of the CY in which paid.

b) Microform Records

The master microform record must be retained for a total retention of 6 years and 3 months following the close of the calendar year in which paid.

2. Carriers Who Do Not Microfilm Claims Records

Cut off at the close of the calendar year (CY) in which paid, then transfer to a Federally-approved records storage facility. Destroy after a total retention of 6 years and 3 months. Earlier cutoff and transfer is authorized. However, the records must be retained for a total retention of 6 years and 3 months following the close of the calendar year in which payment is made.

a) Hardcopy Records - The hardcopy must be retained onsite until the microform has been verified. Cut off at the close of the calendar year in which paid; transfer hardcopy to a Federally-approved records storage facility only if there is a corresponding master microfilm record that can be retained for the period indicated in b. below; otherwise, the hardcopy shall be retained until the 6 years and 3 months period is reached. Earlier cutoff and transfer is authorized. However, the hardcopy must be retained for a total retention of 3 years after the close of the calendar year in which paid.

b) Microform Records - The master microform records must be retained for a total retention of 6 years and 3 months following the close of the calendar year in which payment is made.

When returning a beneficiary submitted claim, the contractor shall inform the beneficiary that the provider or supplier is required by law to submit a claim on behalf of the beneficiary (for services that would otherwise be payable), and that in order to submit the claim, the provider or supplier must enroll in the Medicare program. In addition, contractors shall encourage beneficiaries to always seek non-emergency care from a provider or supplier that is enrolled in the Medicare program.

If a beneficiary receives services from a provider or supplier that refuses to submit a claim to the A/B MAC or carrier, on the beneficiary's behalf, (for services that would otherwise be payable by Medicare), and/or refuses to enroll in the Medicare program, the beneficiary should:

(1) Notify the contractor in writing that the provider or supplier refused to submit a claim to Medicare and/or refused to enroll in Medicare, and

(2) Submit a complete Form CMS-1490S with all supporting documentation.

*The contractor shall process and pay the beneficiary's claim if it is for a service that would be payable by Medicare were it not for the provider or supplier's refusal or inability to submit the claim and/or enroll in Medicare. Claims shall be adjudicated based on whether the service provided is covered or non-covered/excluded rather than on the provider's enrollment status. If f*or a covered service, the claim shall be processed and the allowed amount reimbursed to the beneficiary, if appropriate. If for a non-covered/excluded service, the claim shall be processed and denied with an appropriate MSN message. For sanctioned/excluded and opt-out physicians/practitioners the following MSN messaging is recommended:

<u>Sanctioned/Excluded provider or supplier:</u>

A sanctioned or excluded provider or supplier is an individual or business excluded from participation in the Medicare program for a stated period of time as a result of fraudulent activity, program abuse, or

impermissible conduct as determined by OIG. CMS will pay the first claim submitted by a beneficiary for the services of a sanctioned/excluded physician or practitioner and immediately notify the sanctioned/excluded physician or practitioner of the exclusion. CMS will not pay a claim for sanctioned/excluded physician or practitioner services more than 15 days after the date on the notice to the physician or practitioner, or after the effective date of the exclusion, whichever is later. Under no circumstance may Medicare payment be made to any entity, including beneficiaries, for services rendered by such providers or suppliers after the first claim is paid. An example of language that may be considered:

MSN Message 21.27

English
Services provided by a Medicare sanctioned/excluded provider or supplier. No Medicare payment may be made.

Spanish
Los servicios fueron brindado por un proveedor excluído de Medicare, por lo tanto Medicare no pagó por los servicios.

Opt-Out physicians and practitioners:

Medicare payment may be made for the claims submitted by a beneficiary for the services of an opt out physician or practitioner when the physician or practitioner did not privately contract with the beneficiary for services that were not emergency care services or urgent care services and that were furnished no later than 15 days after the date of a notice by the carrier that the physician or practitioner has opted out of Medicare (see 42 C.F.R. 405.435(c)). Therefore, if the beneficiary submits a claim for a service that was furnished by an opt out physician or practitioner, then the carrier must contact the opt out physician or practitioner in order to ascertain whether the beneficiary entered into a private contract with the opt out physician or practitioner. (Note: The carrier should obtain a copy of the private contract from the opt out physician/practitioner before denying the beneficiary's claim if the beneficiary did, in fact, enter into a private contract with the physician or practitioner.) If the beneficiary did not enter into a private contract with the physician or practitioner and the beneficiary did not receive notice from the carrier that the physician opted out of Medicare, then Medicare payment may be made to the beneficiary for the non-emergency and/or non-urgent care services (assuming that the services would otherwise be payable). On the other hand, if the beneficiary did enter into a private contract with the physician or practitioner for the services or received services from the physician/practitioner 15 days after the date of a notice by the carrier that the physician or practitioner has opted out of Medicare, then no Medicare payment may be made. Medicare has instructed opt out physicians and practitioners that private contract language must include beneficiary instruction precluding the beneficiary from billing Medicare for these services. An example of language that may be considered:

MSN Message 21.26

English
Claim denied because services were provided by an Opt-Out physician or practitioner. No Medicare payment may be made.

Spanish
La reclamación fue denegada porque los servicios fueron brindados por un médico ó proveedor que decidió no participar en Medicare, por lo tanto, Medicare no pagó por los servicios.

Contractors shall maintain documentation of beneficiary complaints involving violations of the mandatory claims submission policy and a list of the top 50 violators, by State, of the mandatory claim submission policy.

Contractors are encouraged to educate providers and suppliers that they must be enrolled in the Medicare program before they submit claims for services furnished or supplied to any Medicare beneficiary.

The above policy, including the NPI requirement, is not applicable for foreign beneficiary claims submitted for covered services. These claims should be processed using guidelines for foreign claims.

The above policy, including the NPI requirement, is not applicable to beneficiary claims submitted to DMEMACs for durable medical equipment, prosthetics, orthotics, and supplies. These claims should be processed by DMEMACs using current procedures.

C. Exception When Physician, Other Practitioner, or Supplier Is Excluded From Participating in Medicare Program

*Section 1848(g)(4) of the Social Security Act requires physicians, other practitioners, or suppliers to submit claims to Medicare carriers for services furnished after September 1, 1990. This **does not** apply to physicians, other practitioners, or suppliers who have been excluded from participating in the Medicare program. Physicians, other practitioners, and suppliers who have been excluded from the Medicare program are prohibited from submitting claims or causing claims to be submitted. See the Medicare Program Integrity Manual for procedures concerning claims submitted by an excluded practitioner, his/her employer, or a beneficiary for services or items provided by an excluded physician, other practitioner, or supplier. Carriers must maintain the systems capability to identify claims submitted by excluded physicians, other practitioners, or suppliers as well as items or services provided, ordered, prescribed, or referred by an excluded party.*

*When an excluded physician, other practitioner, or supplier has not submitted a claim on behalf of the beneficiary and/or the beneficiary has submitted the claim themselves, do **not** send a notification letter to the physician, other practitioner, or supplier warning of civil monetary penalties due to noncompliance with §1848(g)(4)(A) of the Act. Instead, follow the instructions in the Program Integrity Manual.*

70.8.6.2 – Notification Letters
(Rev. 12909; Issued: 10-24-24; Effective: 11-26-24; Implementation: 11-26-24)

A. *The letter sent to the beneficiary should explain why the claim is being returned including an explanation of the corrections needed in order to process the claim. Also, include an explanation of the statutory requirement that providers and suppliers must submit claims for all covered services provided to Medicare beneficiaries. The letter should also provide the beneficiary with instructions on what should be done if the provider or supplier refuses to enroll with Medicare and/or submit the claim.*

B. *A letter shall also be sent to the provider or supplier explaining the statutory requirement for submitting claims for all services rendered to Medicare beneficiaries. The letter should explain to the provider or supplier that they are required to enroll with the Medicare program before a claim can be submitted. Finally the letter should include language explaining the penalties for failure to comply with the mandatory claims submission requirements.*

70.8.6.3 - Violations That Are Not Developed For Referral
(Rev. 12909; Issued: 10-24-24; Effective: 11-26-24; Implementation: 11-26-24)

Claim submission violations need not be developed on beneficiary-submitted Form CMS-1490S claims that include approved charges for services performed on or after September 1, 1990 in the following situations:

- *Used DME purchases from private sources;*

- *Cases in which a physician/supplier does not possess information essential for filing a MSP claim. Assume this is the case if the beneficiary files a MSP claim and encloses the primary insurer's payment determination notice and there is no indication that the service provider was asked to file but refused to do so;*

- *Services paid under the indirect payment procedure;*
- *Foreign claims; and*
- *Other unusual or unique situations that you evaluate on a case-by-case basis.*

NOTE: *It is unlikely that knowing, willful, and repeated noncompliance will apply in the above situations.*