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For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

**FOR FURTHER INFORMATION CONTACT:**

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**SUPPLEMENTARY INFORMATION:**

*Inspection of Public Comments:*

Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. by calling (410) 786-7197.

**I. Background**

The purpose of the statement of intent (SOI) procedures is to extend the timely filing period for the submission of an initial Medicare claim. An SOI, by itself, does not constitute a claim, but rather is a means of extending the deadline for filing a timely and valid claim. Our regulations at 42 CFR 424.32, "Basic requirements for all claims," and § 424.44, "Time limits for filing claims," require that Medicare claims be filed on Medicare-designated claims forms by providers, suppliers, and beneficiaries according to Medicare instructions, by the end of the year following the year in which the services were furnished. Services furnished in the last 3 months of a calendar year are deemed to be furnished in the subsequent calendar year, and thus, in this situation, a provider, supplier, or beneficiary has until December 31 of the second year following the year in which the services were furnished to file claims. Where an SOI has been filed with the appropriate Medicare contractor and the contractor notifies the submitter of the SOI that the SOI is valid (that is, the SOI sufficiently identifies the beneficiary and the items or services rendered), the period in which to file a claim may be extended an additional 6 months after the month of the contractor's notice.

The original regulation on extending the time to file claims for Medicare

benefits was codified at 20 CFR 405.1693, and was based on 20 CFR 404.613, which pertained to applications for Social Security benefits. Section 404.613 reflected the Social Security program's interest in allowing virtually any type of writing to be a placeholder for filing a claim for Social Security benefits, provided that a perfected claim was submitted shortly thereafter. Because we believed that Medicare beneficiaries might sometimes need extra time to file a Part B claim due to extenuating circumstances such as poor health or unfamiliarity with the claims filing process, we instituted the SOI procedures.

Experience has shown, however, that beneficiaries rarely submit SOIs directly. Medicare contractors that we surveyed reported no SOIs were directly submitted by beneficiaries for the claims filing period ending December 31, 2000, the latest year for which we have complete data. One reason for the lack of beneficiary-initiated SOIs is the fact that beneficiaries rarely need to file claims. The percentage of Part B claims taken on assignment is about 98 percent today, compared to about 52 percent in 1975. ("Assignment" is the process by which the physician or other supplier agrees to accept Medicare payment in full for a Part B item or service and file the claim for such payment.) Even for Part B claims not taken on assignment, the law now requires the physician or other supplier to file the claim and provides for sanctions for failure to do so. (See section 1848(g)(4) of the Act (42 U.S.C. 1395w-4(g)(4)). The number of Part A claims filed by beneficiaries has always been minimal because the law requires that payment for Part A services generally be made only to providers of services, with very limited exceptions. (See section 1814(a) of the Act (42 U.S.C. 1395f(a)). Thus, we believe that the SOI procedures are no longer necessary insofar as they are not serving their intended purpose.

Further, we believe retention of the SOI procedures is counterproductive because of the amount of resources needed to process SOIs submitted by States and because the SOI procedures may encourage or facilitate inappropriate behavior on the part of some States and some providers.

Each year, our contractors receive an enormous number of SOIs that are submitted by States that, having first made Medicaid payments to dually-eligible (that is, Medicare and Medicaid) beneficiaries, subsequently believe that Medicare should be the proper payor. Subsequent to several court decisions in the early 1990s, we permitted States to "stand in the shoes" of a dually-eligible

beneficiary with respect to claims filing and appeals. For example, States are not required to obtain a beneficiary's signature in order to request providers to file a Part A claim or in order to file an appeal. We also have permitted States and their contractors to file SOIs on the States' behalf or as appointed representatives of the beneficiaries.

The great majority of these SOIs are filed on paper and thus must be manually processed to determine whether they are valid SOIs. (According to our requirements, SOIs must contain detailed and specific information to ensure that a subsequently filed claim was in fact protected by an SOI. (See Program Memorandum AB-03-61)). Also, these SOIs are typically filed in large batches near the end of the timely filing period. All of these factors contribute to the amount of resources and consequent cost incurred in processing the SOIs.

We also believe that the SOI procedures may contribute to States "paying and chasing" instead of following the required cost-avoidance procedures, and to the incorrect submission of claims to Medicaid by providers. Our regulations at § 433.139(b) provide that, unless a waiver is granted under § 433.139(e), a State Medicaid agency that has established the probable existence of third party liability (including Medicare liability) at the time a claim for Medicaid payment is presented to it, must reject the claim and return it to the provider for a determination of liability. This process is known as cost avoidance. Some States, however, have been paying thousands of Medicaid claims, despite the knowledge that the beneficiaries involved are entitled to Medicare. These States subsequently identify a significant portion of the claims that they have paid as ones for which Medicare should be the proper payor, and use the SOI procedures to extend the time for providers to file claims.

The fact that such large numbers of claims are paid first by Medicaid and then identified as payable by Medicare raises the inference that providers are not as careful as they should be as to which payor they initially submit claims, and that States, by initially paying such claims, are not fully practicing cost avoidance. We are concerned that the availability of the SOI procedures to extend the time for filing claims is contributing to such inappropriate behavior. We also note that many of the claims filed with Medicare subsequent to the SOIs are "demand bills," which require full medical review, thus increasing the