Beneficiary Submitted Claims – JA5683

Note: This job aid was revised to correct the website link to the Code of Federal Regulations (CFR) 411.15. All other information remains the same.

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Key Words	MM5683, CR5683, R1588CP, Beneficiary, Submitted
Contractors Affected	• Medicare Carriers • Part A/B Medicare Administrative Contractors (A/B MACs)
Provider Types Affected	Physicians, providers, and suppliers submitting claims to Medicare Carriers A/B MACs for services provided to Medicare beneficiaries

- CR5683 updates the procedures for processing claims submitted by Medicare beneficiaries to carriers and/or A/B MACs and serves as a reminder to providers and suppliers that they are required by law to submit claims to Medicare for services they render to Medicare beneficiaries.
- These updates do not apply to beneficiary claims submitted to durable medical equipment MACs (DME MACs).

Provider Needs to Know…

- Medicare contractors are instructed to process beneficiary submitted claims for services that:
  - Are not covered by Medicare (e.g., for hearing aids, cosmetic surgery, personal comfort services, etc., in accordance with its normal processing procedures; see 42 CFR 411.15 at http://edocket.access.gpo.gov/cfr_2004/octqtr/pdf/42cfr411.15.pdf for details); and

- Are covered by Medicare when the beneficiary has submitted a complete claim (Patient's Request for Medical Payment, Form CMS-1490S; *http://www.cms.hhs.gov/CMSForms/CMSForms/*) and all supporting documentation associated with the claim, including an itemized bill with the following information:
  - Date of service,
  - Place of service,
  - Description of illness or injury,
  - Description of each surgical or medical service or supply furnished,
  - Charge for each service,
  - The doctor's or supplier's name, address, and
  - The provider or supplier's National Provider Identifier.

- If an incomplete claim (or a claim containing invalid information) is submitted, the contractor will return the claim as incomplete with an appropriate letter. The Centers for Medicare & Medicaid Services (CMS) will be providing suggested language for that letter in a later transmittal.
- In addition, contractors will manually return (to the beneficiary) beneficiary submitted claims, when the beneficiary used Form CMS-1500, along with instructions on how to complete and return the appropriate beneficiary claims on Form CMS-1490S for processing.
- When manually returning a beneficiary submitted claim (Form CMS-1490S) for a Medicare-covered service (because the claim is not complete or contains invalid information), the contractor will maintain a record of the beneficiary submitted claim for purposes of the timely filing rules in the event that the beneficiary re-submits the claim.
- When returning a beneficiary submitted claim, the contractor will inform the beneficiary by letter that:
  - The provider or supplier is required by law to submit a claim on behalf of the beneficiary (for services that would otherwise be payable); and
  - In order to submit the claim, the provider must enroll in the Medicare program.
- Medicare contractors should encourage beneficiaries to always seek non-emergency care from a provider or supplier that is enrolled in the Medicare program.
- If a beneficiary receives services from a provider or supplier that refuses to submit a claim on the beneficiary's behalf (for services that would otherwise be payable by Medicare), the beneficiary should:
  - Notify the contractor in writing that the provider or supplier refused to submit a claim to Medicare, and
  - Submit a complete Form CMS-1490S with all supporting documentation.
- Upon receipt of both the beneficiary's complaint that the provider/supplier refused to

submit the claim, and the beneficiary's claim Form CMS-1490S (and all supporting documentation), the contractor will process and pay the beneficiary's claim if it is for a service that would be payable by Medicare were it not for the provider's or supplier's refusal to submit the claim and/or enroll in Medicare.

- Contractors will maintain:
  - Documentation of beneficiary complaints involving violations of the mandatory claims submission policy, and
  - A list of the top 50 violators (by state) of the mandatory claim submission policy.
- The instructions provided in CR5683 do not apply to foreign claims, and they do not apply to beneficiary claims submitted to DME MACs (for DME, prosthetics, orthotics, and supplies (DMEPOS)).
- The processing of foreign claims will remain unchanged, and DME MACs should continue to follow procedures that are currently in place.

Background

- All providers and suppliers are required to enroll in the Medicare program in order to receive payment.
- In addition, the Social Security Act (Section 1848 (g)(4)(A); *http://www.ssa.gov/OP_Home/ssact/title18/1848.htm*) requires all providers and suppliers to submit claims for services rendered to Medicare beneficiaries.
- The current manual requirement instructs Medicare contractors to provide education to the providers and suppliers explaining the statutory requirement, including possible penalties for repeatedly refusing to submit claims for services provided.

Operational Impact

Contractors will continue to process foreign and DMEPOS claims per current CMS instructions.

Reference Materials

The related MLN Matters® article can be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5683.pdf* on the CMS website.

The official instruction (CR5683) regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1588CP.pdf* on the CMS website.