Frequently Asked Questions on Delayed Claim Submission

1. 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?

   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.

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

   Title 18, Section 540.6 - Billing for medical assistance (18NYCRR 540.6) is available at:
   http://w3.health.state.ny.us/dbspace/NYCRR18.nsf/56cf2e25d626f9f785256538006c3ed7/d6b6263dd889274785256722007691a1?OpenDocument&Highlight=0,540.6

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

   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.

4. Who can I call for assistance in determining what is the correct delay reason to use for my late claim submission?

   It is the provider’s responsibility to determine the appropriate delay reason and, if any reason applies, to report it with the claim. For additional information on acceptable delay reasons refer to the March 2012 Medicaid Update at
   and the Information for All Providers - General Billing section of the provider
5. Is there an appeal process if my reason for late submission is not on the list of acceptable reasons?

A claim cannot be submitted more than 90 days after the date of service if none of the acceptable delay reasons apply to the circumstances causing the delay. Although New York State Medicaid and its Fiscal Agent cannot accept requests for exceptions to these rules, if the delay in claim submission was caused by a State administrative delay or problems with the State’s Medicaid information system, authorization for late submission can be requested from the applicable rate setting or program policy office.

6. Can voided claims be resubmitted more than 90 days after the date of service?

You can resubmit voided claims more than 90 days after the date of service if one of the valid delay reason codes is applicable. If the reason for the void was because the paid claim requires that the beneficiary ID or billing provider ID be corrected, then delay reason code 11 applies to the resubmitted claim. Aside from reason 11, to resubmit a previously voided claim one of the other delay reason codes must apply to the new claim. In most cases adjustments, rather than voids, should be utilized to correct a paid claim.

7. Why was my adjustment to a paid claim denied for one of the edits related to timely submission of claims?

Paid claims requiring correction or resubmission must be submitted as adjustments to the paid claim 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.

8. 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?

Delay reason code 9 is used when the original claim was rejected or denied due to a reason unrelated to the billing limitation rules. If you are submitting an adjustment that means the original claim was paid, not rejected or denied. Delay reason 9 does not apply to a paid claim therefore an adjustment to a paid claim with delay reason 9 code may be denied.

9. 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?

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.
10. I have always used the same late reason code on all my claims for many years. Why am I being denied now?

NY Medicaid has been working to increase provider compliance with delay reason reporting on claims. As part of this effort, enhanced editing is now checking the validity of the delay reason codes used on both original and adjustments to paid claims. If it is determined that the delay reason reported does not apply, the claim is denied.

11. Why did a paper claim which included the same letter I have used for many years to explain the reason for delay, still get denied for a delayed claim edit?

Effective May 1, 2012, paper claims submitted over 90 days from the date of service must include a properly completed eMedNY Delay Reason Code Form. The form is available online at: https://www.emedny.org/info/TimelyBillingInformation_index.aspx.

12. I just found misplaced claims that are over 90 days old, which late reason code can I use to submit the claims?

For claims to be payable, the reason for the late submission MUST be one of the appropriate delay reasons used for circumstances that are outside the control of the provider. If your reason for the late submission is not on the list of valid delay reason codes, the claims cannot be submitted. Misplaced claims are considered within the provider's control.

13. A claim has been submitted three times (the initial and two resubmissions) but denied each time. Can it be submitted again?

The claim should not be submitted again unless you are correcting a previously uncorrected error on the claim and/or providing additional information/documentation not previously submitted (within 60 days of the initial notification of the need for such correction/information). NY Medicaid will also allow the claim resubmission if submitted within 30 days from the time submission first came within control of the provider (for example, when eligibility or third party payer issues caused the delay and are resolved after the third submission).

14. Storm-related problems from a hurricane resulted in claims being delayed beyond ninety days after the date of service. What can be done in this type of situation?

Delay reason 15 is the delay reason code used for delays due to natural disaster and is available for only limited use.

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

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

16. What delay reason code should be used when the delay is caused by problems with a provider's billing system or the provider's billing service?

Provider's system issues or problems with their billing agent do not qualify for use of any of the acceptable delay reasons. Since these circumstances are considered under the provider's control, they do not qualify for an exception to the timeliness regulation.
17. 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?

For questions related to the denial of specific claims, contact the eMedNY Call Center at 1-800-343-9000.