Frequently Asked Questions on Delayed Claim Submission

Q: Effective 5/4/2016, New York Codes, Rules and Regulations (NYCRR), Title 10, Sections 763.7 & 766.4 allow certified home health agencies (CHHAs), long term home health care programs (LTHHCPs), and licensed home care services agencies (LHCSAs) up to 12 months to obtain a physician's signature on orders for services, including verbal and telephone orders. How does a CHHA, LTHHCP, or LHCSA submit a claim delayed beyond 90 days from the date of service because they were obtaining the physician's signature on orders? What delay reason code is appropriate?

A - The 90-day timely filing requirement has been extended **ONLY** for providers affected by the above regulation. Submit the claim within 30 days of obtaining the physician's signature on orders for services. Do not use a delay reason code on claims delayed due to obtaining a physician's signature on orders for services.

Q: Where can the New York State regulation pertaining to timely submission of Medicaid claims be found?

A - Title 18, Section 540.6 - Billing for medical assistance (18NYCRR 540.6) is available at:

https://regs.health.ny.gov/content/section-5406-billing-medical-assistance

Q: My reason for late claim submission does not exist on NY Medicaid's list of delay reason codes. How can I submit the claim?

A – The regulation cited above (18NYCRR 540.6) requires that claims for payment of medical care, services, or supplies to eligible beneficiaries be initially submitted within **90 days of the date of service** to be valid and enforceable, unless the claim is delayed due to circumstances outside the control of the provider. These circumstances are the basis of the acceptable delay reason codes. If none of the acceptable delay reasons apply, the claim is not payable. A claim that is aged over 90 days from the date of service cannot be submitted if no delay reason code is appropriate for the claim. This also applies to paid and denied claim resubmissions delayed more than sixty days from the time of notification of the need for correction or adjustment.

Q: A claim submitted with delay reason code 1 was denied for edit 02157 because a claim had previously been submitted by the same provider for the same beneficiary. Why should a previously submitted claim cause a current claim to be denied?

A - If there is a previously submitted claim in history for a beneficiary from a provider, the patient was already known to be a Medicaid patient for a previous submission. This means subsequent claims cannot be submitted with delay reason code 1 - Proof of eligibility unknown or unavailable because it was known by the provider and available for the previous claim submission.

Q: A claim submitted for Stop Loss reimbursement is denied for a delayed claim edit. What delay reason should be used?

A - No delay reason code should be included with claims submitted for Stop Loss reimbursement by Medicaid Managed Care Plans.

Q: Do these rules also apply to Medicaid Managed Care Organizations (MMC)?

A - All timely filing rules apply to all provider types including Medicaid Managed Care Organizations billing Medicaid.

Q: Can you explain came within control of the provider?

A- Within the control of the provider is the date the provider was notified of a change that would allow a claim to be processed. Examples are: the date of a remittance, notice of acceptance of payment from third party, notice of eligibility or when patient advises of the provider of their Medicaid coverage.

Q: When a remittance from a third-party insurance provider is mailed to the Medicaid member after 90 days, how long does the provider have to submit the claims for services?

A – The provider would have 30 days from the date the remittance was received from the member to submit the claim with the appropriate delay reason code.

Q: Who can we contact to with questions on which delay reason code to use on a specific claim?

A - Neither our billing agent (CSRA) or the Department of Health will advise on the appropriate delay reason code for specific claims submission. It is the provider's responsibility to make this determination. Please review the PowerPoint presentation found at https://www.emedny.org/ProviderManuals/AllProviders/Guide_to_Timely_Billing.pdf for information on selecting an appropriate delay reason code.

Q: We are having problems with our electronic claim vendor. Which would be the most appropriate delay reason?

A - This is not considered appropriate use of a delay reason code for claims processing and would not qualify for use of a delay reason code. It is the providers responsibility to make sure all billing systems are working properly and that claims are submitted according to the timely filing requirements.

Q: Most of the Managed Care recoupments occur beyond two years from the date of service. What is the proper way to submit these claims?

A – These claims would be submitted through normal processing and when the claims are denied for being over two years old, they would be processed under the Two-Year Waiver. Please refer to the billing guidelines for the two-year waiver process at the following web address : https://www.emedny.org/ProviderManuals/AllProviders/PDFS/Information_for_All_Providers-General_Billing.pdf

Q: Where on the UB04 should 11 A, B or C be indicated?

A - The delay reason code does not need to be indicated on the UB04, only on the delay reason code form.

Q: What is the appeal process to use when a claim containing a delay code is denied?

A – There is no appeal process. As stated in the March 2012 Medicaid Update, New York State Medicaid and its Fiscal Agent will not accept requests for exceptions to these rules. https://www.health.ny.gov/health_care/medicaid/program/update/2012/2012-03.htm

Q: Do you need proof the claim was not in our control to use delay reason number 1?

A - The provider is responsible to keep this documentation on file for six years.

Q: If Managed Care Plans are supposed to mirror the rules for MD billing why can't we use delay reason codes with Managed Care billing?

A - Providers should contact the appropriate Agency with oversight for the Managed Care plan type. Contact information can be found at https://www.health.ny.gov/.

Q: If 2017 claims have not been submitted (missed the electronic 837I file) and the provider manually bills these in EPACES (because it is under two years), what delay reason code would we use?

A - If it is provider error why these claims were not billed they are no longer valid for payment. It does not fit any of our valid delay reason codes.

Q: If I have the denied code 29 and re bill more than 2 times for same reason they can pay or not?

A - The regulation is- "any returned claim not correctly resubmitted within 60 days or on the second resubmission is neither valid nor enforceable against the department or a social services district."

Q: Is there any way to bill claims older than 90 days due to provider delays?

A - Provider delays do not qualify for billing beyond 90 days from the date of service.

Q: I used an appropriate delay reason on my claim but it was still denied. I think this claim was denied in error. Who should I contact?

A – For questions related to the denial of specific claims, contact the eMedNY call center at 1-800-343-9000.

Adjustments & Voids

Q: Can a provider void a claim if the payment amount was zero?

A - Yes, a provider can void any paid claim even if the paid amount is zero.

Q: Can a provider adjust a claim if the payment amount was zero?

A - Yes, a provider can submit an adjustment even if the claim paid zero.

Q: Does a voided claim get removed from the system?

A - No it remains in the system.

Q: What should a provider do to void services older than two years?

A – The claim can be voided using standard void procedures. eMedNY allows providers to void claims for an unlimited amount of time.

Q: If there are multiple rate adjustments, which TCN number should be used for a provider-initiated adjustment – the most recent adjusted claim or the original?

A - Retro rate adjustments (system automated) don't change the TCN number. Provider-initiated adjustments would use the most recent paid TCN number.

Q: Why was my adjustment to a paid claim denied for a timely submission claims edit?

A - Paid claims requiring correction or resubmission (adjustment) must be submitted to the Department within 60 days of the notification that a correction is needed (or when the need for correction comes to the provider's attention). Adjustments to paid claims more than 90 days after the date of service now require an appropriate delay reason code.

Q: I submitted an adjustment with delay reason code 9 and the adjustment was denied for edit 02164. Why is delay reason 9 not allowed on a claim adjustment?

A - Delay reason code 9 is used when the original claim was rejected or denied due to a reason unrelated to the timely billing limitation rules. Adjustment can only be made to paid claims. Delay reason 9 does not apply to paid claims and therefore, an adjustment to a paid claim with delay reason 9 code may be denied.

Q: Can you use an adjustment to change the Attending or Referring NPI number on a paid claim?

A – Yes, a provider can adjust a paid claim if they need to correct an attending or referring NPI number.

Q: Would a provider submit a void or adjustment to a claim if they need to return payment for one date of service that should not have been billed on the claim?

A - The provider would adjust the claim and remove the incorrectly billed dates of service. This will return payment for the incorrect date of service.

Q: How do you do a refund to the Department for an overpayment or an error in claims submission?

A - A provider would submit a void to refund the entire claim amount or an adjustment to refund a partial claim amount.

Q: If a claim is over 2 years old and there is an overpayment, how do we return the overpayment to Medicaid and request the correct reimbursement amount?

A - If there is an overpayment to be refunded to Medicaid, the provider would submit an adjustment to the claim with the corrected payment information. Funds more than the correct amount will be returned to Medicaid.

Q: A claim is adjusted using the original TCN number but the adjusted claim is denied for another factor. What TCN number do you use for the next adjustment – the original or the denied adjustment TCN number?

A - You would adjust the original paid claim TCN number since that is the only paid claim in eMedNY.

Q: We have a member that switched from HARP to MMC. The HARP premium claim was voided and the claim re-billed for the MMC premium. Claims were denied using reasons 11 and then 8. What options are available to get the claim paid?

A - The HARP premium claim was voided appropriately if the MMC provider MMIS ID is different. For the new claim submission for the MMC premium, a delay reason code might be appropriate. It is up to the provider to determine the correct delay reason code. Please review the PowerPoint presentation found at https://www.emedny.org/ProviderManuals/AllProviders/Guide_to_Timely_Billing.pdf for information on selecting an appropriate delay reason code.

Q: For claims adjustments that are two years old, does the claim need to be submitted via paper or can it be submitted on ePACES?

A - It depends on what delay reason code you are using. Each delay reason requires a different mode of submission. Currently delay reason code 2,3 and 15 for all claim types, except clinic and inpatient, and delay reason code 11, for professional claims only, are required to be billed on paper.

Q: Can you please verify that we have 6 years to send in an adjusted claim?

A - The system does allow adjustments to a claim for 6 years. This does not supersede the policy requiring submission of adjustments within 60 days of notification.