



Document Number FOD - 7001

90-Day Paper Claim Submission Regulation**Overview**

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:

- Litigation - must be submitted within thirty days from the time submission came within the control of the Provider.
- Medicare and other insurance processing delays must be submitted within thirty days from the time submission came within the control of the Provider.
- Delay in Medicaid Client Eligibility Determination - must be submitted within thirty days from the time of notification.
- Original claim rejected or denied due to a reason unrelated to the 90-day regulation - must be resubmitted within sixty days of the date of notification.
- Administrative Delay - (prior approval, enrollment process, rate changes, etc.) by the Department of Health or other State Agency.
- IPro denial/reversal (Island Peer Review Organization previously denied claim but denial was reversed on appeal.)
- Interrupted Maternity Care (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.

Submitting Claims over 90 Days but less than Two Years Old

Submission Instructions - Attach a cover letter to each claim form and indicate one of the acceptable reasons for late submission as shown above or a copy of the enrollment waiver letter if the State failed to issue the Provider with a Medicaid ID within 90 days of their enrollment application. This cover letter should be exactly the same size and paper quality as that of the claim form.

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.

A sample form follows on the next page.

Computer Sciences Corporation
PO Box 4601
Rensselaer, NY 12144-4601

The attached claim is for services which were provided more than 90 days ago. The reason for late submission is:

- Litigation
- Medicare and other insurance processing delays
- Delay in Medicaid eligibility determination
- Rejection or denial of the original claim for reason(s) other than the 90-day rule
- Administrative delay (enrollment process, prior approval process, rate changes, etc.) by the department or other State agency
- Interrupted Maternity Care
- IPRO denial/reversal

Sincerely,

Enclosure: