CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 454 **Date: JANUARY 28, 2005**

CHANGE REQUEST 3653

SUBJECT: Definitions of Electronic and Paper Claims

I. SUMMARY OF CHANGES: The definitions of electronic and paper claims contained in Chapter 1, §80.2.1.1 have been deleted and replaced with a cross-reference to Chapter 24, §30.2 to avoid duplication of data and eliminate the possibility of differences within the IOM in these definitions.

NEW/REVISED MATERIAL - EFFECTIVE DATE: April 1, 2005
IMPLEMENTATION DATE: April 4, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply only to the red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will only receive the new/revised information, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS:
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	1/80.2.1.1/Payment Ceiling Standards

III. FUNDING: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 454	Date: January 28, 2005	Change Request 3653

SUBJECT: Definitions of Electronic and Paper Claims

I. GENERAL INFORMATION

A. Background: All CMS general electronic media claims policies are contained in Chapter 24. This change is being made to eliminate duplication of data and the possibility of differences in the reported CMS definitions of those words. The definitions previously reported in Chapter 1, § 80.2.1.1 erroneously included claims submitted by diskette in the definitions of both electronic and non-electronic claims, contrary to the information in chapter 24 which indicated that claims submitted by diskette are not considered electronic.

B. Policy: Claims delivered to a Medicare carrier, DMERC, or intermediary via diskette for processing are not considered to be electronically submitted claims for application of the payment floor.

C. Provider Education: None.

II. BUSINESS REQUIREMENTS

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

Requirement Number	Requirements	Responsibility (place an "X" in the columns that apply)								
						Shared System Maintainers				Other
		FI	RHHI	Carrier	DMERC	FISS	MCS	VMS	CWF	
3653.1 Ch. 1, Sec. 80.2.1.1	Medicare contractors shall use the definitions located in Chapter 24, § 30.2 to determine which claims are considered electronic and which are considered paper for application of the payment ceiling.	X	X	X	X					

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

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

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: April 1, 2005 **Implementation Date:** April 4, 2005 **Pre-Implementation Contact(s):** Kathleen Simmons (Ksimmons@cms.hhs.gov) **Post-Implementation Contact(s):** Kathleen Simmons (Ksimmons@cms.hhs.gov)	**Medicare contractors shall implement these instructions within their current operating budgets.**

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80.2.1.1 - Payment Ceiling Standards

(Rev. 454, Issued: 01-28-05, Effective: 04-01-05, Implementation: 04-04-05)

Payment ceilings were implemented for clean claims received by the carrier or FI on or after April 1, 1987. "Clean" claims must be paid or denied within the applicable number of days from their receipt date as follows:

Time Period for Claims Received	Applicable Number of Calendar Days
01-01-93 through 09-30-93	24 for EMC and 27 for paper claims
10-01-93 and later	30

All claims (i.e., paid claims, partial and complete denials, no payment bills) including PIP and EMC claims are subject to the above requirements.

Interest must be paid on claims that are not paid within the ceiling period.

The count starts on the day after the receipt date and it ends on the date payment is made. For example, for clean claims received October 1, 1993, and later, if this span is 30 days or less, the requirement is met.

RAPs submitted by home health agencies under the HH PPS (records with type of bill 322 or 332 and dates of service on or after October 1, 2000) are not Medicare claims as defined under the Social Security Act. Since they are not considered claims, they (records with type of bill 322 or 332 and dates of service on or after October 1, 2000) are not subjected to payment ceiling standards and interest payment.

See Chapter 24, § 30.2 for definitions of electronic and paper claims for use in application of the Medicare payment floor. See Chapter 1, § 80.2.1.2 for differentiation between electronic claims that comply with the requirements of the standard implementation guides adopted for national use under HIPAA and those submitted electronically using pre-HIPAA formats supported by Medicare. This HIPAA format differentiation applies to the payment floor, but not to the ceiling.