



Document Number FOD - 7000
90-Day 837 Electronic Claim
Submission Regulation



Overview

Under HIPAA regulations, the acceptable reasons for a delay in claim submissions over 90 days will expand to eleven. Pre-HIPAA, the number of acceptable reasons was seven. The required codes should be entered in loop 2300, segment CLM, element 20 of the 837P (Professional), 837I (Institutional), or 837D (Dental) claim submission.

837 Electronic Claims over 90 days (but less than two years) from the date of service may be submitted if the delay is due to one (or more) of the following conditions:

<u>Code</u>	<u>Reason</u>
1	Proof of eligibility unknown or unavailable - Eligibility status unknown on Date of Service.
2	Litigation - must be submitted within thirty days from the time submission came within the control of the Provider.
3	Authorized Delays - Delays previously approved.
4	Delay in Certifying Provider - Provider not certified by Medicaid within 90 days of Date of Service.
5	Delay in Supplying Billing Forms - Billing forms were not available within 90 days of Date of Service.
6	Delay in Supplying Custom-made Appliances <i>** NYS Medicaid does not accept this reason for delay and will deny a code value of "6".</i>
7	Third Party Processing Delay - must be submitted within thirty days from the time submission came within the control of the Provider.
8	Delay in Eligibility Determination - must be submitted within thirty days from the time of notification.
9	Original Claim Rejected or Denied – due to a reason unrelated to the billing limitations rule.
10	Administrative Delay in the Prior Approval Process - claims should be submitted within 90 days from the "Review Date" as noted on the prior approval form.
11	Other (IPRO Denial/Reversal or Interrupted Maternity Care) - Island Peer Review Organization previously denied claim but denial was reversed on appeal. Pre-natal care claims over 90 days because delivery performed by a different practitioner.

Note: The 30 day, 60 day and 90 day submission periods referred to are calendar days. For more details about delayed claim submission, please refer to your Provider Manual, Billing Section.

Claims over Two Years Old

Claims over two years old will be denied for edit 1292. The Department will only consider claims over two years old for payment if the Provider can produce documentation explaining the cause of the delay was the result of errors by the Department, the local social services districts, or other agents of the Department. In addition, payments will be made for claims submitted in circumstances where a court has ordered the Department to make payment.

If a Provider believes that claims denied for edit 1292 are payable due to error by the Department, its agents or court order, they may request a review. All claims must be submitted **within 90 days of the date on the remittance advice** with the supporting documentation to:

New York State Department of Health
 Two-Year Claim Review
 150 Broadway, Suite 6E
 Albany, New York 12204-2736

Claims submitted for review without the appropriate documentation, or those NOT submitted within the 90-day time period for review, will NOT be considered.