CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 976	**Date: OCTOBER 28, 2011**
	Change Request 7550

SUBJECT: Determining Claims Processing Timeliness When Held Claims Are Later Subject to an Additional Documentation Request

I. SUMMARY OF CHANGES: This Change Request corrects an error in claims processing timeliness determinations that may affect claims that have been held at CMS direction.

EFFECTIVE DATE: April 1, 2012
IMPLEMENTATION DATE: April 2, 2012

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: 976	Date: October 28, 2011	Change Request: 7550

SUBJECT: Determining Claims Processing Timeliness When Held Claims Are Later Subject to an Additional Documentation Request

Effective Date: April 1, 2012

Implementation Date: April 2, 2012

I. GENERAL INFORMATION

A. Background: Occasionally, it is important for Medicare contractors to hold claims that have been submitted by providers. Typically, this happens when a quarterly systems release needs additional testing or when new legislation contains effective dates that do not allow Medicare systems to make all the required changes in time. In these cases, the Centers for Medicare and Medicaid Services (CMS) issue a technical direction letter (TDL) to contractors with instructions to hold claims for a defined period of time. For institutional claims, these TDLs typically instruct contractors to append condition code 15 (clean claim delayed by the processing system) to the held claims, so that the claims are not counted against the contractor's performance on the claims processing timeliness standard.

Once Medicare contractors release the held claims, the claims are subject to normal claims processing including edits that may select a claim for development. When a claim is suspended and an additional documentation request is triggered, Medicare systems append condition code 64 (other than clean claim) on the claim record. It is appropriate for condition code 64 to be added to these claims, since the documentation request has occurred. Currently, however, the condition code 64 replaces the condition code 15.

Since the claim was held at CMS direction at one point in processing, it is not appropriate for the condition code 15 to be removed in these cases. Removing the code may cause the claim to be counted toward claims processing timeliness in error. The requirements below correct Medicare systems to no longer remove condition code 15 from claims when condition code 64 is added.

Since the dates that condition codes are added to claims are not necessarily recorded on the claim record, the resulting claims may appear to contain contradictory information. They will have codes that indicate both a clean claim and an other than clean claim on the same claim record. Contractors should understand these two codes are representing a series of events, in which the claim was initially held at CMS direction and then subsequently subject to an additional documentation request.

B. Policy: Condition code 15 will not be removed from previously held claims if those claims are subject to an additional documentation request.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
7550.1	Medicare contractors shall not remove condition code 15, if present, from claims when condition code 64 is added and the claim has been subject to an additional documentation request.						X				
7550.2	Medicare contractors shall exclude claims from claims processing timeliness calculations when both condition code 15 and 64 are present.						X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
	None.										

IV. SUPPORTING INFORMATION

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

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Wil Gehne, wilfried.gehne@cms.hhs.gov, 410-786-6148

Post-Implementation Contact(s): Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

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Section B: *For Medicare Administrative Contractors (MACs)*:

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