CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1312	**Date: JULY 20, 2007**
	Change Request 5513

SUBJECT: Timeliness Standards for Processing Other-Than-Clean Claims

I. SUMMARY OF CHANGES: On February 2, 2007, CMS published instructions to implement requirements for all carriers and Medicare Administrative Contractors (MACs) for timeliness for processing ýother-than-cleaný claims. This instruction implements those same requirements for the Fiscal Intermediaries (FIs), the institutional branches of MACs, and the Durable Medical Equipment (DME) MACs.

New / Revised Material
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

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
N	1/80.3.3/Timeliness Standards for Processing Other-Than-Clean Claims

III. FUNDING:
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2008 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: 1312	Date: July 20, 2007	Change Request: 5513

SUBJECT: Timeliness Standards for Processing Other-Than-Clean Claims

Effective Date: January 1, 2008

Implementation Date: January 7, 2008

I. GENERAL INFORMATION

A. Background:

The Social Security Act, at §1869(a)(2), mandates that Medicare process all "other-than-clean" claims and notify the individual filing such claims of the determination within 45 days of receiving such claims.

Claims that do not meet the definition of "clean" claims are "other-than-clean" claims. "Other-than-clean" claims require investigation or development external to the contractor's Medicare operation on a prepayment basis.

On February 2, 2007, CMS published instructions to implement requirements for all carriers and Medicare Administrative Contractors (MACs) for timeliness for processing "other-than-clean" claims. This instruction implements those same requirements for the Fiscal Intermediaries (FIs), the institutional branches of MACs, and the Durable Medical Equipment (DME) MACs.

B. Policy:

The contractor shall process all "other-than-clean" claims and notify the provider and beneficiary of the determination within 45 calendar days of receipt. (See Medicare Claims Processing Manual, Publication 100-4, Chapter 1, §80.2.1 for the definition of "receipt date" and for timeliness standards for clean claims.) However, when the contractor develops the claim by asking the provider/supplier or beneficiary for additional information, the contractor shall cease counting the 45 calendar days on the day that the contractor sends the development letter. Upon receiving the materials requested in the development letter from the provider/supplier and/or beneficiary, the contractor shall resume counting the 45 calendar days.

EXAMPLE:

The contractor receives a claim on June 1st, but does not send a development letter to the provider/supplier/ and/or beneficiary until June 5th. In this situation, 5 of the 45 allotted calendar days will have already passed before the contractor requested the additional information. Upon receiving the information back from the provider/supplier and/or beneficiary, the contractor has 40 calendar days left to process the claim and notify the individual that filed the claim of the payment determination for that claim.

Contractors shall follow existing procedures relative to both the length of time the provider/supplier and/or beneficiary is afforded to return information requested in the development letters and situations where the provider/supplier and or beneficiary does not respond.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)											
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	EDC	Shared-System Maintainers				OTHER
									FISS	MCS	VMS	CWF	
5513.1	For dates of receipt on and after January 1, 2008, the contractor shall process all "other-than-clean" claims and notify the provider filing the claim within 45 calendar days of receipt, except as noted in subsequent requirements below.	X	X	X			X						
5513.1.1	When the contractor requests additional information from the provider/supplier or beneficiary, or from another contractor (e.g., the Coordination of Benefits Contractor, another claims processing contractor), the contractor shall cease counting the 45 calendar days on the day that the contractor generates the development letter. Upon receiving the materials requested in the development letter from the provider/supplier and/or beneficiary, the contractor shall resume counting the 45 calendar days.	X	X	X			X		X		X		
5513.1.2	Contractors shall follow existing procedures relative to the length of time the provider/supplier or beneficiary, or to another contractor (e.g., the Coordination of Benefits Contractor, another claims processing contractor) is afforded to return information requested in the development letters.	X	X	X			X		X		X		
5513.1.3	Contractors shall follow existing procedures relative to situations where the provider/supplier, beneficiary or other contractor does not respond.	X	X	X			X						
5513.1.4	These standards do not apply to claims in development due to processing requirements (e.g., medical review, PSC development), in Publication 100-08, the Medicare Program Integrity Manual.	X	X	X			X		X		X		
5513.1.5	Claims where the Social Security Administration blocks a beneficiary's Health Insurance Claim (HIC) Number are not subject	X	X	X			X		X		X		

Number	Requirement	Responsibility (place an "X" in each applicable column)											
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	EDC	Shared-System Maintainers				OTHER
									FISS	MCS	VMS	CWF	
	to this instruction.												
5513.1.6	Claims that the contractors are required to hold due to CMS instructions are not subject to this instruction.	X	X	X			X		X		X		
5513.1.7	This instruction does not apply to translator rejects.	X	X	X			X		X		X		
5513.1.8	Claims where CWF is unable to process due to technical issues with the CWF beneficiary record or beneficiary identification issues are not subject to the requirements of the CR.	X	X	X			X		X		X	X	
5513.1.9	Contractors shall exempt claims submitted by a hospice from the mandated 45 day timeliness standard for "other-than-clean" claims and process per instructions in Pub 100-4, Chapter 1, Section 50.2.3.						X		X				
5513.2	Processing of claims in development will be based on the Julian date of receipt.	X	X	X			X		X		X		
5513.3	Claims developed due to the PIM shall be excluded for purposes of reporting to the 45 day "other-than-clean" claims rule on CROWD Form Y.	X	X	X			X		X		X		
5513.3.1	In producing claim data for reporting CROWD Form Y, the shared systems maintainers shall build reporting logic to exclude all claims not subjected to the 45 day "other-than-clean" claims rule. Exclusions are noted in requirements 5513.1.4 - 5513.1.8 and 5513.3.	X	X	X			X		X		X		
5513.4	For purposes of this instruction, the standard remittance advice (RA) and Medicare Summary Notice (MSN) satisfy the requirement to notify the provider/supplier and beneficiary of the payment determination.	X	X	X			X		X		X		
5513.4.1	Contractors send MSNs to beneficiaries on a quarterly basis and this practice will not change. Therefore, contractors shall notify beneficiaries of the payment determination on the next available quarterly MSN.	X	X	X			X		X		X		
5513.5	The contractors and shared systems maintainers shall continue to send data to the Claims Processing Timeliness (CPT) reports in the	X	X	X			X		X		X		

Number	Requirement	Responsibility (place an "X" in each applicable column)											
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	EDC	Shared-System Maintainers				OTHER
									FISS	MCS	VMS	CWF	
	Contractor Reporting of Operational and Workload Data (CROWD) in the same manner they always have. Nothing in this instruction requires changes to CPT reporting in CROWD.												
5513.6	Contractors shall report the number of other-than-clean claims processed in 45 days or less (using the method to calculate the 45 days as detailed in 5513.1) on Form Y of the CROWD system.	X	X	X			X		X		X		CROWD
5513.6.1	Report this number under column 1 on a line using code "0005" as the identifier.	X	X	X			X		X		X		CROWD
5513.7	Contractors shall report the number of "other-than-clean" claims processed in 46 days or longer (using the method to calculate the 45 days as detailed in 5513.1, with the exception of claims subject to requirements 5513.1.4 through 5513.1.9) on Form Y of the CROWD system.	X	X	X			X		X		X		CROWD
5513.7.1	Report this number under column 1 on a line using code "0006" as the identifier.	X	X	X			X		X		X		CROWD

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)											
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	EDC	Shared-System Maintainers				OTHER
									FISS	MCS	VMS	CMS	
5513.8	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	X	X	X			X						

Number	Requirement	Responsibility (place an "X" in each applicable column)											
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									FISS	MCS	VMS	CMS	
	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.												

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
All requirements	Note that these requirements have already been implemented for the carriers under CR 5355. This instruction implements these same requirements, but for DME MACs and FIs.

B. For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s):

Stuart Barranco for FIs/MAC institutional claims at stuart.barranco@cms.hhs.gov or 410-786-6152, Renée Hildt for DME MAC claims at renee.hildt@cms.hhs.gov or (410) 786-1446

Post-Implementation Contact(s):

Stuart Barranco for FIs/MAC institutional claims at stuart.barranco@cms.hhs.gov or 410-786-6152, Renée Hildt for DME MAC claims at renee.hildt@cms.hhs.gov or (410) 786-1446

VI. FUNDING

A. ***For Fiscal Intermediaries, Carriers, and the Durable Medical Equipment Regional Carrier (DMERC),*** **use only one of the following statements:**

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2008 operating budgets.

B. ***For Medicare Administrative Contractors (MAC),*** **use only one of the following statements:**

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified 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.

Medicare Claims Processing Manual

Chapter 1 - General Billing Requirements

Table of Contents

(Rev.1312, 07-20-07)

80.3.3 – Timeliness Standards for Processing Other-Than-Clean Claims

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(Rev. 1312, Issued: 07-20-07, Effective: 01-01-08, Implementation: 01-07-08)

The Social Security Act, at § 1869(a)(2), mandates that Medicare process all "other-than-clean" claims and notify the individual filing such claims of the determination within 45 days of receiving such claims.

Claims that do not meet the definition of "clean" claims are "other-than-clean" claims. "Other-than-clean" claims require investigation or development external to the contractor's Medicare operation on a prepayment basis.

The contractor shall process all "other-than-clean" claims and notify the provider and provider of the determination within 45 calendar days of receipt. (See Pub100-4, Chapter 1,§80.2.1 for the definition of "receipt date" and for timeliness standards for clean claims.) However, when the contractor develops to the provider/supplier or beneficiary for additional information, the contractor shall cease counting the 45 calendar days on the day that the contractor sends the development letter. Upon receiving the materials requested in the development letter from the provider/supplier and/or beneficiary, the contractor shall resume counting the 45 calendar days.

EXAMPLE:

> *The contractor receives a claim on June 1st, but does not send a development letter to the provider/supplier/ and/or beneficiary until June 5th. In this situation, 5 of the 45 allotted calendar days will have already passed before the contractor requested the additional information. Upon receiving the information back from the provider/supplier and/or beneficiary, the contractor has 40 calendar days left to process the claim and notify the individual that filed the claim of the payment determination for that claim.*

Contractors shall follow existing procedures relative to both the length of time the provider/supplier and/or beneficiary is afforded to return information requested in the development letters and situations where the provider/supplier and or beneficiary does not respond.

Contractors shall report the number of other-than-clean claims processed in 45 days or less on Form Y of the Contractor Reporting of Operational and Workload Data (CROWD) report. Use identifier code "0005" in column 1 to report this information Report the number of other-than-clean claims processed in 46 days or longer on Form Y of the CROWD system, under column 1 on a line using code "0006" as the identifier.

The following types of claims do not apply to this instruction:

- *Claims where the Social Security Administration blocks a beneficiary's Health Insurance Claim Number (HIC),*
- *Claims the contractors are required to hold due to CMS instructions,*
- *Translator rejects,*
- *Claims where CWF is unable to process due to technical issues with the CWF beneficiary record or beneficiary identification issues,*
- *Claims submitted by a hospice, and*
- *claims in development due to processing requirements (e.g. medical review), in Publication 100-8, the Medicare Program Integrity Manual*