80.2.1 – Receipt Date

(Rev. 114, 02-27-04)

A3-3600.1-Item 7

The receipt date is the date the carrier or FI receives a claim on which the data are sufficiently complete to qualify as a claim. The receipt date is used to calculate interest payments when due for clean claims, to report statistical data on claims to CMS, such as in workload reports, and to determine if a claim was received timely.

Paper claims received by 5:00 p.m. on a business day, or by closing time if the carrier or FI routinely ends its public business day between 4:00 p.m. and 5:00 p.m., must be considered as received on that date, even if the carrier or FI does not open the envelopes in which the claims are received or does not enter the data into the claims processing system until a later date. Paper claims received after 5:00 p.m. or the carrier or FI's close of business between 4:00 p.m. and 5:00 p.m. may be considered as received on the next business day.

Paper claims are considered received if delivered to the carrier or FI's place of business by the U.S. Postal Service, picked up from a P.O. box(es), or otherwise delivered to the carrier or FI's place of business by its normal close of business time. If the carrier or FI uses a P.O. box for receipt of mailed claims, it must have its mail picked up from its box(es) at least once per business day unless precluded on a particular day by the emergency closing of its office or its postal box site.

As electronic claim tapes and diskettes *that may be* submitted by providers or their agents *to an FI* are also subject to manual delivery, rather than direct electronic transmission, the paper claim receipt date establishment rule also applies to *establish the date of receipt of claims submitted on s*uch tapes and diskettes.

Electronic claims transmitted *directly* to a FI, *carrier,* or to a clearinghouse with which the FI *or carrier* contracts as its representative for the receipt of its claims, by 5:00 p.m. in the *FI's or carrier's* time zone, or by its closing time if it routinely closes between 4:00 p.m. and 5:00 p.m., must likewise be considered as received on that day even if the FI *or carrier* does not upload or process the data until a later date. ***NOTE:*** *The payment floor differentiation in 80.2.1.2 does not apply when establishing date of receipt. Use the same methodology to establish the date of receipt for all electronic claims.*

Paper and electronic claims that do not meet the basic legibility, format, or completion requirements are not considered as received for claims processing and may be rejected from the claims processing system. Rejected claims are not considered as received until resubmitted as corrected, complete claims. The carrier or FI may not use the data entry date, the date of passage of front-end edits, the date the document control number is assigned, or any date other than the actual calendar date of receipt as described above to establish the official receipt date of any claim.

The following exception applies to establishment of receipt date. Where its system or hours of operation permit, *an FI or carrier* may, at its option, classify a paper or electronic claim received between 5:00 p.m. (or its closing time between 4:00 p.m. and 5:00 p.m.) and midnight, or on a Saturday, Sunday, holiday, or during an emergency closing period as received on the actual calendar date of delivery or receipt. Unless its office closes early in an isolated situation due to an emergency, its cutoff time for establishment of a receipt date may never be earlier than 4:00 p.m.

A carrier or FI may not make system changes, extend its hours of operation, or incur significant additional costs solely to begin to accommodate late receipts if not already equipped to do so.

The cutoff time for paper claims may not exceed the cutoff time for electronic claims. A number of carriers or FIs have reported that a later electronic cutoff time has been an incentive for provider use of electronic filing. Carriers and FIs are encouraged to use this tool where their system and overnight batch run schedules permit. Likewise, at a carrier or FI's option, it may consider electronic claims received on a weekend or holiday as received on the actual calendar date of receipt, even though paper claims received in a P.O. box on a weekend or holiday would not be considered received until the next business day.

Where a carrier or FI prepares bills for payment for purchased DME because the $50 tolerance is exceeded (see §40.4.1) it establishes any date consistent with its system processing requirements as the receipt date for the second and succeeding bills. It uses the date as close to its payment as possible.

80.2.1.1 - Payment Ceiling Standards

(Rev. 114, 02-27-04)

A3-3600.1A.1, B2-5240.11.C

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.

For purposes of the payment floors and ceilings, *for Medicare purposes*:

An "electronic claim" is one that is submitted via central processing unit (CPU) to CPU transmission, tape, diskette, direct data entry, direct wire, or personal computer upload or download. *C*laims submitted via digital FAX/OCR*, diskette or touch-tone phone* are not counted or paid as EMC. *See 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.*

A "paper claim" is submitted and received on paper, including fax print-outs. This also includes claims the carrier or FI received on paper and read electronically with OCR technology.

80.2.1.2 - Payment Floor Standards

(Rev. 114, 02-27-04)

A3-3600.1, HO-401.B, B2-5240.11.D

Carriers or FIs do not pay, issue, mail, or otherwise pay for any claim receive*d* from providers within the waiting period as indicated below. The length of the waiting period is determined by the date a claim is received. The carrier or FI starts its count on the day after the day of receipt. For example, a paper claim received October 1, *2003*, can be paid on or after October 28, *2003*. An electronic claim received November 1, *2002*, can be paid on or after November 15, *2002*. See §80.2.1.1 for the definition of EMC and paper claims.

Claim Receipt Date	**Waiting Period (Days)**
01-01-93 through 09-30-93	14 for EMC and 26 for paper claims
10-01-93 *through 6/30/04*	13 for EMC and 26 for paper claims

07-01-04 and later *13 for HIPAA-compliant EMC*

26 for paper and non-HIPAA EMC

NOTE: No-payment claims are not subject to the payment floor standards. *Also RAPs submitted by Home Health Agencies and PIP payments are not considered claims. PIP payment and payment for RAPs are not subject to payment floor standards.*

Effective October 16, 2003, HIPAA requires that claims submitted to Medicare electronically comply with standard claim implementation guides adopted for national use under HIPAA. Claims submitted via direct data entry (DDE) where supported by carriers and FIs are considered to be HIPAA-compliant electronic claims. A contingency plan has been approved to enable claims to continue to be submitted temporarily after October 15, 2003 in a pre-HIPAA electronic format supported by Medicare. Effective July 1, 2004, the Medicare contingency plan is being modified to encourage migration to HIPAA formats. Effective July 1, 2004, for purposes of the payment floor, only those claims submitted in a HIPAA-compliant format will be paid as early as the 14th day after the date of receipt. Claims submitted electronically under a pre-HIPAA format supported by Medicare under the contingency plan period, including the UB-92 flat file, the National Standard Format (NSF), a pre-version 4010A1 X12 837, or on paper after July 1, 2004 will not be eligible for payment earlier than the 27th day after the date of receipt. All claims subjected to the 27-day payment floor, including non-HIPAA electronically submitted claims, are to be reported in the paper claims category for workload reporting purposes.

This differentiation in treatment of HIPAA-compliant and non-HIPAA-compliant electronic claims does not apply to Contractor Performance Evaluation (CPE) reviews of carriers and FIs conducted by CMS. For CPE purposes, carriers and FIs must continue to process the CPE specified percentage of clean paper and clean electronic (HIPAA or non-HIPAA) claims within the statutorily specified timeframes.

80.2.2.1 - Determining and Paying Interest

(Rev. 114, 02-27-04)

The carrier or FI must pay interest on clean, non-PIP (FIs) claims for which it does not make payment within 30 calendar days beginning on the day after the receipt date. It will select claims for interest based upon:

- Reimbursement amount is greater than zero.
- Processing time exceeds 30 days (Julian payment date minus Julian receipt date equals more than 30).

The interest rate and formula for calculation are shown above. The interest rate is determined by the rate applicable on the carrier or FI's payment date.

The carrier or FI applies interest to the payment after all deductions (e.g., deductible, coinsurance, and MSP). Interest is rounded to the nearest penny.

A - Reporting Interest Payment on Remittance Record

See 100-22 for remittance advice completion instructions.

B - Payment Made to Beneficiary

If payment is made directly to the beneficiary on a clean claim for which the carrier or FI did not make payment within the applicable number of days (as described in subsection A.1.) the carrier or FI must apply interest. It adds the following messages on any beneficiary notice that it prepares:

> Your payment includes interest since we were unable to process your claim timely.

C - Claims Paid Upon Appeal

Interest payments are not payable on clean claims initially processed to denial and on which payment is made subsequent to the initial decision as a result of an appeal request. This applies to appeals where more than the applicable number of days elapsed before an initial denial, but the claim was later paid upon appeal. Where an appeal of a previously paid claim results in increased payment FIs follow the following section.

D - Interest on Postpayment Denials and Other Adjustments

If a paid claim is later denied in full, the carrier or FI recovers any interest paid as well as the incorrect payment. It does not pay interest on the related no payment bill. If the claim is partially denied, interest is payable on the reduced amount. The FI recalculates the interest due based upon the new reimbursement amount. It uses the rate of interest and elapsed days applicable to the original claim. This can be accomplished by applying a ratio of the new reimbursement amount (from its debit action) to the reimbursement amount on the initial claim (from its credit action). It multiplies the result by the interest amount paid on the initial claim. The result is the interest amount payable on its debit action. The following formula is used to calculate interest:

$$\text{Interest} = \frac{\text{Debit action reimbursement amount}}{\text{Credit action reimbursement amount}} \times \text{original interest paid}$$

Use of the formula is preferable to expanding an FI system to handle multiple scheduled payment dates and calculation procedures.