Program Memorandum Intermediaries

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

Transmittal A-03-034 Date: MAY 2, 2003

CHANGE REQUEST 2593

SUBJECT: Modification to Medicare Timely Filing Edit for Claims Paid Under Certain Prospective Payment Systems

I. GENERAL INFORMATION

A. Background

Federal regulations define the timely filing period for Medicare claims relative to the date a service is provided. Services provided in the first 3 quarters of a calendar year are considered timely if received by December 31 of the year following the service year. Services provided in the last quarter of a calendar year are considered timely if received by December 31 of the second year following the service year.

The payment methodologies of certain Medicare prospective payment systems require services for extended periods of time to be paid a single bundled payment. The prospective payment systems for home health agencies, inpatient hospitals, Long Term Care Hospitals (LTCH), and Inpatient Rehabilitation Facilities (IRF) all require single per episode or per discharge payments for a periods of days or weeks. Claims paid under these prospective payment systems cannot be split into discrete September and October billing periods. For instance, Home Health Prospective Payment System (HH PPS) claims represent an episode of care of up to 60 days and so may easily span from the third quarter into the fourth quarter of a given calendar year. Since these claims cannot be split into discrete September and October billing periods and paid accurately, HH PPS episode claims with any service dates on or after October 1 must be considered timely if received by December 31 of the second year following the service year. Similarly, inpatient hospital, LTCH, and IRF claims can represent extended periods of time between admission to and discharge from the facility. Claims for these facilities with discharge dates on or after October 1 must be considered timely if received by December 31 of the second year following the service year.

Medicare systems are not currently programmed to reflect this. The edit enforcing timely filing of these claims sets based on the claim "From" date (or HH PPS Request for Anticipated Payment [RAP] "From" date). The edit does not recognize that a claim with a "From" date in September will frequently contain services spanning into October. The requirements below provide instructions to correct Medicare systems programming so that the timely filing edit does not set in error on claims spanning October 1 in 2003 and subsequent years.

Note that provider initiated adjustment requests for inpatient hospital claim types (type of bill 117) are required to be submitted within 60 days of the date of the remittance advice if the adjustment results in a change to a higher weighted DRG. As a result, there is a limited exclusion for this type of bill in the requirements below. Note also that claims for SNF Part A and Swing Bed stays, while also paid under an inpatient prospective payment system, are not included in these changes since the claims are paid on a per diem basis and can be split into discrete September and October billing periods.

B. Policy

Regulations regarding the timely filing period for Medicare claims are found at 42 CFR 424.44. The 60 day requirement for inpatient hospital claim types is found in the Medicare Intermediary Manual at §3610.8 as modified by Interim Manual §3664.2 (IM-93-2).

II. BUSINESS REQUIREMENTS

Req. #	Requirements	Resp.
2593.1	Medicare systems shall allow a timely filing period ending December 31 of the service year plus two years to a HH PPS Request for Anticipated Payment (RAP) if the corresponding episode period may span October 1 of a given year.	SS
2593.1.1	Medicare systems shall identify HH PPS RAPs using types of bill 322 and 332 and dates of service on or after October 1, 2000.	SS
2593.1.2	Medicare systems shall identify episodes that may span October 1 using RAP "From" dates on or after August 3 and on or before September 30 of a given year.	SS
2593.2	Medicare systems shall compare the receipt date of an HH claim to the latest line item service date to determine whether the HH claim is beyond the Medicare timely filing period.	SS
2593.2.1	Medicare systems shall identify HH PPS claims using all types of bill 32x and 33x other than 322 and 332 and dates of service on or after October 1, 2000.	SS
2593.2.2	Medicare systems shall allow HH PPS claims with all line item service dates on or before September 30 of a given year a timely filing period ending December 31 of the service year plus one year.	SS
2593.2.3	Medicare systems shall allow HH PPS claims with any line item service dates on or after October 1 of a given year a timely filing period ending December 31 of the service year plus two years.	SS
2593.3	Medicare systems shall compare the receipt date of inpatient PPS hospital, LTCH and IRF claims to the claim "Through" date to determine whether the original claim is beyond the Medicare timely filing period.	SS
2593.3.1	Medicare systems shall identify inpatient PPS hospital claims using all types of bill 11x, except 117 where another limit applies, where the last four digits of the provider number are in the 0001 - 0879 range.	SS
2593.3.2	Medicare systems shall identify IRF claims using all types of bill 11x, except 117 where another limit applies, where the last 4 digits of the provider number are in the 3025 – 3099 range or where the 3rd digit of the provider number is "T."	SS
2593.3.3	Medicare systems shall identify LTCH claims using all types of bill 11x, except 117 where another limit applies, where the last 4 digits of the provider number are in the 2000 - 2299 range.	SS
2593.3.4	Medicare systems shall allow inpatient PPS hospital, LTCH and IRF claims with claim "Through" dates on or before September 30 of a given year a timely filing period ending December 31 of the service year plus one year.	SS
2593.3.5	Medicare systems shall allow inpatient PPS hospital, LTCH and IRF claims with claim "Through" dates on or after October 1 of a given year a timely filing period ending December 31 of the service year plus two years.	SS

III. Supporting Information and Possible Design Considerations

A. Other Instructions

X-Ref Requirement #	Instructions
2593.3.1, 2593.3.2, 2593.3.3, 2593.3.4, and 2593.3.5	The edit applies only if the provider is PPS effective as of the 'through' date of the claim
2593.3.1, 2593.3.2, and 2593.3.3	Current enforcement of the 60-day requirement for inpatient adjustments that result in a change to a higher weighted DRG should not be modified.

B. Design Considerations N/A

C. Interfaces N/A

D. Contractor Financial Reporting/Workload Impact N/A

E. Dependencies N/A

F. Testing Considerations N/A

IV. Attachment(s) N/A

Version: Final 4/03/2003 Implementation Date: October 1, 2003 Discard Date: October 1, 2004 Post-Implementation Contact: Regional Offices	Effective Date: October 1, 2003 Funding: These instructions should be implemented within your current operating budget. Pre-Implementation Contact: Wil Gehne, (410) 786-6184, wgehne@cms.hhs.gov